

Conceiving Conception: A Qualitative Examination of
Women's Experience of Medically Unexplained Infertility, Prior to
Medical Intervention.

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Abstract.

This study attempts to explore the subjective experience of women with medically unexplained infertility (MUI), prior to a medical intervention. Previous literature has yet to investigate MUI ideographically, through a phenomenological lens and most studies have taken place during or after a medical treatment. This study consists of semi-structured interviews with six women. The transcribed interviews were analysed according to the principles of Interpretative Phenomenological Analysis (IPA) and three themes were derived from the analysis: (1). The Explanatory Vacuum, exploring how the lack of medical diagnosis led the women to ‘seeking’ answers. This emphasised a special vulnerability toward self-blame and seemed to be framed by societal and cultural expectation. (2). Uncertainty, this theme examined that the core of MUI seemed to be dominated by uncertainty, manifesting in predictions of an impending medical intervention and possible outcomes. How the participants managed the uncertainty was examined, as an interesting interplay between fear and excitement emerged. (3). The Concept of Pregnancy, Past and Present, exploring how the participants ideas around pregnancy and having children dramatically shift over time. The concept of pregnancy in the present seems to be characterised in a two-sided perspective, sometimes resulting in an idealised version of pregnancy and contrasted by a disconnection from the concept of conceiving. The findings of this research thesis highlight that the experience of MUI is a multi-layered and complex phenomenon. Thus, whilst the cause of their infertility may remain unknown, the lived experience of MUI shouldn’t have to. The results of this study endeavours to inform clinical practise, apprise empirical research and hopefully contribute to further research in this area.

1.0 Introduction.

This chapter will begin by providing a critical overview of infertility and the dominant conceptualisations of infertility that are currently identified within the academic literature, this will include the underpinning epistemological assumptions. Alternative approaches to the study of infertility will then be compared, focusing on the relatively unexplored construct of medically unexplained infertility (MUI). The rationale for focusing specifically on MUI will then be outlined. This will draw on previous infertility research that has predominantly been explored during and after medical treatment. Finally, the key aims and rationale for the current research study will be discussed, including the study's research questions.

1.1 Introduction to Infertility.

The experience of infertility and involuntary childlessness and attempting to overcome that state is part of a dynamic process, with a different trajectory for each individual (Connolly et al., 1987; Woollett, 1991). The Office for National Statistics conducted a recent measure of the country's well-being (2014-2015). The study found that whilst having children does not necessarily make people happier or more satisfied; it does make them feel they have more of a reason for living. Not all couples or individuals who desire biological children are successful. This inability to have biological children is called infertility. This is defined as "the inability to naturally conceive, carry or deliver a healthy child" Deka and Sarma (2010). The failure to be able to conceive children can be experienced as a uniquely stressful situation by individuals and couples (Cousineau and Domar 2007). Assisted reproductive technologies are methods for infertile couples to achieve pregnancy by artificial or partially artificial means and the use of assisted reproductive technology has today become more familiar (Mann 2014, pg 77). Unfortunately, the suffering associated with the experience of infertility remains (Darwische 2013). The following chapter aims to

illustrate that infertility is a complex and multi-layered experience and that an awareness of the subjective experience of those effected should inform the practice of counselling psychology; in terms of both empirical research and practice.

1.2 Definitions of Infertility.

The National Institute for Health and Care Excellence (NICE) outlines the following: fertility problems exist when a woman cannot conceive (get pregnant) despite having regular unprotected vaginal intercourse, or artificial insemination, at and around the time of ovulation. Achieving pregnancy is regarded as a challenging process for all, as there is a very short window in a woman's menstrual cycle during which conception is possible (Palhaa and Lourençob 2011, pg 164). This equates only to a twenty-five percent probability of pregnancy each month.

In practice, infertility is defined in terms of time that people have been trying to conceive without success, after which formal investigations are justified and possible treatment implemented. The main causes of infertility in the UK with approximate prevalence given as a percentage are as follows: medically unexplained infertility (no identified male or female cause) accounts for twenty-five percent of the phenomena, a female's ovulatory disorders account for twenty-five percent and tubal damage has a twenty percent prevalence. Furthermore, uterine or peritoneal disorders in the female explain ten percent of infertility and the male factor for infertility has a thirty percent causation. (Source HFEA 2014).

1.3 Prevalence.

The Human Fertilisation and Embryology Association (HFEA) is the independent regulator of fertility treatment in the UK. The HFEA estimate that infertility affects one in seven heterosexual couples in the UK and it is further estimated that infertility affects approximately seventy-million people worldwide. Infertility is now an issue affecting a large

majority of our population and approximately nine percent of all couples are said to be infertile (Boivin, Bunting, Collins, & Nygren, 2007). In recent years, the number of couples seeking treatment for infertility has dramatically increased, due to factors such as postponement of childbearing in women, development of newer and more successful techniques for infertility treatment and increasing awareness of available services (Deka and Sarma 2010). Furthermore, environmental toxins, declining health conditions, medical problems, inappropriate timing of sexual intercourse, stressful lifestyles, personal problems, vocational pressures, general mental health can all be considered as contributors to infertility in both sexes (Allgeier and Allgeier 2000, Zastrow and Kirst-Aschmann 2001). It is important to note that MUI accounts for twenty-five percent of infertility and accounted for almost half of all IVF cycles in 2013. Suggesting that more and more women are seeking medical treatment for MUI. This further suggests that research into the subjective experience of those who present with infertility and MUI in clinical practise is even more relevant and potentially necessary.

1.4 Terminology.

There is a need to use careful and accurate terminology when referring to people who are involuntarily childless. Not all involuntarily childless people are infertile, and fertility appears to be a continuum, rather than a fixed definitive state (Bell 2013). The author of this thesis further identifies that infertility is a sensitive issue and it is important that the language used within this study is reflective of that understanding. Through the course of the chapters the words ‘infertile’ and ‘infertility’ will be used to describe ‘involuntarily childlessness’ with awareness, respect and sensitivity.

1.5 Infertility Counselling to Date.

Within western culture the experience of infertility is associated with more health complaints, greater anxiety, depression and complicated grief for women (Lechner, Bolman, & van Dalen, 2007). The perception of a stigma related to infertility can have an impact on the level of physical, emotional, sexual and social wellbeing (Dyer et al 2004). Both men and women will often experience a strong need for psychosocial support and guidance, which is not always adequately met by existing sources (Alesi, 2005; Malik and Coulson, 2008a; Schmidt, 2009). Boivin and Gameiro (2015) reviewed the evolution of counselling and psychotherapy in the field of infertility. Five key paradigm shifts were identified: the first paradigm focused on the 1930s when psychosomatic concepts were introduced as causal factors to infertility. The second paradigm shift occurred with the nurse advocacy movement of the 1970s, which considered the psychosocial consequences of infertility and promoted counselling to help couples grieve childlessness. The third paradigm shift occurred with the advent of assisted reproductive technology, which created a demand for mental health professionals in fertility clinics. The 1990s realised a fourth shift as reproductive medicine embraced the principles of evidence-based medicine. This introduced a much more rigorous approach to medical practice encompassing efficacy and safety, which was also extended to psychosocial interventions. The fifth and most recent paradigm shift in the new millennium occurred with the realisation that compliance with protracted fertility treatment depended on the adoption of an integrated approach to fertility care.

Regarding paradigm 1 described above; Apfel and Keylor (2002) suggest that for many years the primary psychoanalytic focus had been on ‘psychogenic explanations’. This emphasised an “unconscious repudiation of femininity, motherhood and fears of sexuality”. Mann (2014) asserts this focus is now more problematic, obsolete and outdated. Giuliani (2009) stated “our knowledge about infertility has changed, and that we now view the

concept of ‘psychogenic infertility’ as simplistic and anachronistic, since new technology can enable conception”. During the last few years, the study of the emotional aspects of infertility has now advanced further. For instance, with a few exceptions, anxiety is now considered a result and not a cause of infertility (Palhaa & Lourençob 2011). Fortunately, psychological interventions, especially those emphasising stress management and coping-skills training, have been shown to have beneficial effects for infertility patients (Cousineau and Domar 2007). Furthermore, psychodynamic work can broaden the treatment to encompass the unconscious meaning of the wished-for child and the psychological effects of the lack of success (Klempner 1992).

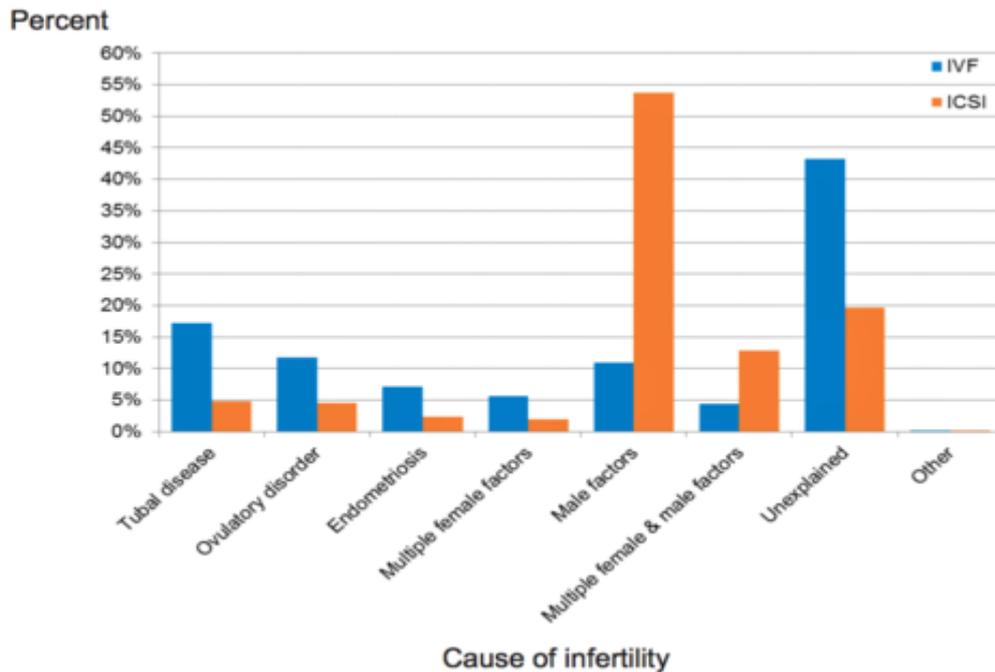
However, infertility is more than a medical condition (Hart 2002). It affects how individuals feel about themselves, their relationships and their life perspective. It is proposed by Day (1992) that much of the literature on the theory and practice of counselling is gender-blind, the assumption being that the emotional worlds of women and men are the same. An intuitive assumption could, therefore, also be made that psychosocial consequences of infertility are experienced the same, by all women; in that it is culturally and socially blind, operationalised on the assumption that all women desire children. A woman’s life perspective can often be pathologised by the psychosocial discourse that promotes an idea of compulsory motherhood (Shchurko 2012). It could be argued that a woman’s body, endowed with particular symbolic meanings, can act as a representation of the self, as a sign of acceptance or rejection of prevailing norms and rules, as well as a marker of belonging to a certain social group. For women, there is no real evidence to support the notion that there is a biological process that creates that deep longing for a child (Caroll 2012, pg 3). Shchurko (2012) argues that female reproductive function is signified as a purely medical phenomenon, not only inscribing women within a medicalised space but also imposing on them the medical manipulation of their bodies. For it is the woman that fertility interventions focus on and

cultural assumptions about women's reproductive responsibilities have shaped medical science and the medical system (Barnes 2014). Although male infertility accounts for thirty percent of infertility (HFEA 2014) we live in a world where there are more practitioners and technologies focused on treating women (Barnes 2014). This should be an important consideration for the counselling psychologist. Therefore, counselling psychology could benefit from extending the fifth paradigm described above by encompassing, in this context, western social and cultural expectations and what it means to have MUI. We should recognise that infertility is perhaps a crisis to which every woman will have a unique reaction. It is the infertile woman's reaction to the crisis situation of infertility that makes it an important consideration to the counselling psychologist and allied professions.

1.6 Medically Unexplained Infertility (MUI).

MUI accounts for twenty-five percent of infertility (Source HFEA 2014). The diagnosis of MUI can be made only after excluding common causes of infertility using standard fertility investigations. These include semen analysis, assessment of ovulation and tubal patency test. The tests have been selected as they have definitive correlation with pregnancy (Gelbaya, Potdar, Jevé, Nardo 2014). A diagnosis of MUI is made after the above-recommended testing fails to reveal any abnormality. The treatment for MUI is therefore by definition empiric because it does not address a specific defect or functional impairment (Quaas & Dokras 2008). Despite this the principal treatments for MUI include expectant observation with timed intercourse and lifestyle changes. In addition to medical interventions such as intrauterine insemination (IUI), controlled ovarian hyperstimulation (COH) and in vitro fertilisation (IVF). IVF is the most successful intervention for couples with MUI and the most costly (Quaas and Dokras 2008). According to the HFEA (2013) in the UK unexplained infertility accounted for forty-three percent of all IVF cycles started and twenty percent of all ICSI cycles (IVF where the sperm is injected directly into the egg). See the table below;

Table 1. Percentage of Standard IVF or ICSI cycles started by the reasons seeking treatment. (2013).



(Source: "Fertility treatment in 2013: trends and figures", HFEA).

In 2013, forty-nine thousand six-hundred and thirty-six women had a total of sixty-four thousand and six hundred cycles of IVF or ICSI (Source HFEA). Suggesting there are tens of thousands of women having IVF for unexplained infertility each year. It is not surprising to find that anxiety and depression are the two predominant emotional reactions for the diagnosis of MUI (Wischmann, Stammer, Gerhard and Verres 1998). MUI has yet to be researched as a unique phenomenon. Therefore, whilst the cause of MUI may remain an unsolved mystery that the couple may need to accept; the subjective experience of how this may affect them doesn't have to. To provide a conceptual analysis of MUI, incorporating a holistic ontology, perspectives that incorporate biological, psychological and social factors are examined in order to present a multidimensional view of MUI research to date.

1.7 The Bio-Psycho-Social Model.

The gulf between illness presentation and traditional biomedical explanations, where a pathological cause cannot be established, led to the study of social and cultural effects on illness (Kirmayer et al 2004). To bridge this gap without abandoning the benefits of the biomedical approach many healthcare professionals adopt a bio-psycho-social perspective (White, 2005 pg 242). The bio-psycho-social model is a broad view that attributes disease outcome to the intricate variable interactions of biological and psychosocial factors. The latter considering mood, personality, behaviour, social influences, culture, family and socioeconomic factors (Santrock 2007). Crucial to this is the belief that illness is not just the result of discrete pathological processes but can be meaningfully explained in terms of psychological and sociocultural factors. The dominant discourse in assisted reproduction is biomedical and infertility is typically constructed within this dominant paradigm (Seguin 2001). Since there is currently scarce literature regarding the experiences of MUI; an intuitive association is made between a social and psychological influence, in light of no medical explanation.

2.0 Review of the literature.

Thus far, infertility has been introduced via a biomedical definition; as infertility in most cases is considered to be the result of a physical impairment or a genetic abnormality that may be regarded as a disease (Khetarpal and Singh 2012). The following review of the infertility literature attempts to demonstrate that the impact of infertility from psychosocial perspectives is considerable.

2.1 The Psychological Impact of Infertility.

Infertility has been described as a serious life event that may have severe emotional repercussions (Cook, 1987; Lalos, 1998). The increasing participation in fertility treatments

has raised awareness and inspired investigation into the psychological ramifications of infertility (Deka and Sarma 2010). Emotional responses to infertility, largely measured through self-reported data, questionnaires and surveys, are said to include diminished self-esteem, uncertainty about social status, a disrupted sense of life's continuity and chronic stress while awaiting pregnancy (Wright, Allard, Lecours and Sabourin 1989; Stanton, Tennen, Affleck and Mendola 1992; Boivin, Takefman, Tulandi and Brender 1995; Greil, Slauson- Blevins and McQuillan 2010).

A meta-analysis by Greil, Slauson-Blevins and McQuillan (2010) found that the infertility literature emphasises the numerous characterisations among infertile women, in line with the research by Becker 2000, Clarke et al. 2006, Earle and Letherby 2007, Johansson and Berg 2005, Redshaw et al. 2007. For example, Williams (1997) extracted 11 themes from interviews among infertile women that comprised of: negative identity; a sense of worthlessness and inadequacy; a feeling of lack of personal control; anger and resentment; grief and depression; anxiety and stress; lower life satisfaction; envy of other mothers; loss of the dream of co-creating; the 'emotional roller coaster'; and a sense of isolation. This points to the association between psychological states and infertility.

Stress, depression and anxiety are described as common consequences of infertility (Deka and Sarma 2010). The incidence of depression in infertile couples presenting for infertility treatment is significantly higher than in fertile controls, with estimates of major depression in the range of fifteen percent to fifty-four percent (Domar, Zuttermeister, Seibel and Benson 1992; Demyttenaere 1998; Lukse and Vacc 1999; Chen, Chang, Tsai and Juang 2004). Anxiety has also been shown to be significantly higher in infertile couples when compared to the general population, with eight to twenty-eight percent of infertile couples reporting clinically significant anxiety (Chen, Chang, Tsai and Juang 2004; Anderson, Sharpe, Rattray and Irvine 2003). However, as previously stated anxiety is now regarded as a

consequence of IVF rather than a casual factor of infertility (Palhaa & Lourençob 2011). As counselling psychologists, we should perhaps be open to a possible two-way process and seek to raise an awareness of how and why anxiety appears to manifest.

Of the psychological factors thought to be involved in infertility, stress is possibly the most salient (Williams, Marsch and Rasgon, 2007). Relaxation techniques have been found to enhance conception rates (Domar, Zuttermeister, Seibel, Benson, 1992). It is also suggested that outcomes in IVF correlate with patients positively managing their stress (Panagopoulou, Vedhara, Gaintarzi and Tarlatzis 2006). Similarly, daily stress levels of women undergoing IVF were shown to be higher for those who failed to conceive compared to those who were successful (Boivin and Takefman 1995).

The constructs of grief and loss encountered in infertility is pervasive within the literature. Women especially have been found to experience more health complaints, anxiety and depression symptoms and more complicated grief than the general population (Lechner, Bolman, Van Dalen 2007). It is suggested that infertile women go through a process of mourning a child which, has ceased to be a possible reality (Daniluk 2001; Verhaak 2003). A clinical level of grief is found in women experiencing infertility (Van den Bout et al 1998). They seem to experience distress due to a sense of loss, the result resembling a period of bereavement (Daniluk, 2001). Lee et al (2010) found the most common grief response among the infertile patients are bargaining; followed by acceptance, depression, anger, denial and isolation. Arguably, treatment failures may retrigger these emotions, adding to a ubiquitous cycle of grief and distress. In essence, the descriptive literature presents infertility as a devastating experience, particularly for women.

2.2 Infertility in Cultural Context.

“In our society, all too often - the only way to deal with female experience is to put it into a category which is easy to recognise – sickness” (Laws, 1983 pg 20). However, the

influence of culture is present in all human health and reproductive behaviours (Arousell and Calbom 2016). Infertility is not only a phenomenon of biology it also draws into question a perceived truth of the femininity and masculinity representations prevailing in a culture (Palhaa and Lourençob 2011). A great part of the stigma associated with infertility depends on cultural aspects within their system of organised beliefs and values (Papreen et al 2000). Social norms play an important role in determining behaviour and have special relevance to issues of parenthood, fertility and sexuality (Kee, Jung and Lee 2000). The fragile balance between what the individual needs and what society accepts can have a profound impact on personality, coping, wellbeing and sexual behaviour (Palhaa & Lourençob 2011). For example, Parry (2004) published; 'Understanding women's lived experiences with infertility: five short stories'. The data was collected from thirty-two subjects, at various stages of an IVF process. The narratives, constructed by the author, echoed that women faced profound social and political pressure to define themselves as unsuccessful childbearing objects. The collection of stories gave insight to the various meanings the women developed and the experiences they encountered from the medical intervention. The author states; "...to assert that knowing and knowledge about infertility must begin with those who have experienced these struggles". Parry refers to our society as "pro-natalist" meaning "pro-natal" or "pro-baby." This encompasses the idea that parenthood and raising children should be the central focus of every person's adult life. Pro-natalism is a strong social force and includes a collection of beliefs so embedded that they have come to be seen as "true" (Caroll 2012, pg 5). For these women, the experience of infertility in a pro-natalist culture is brutal (Covington and Hammer Burns 2006, pg 422).

2.3 Societal Impact of Infertility.

Health and illness are not objective states but socially constructed categories (Griel, McQuillan, Slauson-Bevins 2011). This is particularly relevant to the study of infertility.

Turner and Robinson (1993) found people's reasons for having children include; that children are an extension of the self or a source of personal fulfilment and satisfaction and children enhance their identity. They also explained that people look forward to the companionship that youngsters will bring and that they want to nurture, motivate, and help children become happy and mature. Furthermore, they want to give their children what they themselves never had. Additionally, many couples want children because society expects it of them; it is what married people do. Therefore, when infertility is experienced, the societal impact is manifold. Ulrich and Weatherall (2000) suggested that women experience infertility as an unanticipated life-course disruption. Martin-Matthews and Matthews (2001) focused on the feeling among infertile women that time is slipping away and explored the interaction between familial, societal timetables, body timetables and treatment timetables, suggesting a significant impact on all aspects of well-being. Parry and Shiness (2004) report that social life is impaired by the process of seeking treatment leading to feelings of social isolation. This points to a clear societal impact from infertility.

Interestingly, Van Balen and Bos (2009) believe that social and cultural consequences are seldom mentioned in the reports on infertility studies. They stated that when these aspects are considered, they are often related to studies about elderly people without children, regardless of the reason for being childless. Perhaps this is because of the way in which infertility has been approached, pre-dominantly through a bio-medical lens. Whereas, Greil, Slauson-Blevins and McQuillan (2010) explain "The societal impact of health and illness is perhaps even more striking in the case of infertility than it is for other conditions". They state that no matter how medical practitioners may define infertility, couples do not define themselves as infertile or present themselves for treatment unless they embrace parenthood as a desired social role. The authors go on to clarify that while the biomedical model treats medical conditions as a phenomenon affecting the individual, infertility is often seen,

especially in developed countries, as a condition that affects a couple regardless of which partner may have a functional impairment. Thus, defining oneself as infertile involves not simply negotiations between the individual and medical professionals but also negotiations within the couple and possibly the larger social networks. In addition, the presence of infertility is indicated not by pathological symptoms but by the absence of a desired state. Finally, the authors assert that it is more obvious in the case of infertility, than it is for other medical conditions, that other possibilities exist rather than pursuing a 'cure'. Possible alternatives to treatment include self-definition as voluntarily child-free, adoption, fostering or changing partners. To surmise; "Infertility is best understood as a socially constructed process whereby individuals come to define their ability to have children as a problem, to define the nature of that problem and to construct an appropriate course of action" Greil, Slauson-Blevins and McQuillan (2010). Suggesting the bio-medical approach is perhaps limited in its exploration of infertility, and that further research encompassing a more holistic ontology is warranted.

Finally, with regard to MUI it appears that the socio-cultural impact is even more profound. Smith et al (2009) found that couples with no clear aetiology for infertility experienced the most social strain. Volgsten, Skoog Svanberg and Olsson (2010) further propagated that couples with MUI had unresolved issues, even three years after a failed IVF attempt. The study found that the couples felt haunted by their inability to explain to others and themselves why they couldn't become pregnant. It is suggested that it is the ambiguity that is at the root of the distress (Paul et al 2010).

2.4 Alternative Research.

The review of the literature thus far has illustrated the difficult psychosocial impact of infertility, this has been reported mainly, although not solely, utilising a quantitative

approach. Currently, although qualitative methods in researching infertility are somewhat scarce they enable a more robust understanding of the subjective experiences of infertility.

Further studies that employ a qualitative paradigm exploring infertility have more recently surfaced. For example, Jafarzadeh-Kenarsari, Ghahiri, Habibi, and Zargham-Boroujeni (2015) deconstructed the need for support in infertility. This need comprises of four main categories as follows: Infertility and social support, Infertility and financial support, Infertility and spiritual support and Infertility and informational support. It is important to note that this study was undertaken in Iran and whilst the findings can perhaps be generalised; 'need' is a complicated phenomenon and is rooted in the cultural, social and economic context of communities. Further qualitative studies include; Teg-NefaaH-Tabong and Baba-Adongo (2013) found that in North Ghana, couples were socially stigmatised and excluded and engaged in sex with multiple partners to improve fertility. This study reflects the pro-natalist or compulsory motherhood discourses that exist in the western culture, that have been described previously (Parry 2004, Shchurko 2012). Read et al (2014) found couples needed social support and focused on relationship conflict and coping during fertility treatment. Redshaw, Hockley and Davidson (2007) investigated women's experiences and attitudes post successful IVF treatment, via a qualitative postal study. Emergent themes related to the treatment process, pain and distress, lack of choice and control, timing, emotional and financial costs, fairness and contrasts in care. Male infertility has also been studied through qualitative research methods (Bainbridge, 2007; Culley, Hudson and Hohan, 2013; Fahami, Quchani, Ehsanpour and Boroujeni, 2010; Galdas, Cheater and Marshall, 2004; Gough, 2015, Wischmann and Thorn, 2013). The qualitative nature of these studies has allowed greater and more in-depth insight into the subjective experience of infertility, despite where the studies have been located which does question the context specific nature of infertility. Relatively few studies have used a qualitative approach when investigating the

experiences and attitudes of infertile women. Moreover, this has not included the examination of the experience of MUI as a singular construct.

2.5 Limitations of Infertility Research to Date.

So far, this review has critically analysed the infertility research, illustrating that many couples, presenting for infertility treatment experience high levels of distress associated with the diagnosis of infertility, this has been evidenced both psychologically, culturally and socially. The review has further highlighted that the process of assisted reproduction is also associated with increased levels of anxiety, depression and stress (Klemetti et al 2010). The previous studies seem to have focused on the experiences of infertile women/ couples during and after a medical intervention. This is criticised by Henning, Strauss and Strauss (2002) who argue that the many studies rely primarily on self-reported data and do not allow the separation of the psychological consequences of infertility from the possible consequences of the infertility treatment. This is important as we are unable to distinguish what the impact of infertility may be, from the impact of any infertility treatment per se.

Further limitations of the infertility research were reported by Pasch and Christensen (2000) who identified: small sample sizes, poor sampling methods, use of non-standardised measures, lack of adequate control groups and the potential for researcher bias. It could be argued that the limitations listed are due to the methodological approach that seems to have dominated the research, namely the traditional medical model of research, informed by a positivist epistemology. This is most likely because biomedical knowledge is largely constructed through empirical research (Al-Azri 2012). However, it is well recognised that this approach addresses only a fractioned part of the health and illness phenomena as it may have flaws, false findings and has a gap between research results and clinical practice (Smith 2006; Ioannidis 2005; Bero et al 1998). It also seems that where the positivist approach is appropriate for studying the physical and natural world, it may not be as appropriate when the

object of study is human experience (Bryman 2004). Fertility is perhaps best described as a fundamental human experience, we have all been gestated inside a woman's womb, so perhaps more credence could be given to the study of infertility as less of a scientific endeavour and more phenomenologically, to determine the meaning of an experience; as fundamentally those with infertility are not 'ill', nor noticeably disabled but are indeed afflicted by a condition that prevents full participation in the life cycle. The volume of literature on infertility is comprehensive but there has been little attention paid to the twenty-five percent of infertile women who have MUI. These women are arguably falling into the traditional bio-medical approach to illness and well-being, despite the fact that MUI has clear absence of biological etiology.

The gap in the literature appears to exist on four levels. Firstly, infertility has rarely been studied from a phenomenological approach, this would perhaps be beneficial to apply to counselling psychology whereby practitioners work with people and where reflection and meaning-making are key (Rennie, 1994). Secondly, there are distinct methodological shortcomings in the literature, in particular the lack of research conducted prior to a medical intervention. Thirdly, infertility has been largely understood as a medical pathology, rather than a lack of a socially desired role. Finally, the subjective experience of MUI has not been explored as a construct outside of all those with fertility issues, despite its prevalence. A study that re-addresses these matters could potentially lead to a more robust understanding of unexplained infertility and the subjective psychosocial impact, as it appears that it is the nuances and grey areas of a human experience that the breadth of previous research hasn't been able to detect.

3.0 Aims of Present Study.

The aim of this research thesis is to explore the subjective experience of women who have been diagnosed with MUI, prior to a medical intervention. The complex relationship

between women, pregnancy and infertility is a fundamental consideration of this research thesis and aims to attempt to readdress research limitations outlined in the previous section.

Firstly, the literature review seems to imply there is a direct relationship between psychological and societal consequences of infertility. This has largely been examined through quantitative methods which evoke the traditional bio-medical approach and a positivist epistemology. Therefore, whilst this research project takes into account the previous research literature, it is thought that the field may be further advanced by modifying the research paradigm and dissecting the area through the epistemological position of phenomenology, aiming to specifically explore the lived experiences of MUI.

Traditionally any exploration of MUI has been conducted within an infertility study that has not excluded the MUI sample from the biologically impaired sample. A distinction should be made when there is no etiology for infertility and this study will focus on MUI exclusively, as it is likely that infertility will be experienced differently when there is an absence of reason in comparison to those who have medical diagnosis.

Infertility research, in many studies, has been approached as though there is a presence of disease as opposed to the absence of a socially desired role. The present study aims to reconfigure this discourse by approaching from a multidimensional understanding of infertility framed by person's subjective experience, that goes beyond an everyday or common-sense awareness of a physical well-being. This will be achieved through the methodological design choices of a qualitative study informed by a phenomenological epistemology.

Furthermore, the literature fails to account for the experience of women prior to a medical intervention, which suggests we may not completely understand how infertility impacts individuals, as the experience has potentially been contaminated by a medical

intervention. The present study aims to recruit participants prior to undergoing a fertility treatment in order to address this issue and contribute to the evolution of infertility counselling outlined in section 1.5.

3.1 Summary.

This chapter has presented the wealth of research regarding infertility and critically analysed it terms of where limitations exist. The aims and rationale for this study have been outlined and it is hoped that this study will contribute to our knowledge in the field of infertility. In summary, this study, in its phenomenological approach is necessary as this is yet to be addressed within the field of MUI. Only then we can begin to understand what psychosocial processes are involved in a woman's subjective experience of MUI. This may lead to a more empirically informed approach to counselling psychology and may aid us in supporting our clients who suffer the pain of infertility and recurrent miscarriage. Within a wider context of a woman's experience of herself through means more dynamic than past endeavours that have, perhaps, failed to represent the suffering associated with infertility as little more than a scientific endeavour. Any recurrent phenomenology will be identified and synthesised for future research. The following chapter outlines the methodological rationale involved in this research thesis.

4.0 Methodology.

The previous chapter has attempted to illustrate that infertility research has been dominated by a traditional medical paradigm underpinned by the positive approach. This chapter outlines the alternative research paradigm undertaken in the present study to understand the subjective experience of women with medically unexplained infertility (MUI) prior to medical intervention. To add to the wealth of infertility studies, the present research employed a qualitative methodology and utilised an interpretative phenomenological analysis.

4.1 Qualitative Methodology.

The value of employing a qualitative methodology when investigating health-related psychology is now widely recognised (Smith, 1994; Biggerstaff and Thompson, 2008) and has in the last decade been placed firmly alongside its statistical counterpart. As previously outlined, infertility to date has primarily been researched through quantitative measures. Therefore, the qualitative methodology was selected as I wanted was to give voice to the subjective experience of MUI which is yet to be fully explored. A qualitative method does not seek to devalue the contribution of quantitative paradigms of infertility but more so, seeks an idiographic perspective on MUI, to focus on the unique psychosocial processes of infertility that may have previously been obscured by a bio-medical traditional approach. In this case, as qualitative researcher I will attempt to make sense of psychosocial phenomena of infertility and the meanings people make (Denzin & Lincoln, 2000). This could offer a unique insight into MUI, where biology has been the approach to it so far, despite the absence of a biological impairment.

4.2 Epistemological Stance.

As a counselling psychologist in training, the epistemological position of my research is underpinned by the psychological and theoretical concepts that inform my clinical practice.

Counselling psychology is particularly focused on the prioritisation of the practitioner's reflexive activity and the abandonment of a fixed notion of 'truth' (Strawbridge & Woolfe, 2003). Therefore, this study will be reflective of a personal epistemology but the aim being that I, in turn, inform evidence-based, theoretically-driven practice as a result of this position.

To gain an insight into the lived experience of MUI I aimed to approach the subject phenomenologically. The purpose of the phenomenological approach in this study is to illuminate possible nuances and grey areas and to identify any phenomena through how it may be perceived by the participants diagnosed with MUI. Phenomenological research is concerned with the study of experience from the perspective of the individual (Lester 1999). Epistemologically, phenomenological approaches are based in a paradigm of personal knowledge and subjectivity. They emphasise the importance of personal perspective and interpretation. As such they are powerful for understanding subjective experience and gaining insights into people's motivations and actions (Van Manen 1990, pg. 5). Specifically, exploring the ideographic nature of MUI, the importance of their subject narratives and how these women assign meaning to their current state of infertility. The essence of a phenomenological approach is synthesised in the key phrase "going back to the things themselves" in order to apprehend their "ordinary givenness" (Husserl, 1970a, p. 252). This research thesis examines what is at the core of the subjective experience of MUI, prior to medical intervention.

The experience of MUI has yet to have been relatively unexplored from the phenomenological approach. It was therefore considered appropriate as it allowed the researcher to "capture and represent the richness, texture, and depth of what they study" (Rossman & Rallis, 2003, pg. 174). In phenomenological research, the researcher aims to situate themselves in the participant's world and to understand the subjective (personal) experiences of their research participants. In doing so the researcher can "turn these

subjective experiences into representations that allow interpretation and reveal insights that apply more generally beyond those individuals studied” Lambert, Jomeen and McSherry (2010). Interpretations of the data aim to be considered ethically, with sensitivity and with an intent to creating an internal consistency. The researcher is thus moving between the emic (from the perspective of the subject) and etic (from the perspective of the observer) perspectives. The latter is achieved by looking at the data through psychological lens and interpreting it with the application of psychological concepts and theories which the researcher finds helpful to illuminate the understanding of research problems (Pietkiewicz and Smith 2012).

4.3 Interpretative Phenomenological Analysis.

Interpretative Phenomenological Analysis (IPA) was developed to rigorously explore idiographic, subjective experiences and specifically social cognitions (Smith, 1996). IPA is an approach to qualitative research concerned with exploring and understanding the lived experience of a specified phenomenon (Smith, 2004). This type of methodology allows the researcher to explore, analyse, and reflexively amplify participants’ subjective experience of their infertility with the view of making their inner world explicit. The idiographic approach as set out by IPA methodologies, allows the flexibility needed to explore this phenomenon (Smith et al., 2009). IPA is deemed to be appropriate when the topic of research is considered to be complex and sensitive (Smith, 1995) reflecting the nature of MUI. The IPA approach was also selected due to its concern with exploring and understanding the lived experience of a specified phenomenon (Smith 2004). This method involves a detailed examination of participants’ ‘life worlds’, their experiences of a particular phenomenon, how they have made sense of these experiences and the meanings they attach to them (Smith 2004). IPAs interpretative methodology focussing as it does on the epistemological stance, allows the researcher access to the meanings that participant’s attach to their ‘being-in-the-world’

(Smith et al., 2009). Perhaps more simplistically, the meanings that surround their idiosyncratic view of infertility.

IPA also emphasises that the research is a dynamic process with which the researcher plays an active role in the process. The researcher attempts to get close to the participant's personal world, attempting to gain an 'insider's perspective' (Conrad 1987). Access to this unique perspective requires a two-stage interpretation process, or double hermeneutic (Smith and Osbourne 2007). The participants are trying to make sense of their world and the researcher is trying to make sense of the participants trying to make sense of their world. IPA is therefore intellectually connected to hermeneutics and theories of interpretation (Packer and Addison, 1989; Palmer, 1969; Smith 2004). Different interpretative stances are possible, IPA combines empathic hermeneutics with questioning hermeneutics (Pietkiewicz and Smith 2012). This propagates that the researcher approaches the subject from the insiders perspective but also questions what else may be going on at any time in the process. Allowing for both aspects in the inquiry is likely to lead to a richer analysis (Smith and Osbourne 2007).

4.4 Reflexivity.

Reflexivity is commonly used in qualitative research and is accepted as a method where researchers can validate their research practices (Cutcliffe and McKenna, 2002; Pillow, 2003; Kingdon, 2005). Qualitative researchers acknowledge that they are an integral part of the process and they reflect on their own influence and experience in the research at all stages of the process. They accept they are not 'neutral' and therefore need to be acutely aware of their own underlying assumptions. It is proposed by Rennie (2000, p. 484) that "regardless of the extent to which persons (the researchers) are prepared to represent their experience in 'good faith', the experience is both constituted in part and influenced by interests, values, beliefs, and so on". This type of methodology recognises the significance of the researcher's

presuppositions and that they can both hinder and enhance the interpretation of another's lived experience, consequently reflexivity is imperative (Shaw 2010). To be reflexive, researchers need to be aware of personal responses and to be able to make choices about how to use them (Etherington, 2004, p. 19).

The practise of being reflexive is more complex than being reflective. The researchers own disciplinary position and political position could impact a research study. Indeed, Lipson (1991) affirms that reflexivity "requires critical self-reflection of the ways in which the researcher's social background, personality, personal assumptions, position and behaviour can impact on the research process". Here, in the spirit of personal reflexivity and transparency, context regarding the author and the subject of infertility should be acknowledged. I, the author has worked in the field of fertility for over seven years as a Nurse. Whilst the job is extremely rewarding in many areas, I have also witnessed the pain and suffering associated with the inability to conceive or maintain pregnancy. The familiar echoes of guilt, worthlessness and self-blame have become something I experience with my patients often. More recently my curiosity grew as I became a counselling psychology trainee and I have worked with several patients who were trying for pregnancy. This is where I began to gain further insight into this topic. Interestingly, I found that they were often treated as though they had a medical condition, which aligns with the medical approach that has been discussed in the first chapter. It is my personal belief that infertility should not be viewed as a medical pathology and that it correlates better with the absence of a socially desired role. I have myself had my own struggles and experience with infertility. The drive to understand the experience of these patients comes from not only a wanting to be able to support and nurture these women in a professional capacity but to expand my understanding of this phenomenon and in the way that it is constructed for each individual. With a view to ascertaining if there are recurrent themes shared between women who are diagnosed with

MUI and how counselling psychology can support these women in the most current and valuable manner. I had to be aware of bracketing my own assumptions of what I thought may arise in the data, since I have been professionally immersed in fertility for so long. In this way I was given an opportunity to think about some of my own personal assumptions around motherhood, family and femininity. It was imperative that my awareness of my political and social identity as a single woman, without children was explored and then bracketed with sensitivity and awareness. Bracketing is a way of “deliberately putting aside one’s own beliefs and assumptions about the investigated phenomenon during the analytic process and it regarded as essential” (Chan, Fung and Chien, 2013). Furthermore, regular supervision and personal therapy provided an invaluable space for me to explore my perspective, from a more objective position. Additionally, I kept a research journal throughout the study. This helped by facilitating the development of my skills in reflexivity (Ahern, 1999).

In summary, the qualitative research characteristics of this study enable the researcher to become an ‘instrument’ (Rossman & Rallis, 2003) but an awareness of how this may affect the study, is paramount. If the researcher is to gain knowledge, accumulate data and perform accurate analysis to be transformed into useful information an implicit awareness of reflexivity is imperative (Rossman & Rallis, 2003). The experiences of the author in the field of infertility can't be easily compartmentalised or disentangled from the research. However, it should be understood and bracketed using critical awareness and a conscious reflection on any assumptions.

4.5 Recruitment.

It was originally envisaged that the study would recruit participants from online infertility forums, attempting to rule out any participant/ researcher affiliation. The aim being to maintain the boundaries of the research relationship and to negate any ethical distortion. Achieving recruitment in this way became challenging as the inclusion criteria

was not met by those offering participation via online advertising. Therefore, an adaptation to the recruitment process was required. The participants were identified, following an initial consultation at the fertility clinic with whom the researcher is employed once ethical clearance had been granted by the clinical director. The clinic is privately owned and whilst supportive of this endeavour, expressed a wish to remain anonymous. Agreement was reached by the researcher and clinical directors. This stipulation was also made explicit to the participants to protect their anonymity. Several possible candidates were identified and expressed interest following correspondence. Six participants were recruited, in accordance with IPA recommendations (Smith et al 2009). The participant selection was based on the inclusion criteria, availability and interest. Transparency and reflexivity were integral to the recruitment process. It was identified and disclosed to potential participants that I also worked at the clinic as a Nurse. It was explained that due to the nature of my role at the clinic, it would be unlikely that we met in a clinical environment, but this could not be guaranteed. It was also made known to the participant that the clinic itself was not conducting the research and any disclosures would not impact any subsequent treatment. No rewards for participation were offered and they were informed that no remuneration would be received on any future medical treatment. This was achieved as the researcher did not have any future contact with the participants following the interviews.

4.6 Sampling.

Six participants were chosen for the study. The researcher intentionally selected fundamental criteria for inclusion to ensure that the elements would have certain characteristics relevant to the study (Suri 2011). These were: (1) The participants had been formally diagnosed with MUI. This diagnosis was central to the inclusion criteria as this has not been explored rigorously in the past as a tenant of this phenomenon exclusive of other biological reasons for infertility, as outlined in the literature review. (2) No medical

intervention had taken place. This was important as this had been negated in previous studies and infertility has historically been investigated during or after a medical intervention. It is therefore unknown how participants experiences may have been informed or indeed contaminated by a medical intervention. A medical intervention for infertility is deemed as intrauterine insemination (IUI), controlled ovarian hyperstimulation (COH) or in vitro fertilisation (IVF). However, it should be noted that the participants had attended a consultation at a fertility clinic and they had been diagnosed with MUI. Meaning they had made the decision to 'seek help' and infertility testing had occurred. (3) The participants were female. The decision to focus purely on the female perspective in this study was not taken lightly. As the literature review has revealed women/ couples have been the focus of ample quantitative endeavours and the infertility from the male perspective has been more significantly explored qualitatively. To date there is a scarcity of female studies of the phenomenological experience. This study was justified in the selection of women only with a view to synthesising data for future research. (4) The age criteria for inclusion was under 40. Unfortunately, age has a negative impact on a woman's fertility and therefore needed to be ruled out as a reason for infertility. A purposive sample was selected to provide a diverse range of cases relevant to infertility as the purpose of this kind of sample design is to provide as much insight as possible into the event or phenomenon under examination (Palys 2008), in this case MUI. Participants were identified following an initial consultation by myself, based on their medical notes and participants were enlisted through correspondence via a letter.

4.7 Research Participants.

Six women participated in the study all of whom met the inclusion criteria. The women were all heterosexual of White-European descent, living in London and of middle-class backgrounds. The mean age at the point of interview was 33.3. See table below for participant demographics.

Table 2: Participant Demographics.

Pseudonym	Age	Ethnicity.	Relationship Status.	Time trying to conceive.	Pregnant in the past.	Means of Recruitment.
Beth	39	White European	Married	2 years	Yes.	Clinic
Jaime	34	White European	Married	1.5 years	Yes	Clinic
Rachel	31	White European	Engaged	1 year	Yes	Clinic
Alex	33	White European	Engaged	1 year	No	Clinic
Jude	27	White European	Co-Habiting	1.5 years	No	Clinic
Astra	36	White European	Married	1 year	Yes	Clinic

4.8 Written Materials.

Once the possible participants were identified they were sent a letter via post outlining and inviting them to take part in the study (See appendix 1). Means of contact was provided and some correspondence took place between the researcher and potential participants. Information sheets and consent forms were designed by the principal researcher for participants detailing the reasons for the study, what was involved (including ethical considerations) and how to participate (See appendix 2). Informed consent was then obtained (See appendix 3) and an opportunity to discuss any concerns was provided at several stages of the process.

4.9 Interview Setting.

The interviews took place at one of the fertility clinic sites. The setting was neutral, in that no medical procedures took place there aiming for the environment to be the least clinical as possible. The room selected for the interviews was a quiet office, comfortable and reflective of a more neutral setting than one associated with a clinical setting. The fertility clinic is situated in Central London.

4.10 Pilot Interview.

A pilot interview took place prior to the recruitment process to evaluate feasibility, time and any adverse events. Feedback could then be gathered to identify any strengths or areas for development for the drafted interview schedule and to allow an opportunity to make any necessary adaptations. The pilot interview proved advantageous as one participant disclosed that she had felt the process had been “psychologically demanding”. She fed back she felt the questions were somewhat “intrusive” and had caused her to “think more than she had in the past”. This resulted in an adaptation of the interview schedule, as although the subject itself is evocative and fundamentally personal and sensitive; the researcher wanted to avoid causing any distress to the participants, which suffice to say was never intentional. The questions were reviewed and restructured accordingly (the interview schedule is provided in Appendix 4). This was achieved by the exclusion of any questions that seemed to be derivative of a similar question, in other words the questions became less repetitive in an attempt to feel less intrusive. A risk in losing valuable or rich data was assessed at this stage yet it seemed vital not to overwhelm the participant and avoid delving into areas that may be better suited to a therapy session. This also meant that I needed to adapt my interviewing style in order to respect the boundary between researcher and therapist. This was difficult to achieve due to a genuine curiosity and interest in the answers provided. However, a more neutral stance of researcher was adopted as opposed to an empathetic and probing stance of a therapist. The pilot interview took approximately forty-five minutes allowing for time before and after the questions for setting the scene and feedback. The interviews for the actual research were shorter following the adaptation. The overall feedback following the pilot was positive as the participant stated she felt comfortable, safe and felt some “relief” after discussing some of her fears; something that opportunity had not previously permitted. Another important facet was found from the pilot interview. The researcher had certain expectations of the responses that

may be elicited, despite attempting to remain impartial and unbiased. Through the use of supervision, it was deemed that an explicit awareness of the demeanour adopted by the researcher is adhered to at all times. For example, an awareness of how the researcher reacts to responses. The pilot interview provided important information for the proceeding interviews, improvements were identified, and procedures adapted.

4.11 Data Collection.

The start of the interviewing process allowed time for me to reiterate the participants' rights and provided a space for them to ask any questions. All participants were informed that should they have any reservations or felt unclear regarding the information, which they had received previously they should feel free to ask. This process served as an opportunity to build rapport and reduce any anxiety that may have been present prior to the recorded segment. Measures were taken to ensure that the interviews would not be interrupted, and that the participant felt comfortable and at ease. This was in order to ensure confidentiality would be maintained as far as possible and that the environment felt like a safe space to explore their experience of MUI. Informed consent was again verbally agreed prior to the interview and reiteration of their anonymity and confidentiality made explicit. Participants were given a short verbal explanation of the purpose of the research and the intended use of the data. The written consent form was checked and signed by participants (Appendix 3). The interviews lasted for approximately thirty minutes, which was deemed as appropriate given the sensitive nature of the topic and followed the procedural guidelines recommended by Smith et al (2009). Factors that were exposed in the pilot interview were also considered and maintained as far as I, the researcher was able.

Semi-structured interviews were chosen over a more structured format to encourage rapport, empathy and to provide flexibility. This was to allow the researcher to attempt to engage with respondents' areas of interest intending to lead to a richer corpus of data (Smith,

1995). All the interviews were recorded using a digital voice recorder. The recording was ceased once the final response had been obtained. Some time was then awarded at the end of the session to provide participants with a short debrief and they were given a debrief sheet to take home with them (See appendix 5 for example debrief sheet). An opportunity was again given to ask any questions and for the participant to feel they had a space for restoration following the exploration of very personal and sensitive subject matter. The participants were thanked for their time and provided with contact details of the researcher, research supervisor and an online support group should they feel they wanted support in the future. It was also discussed that should the participants wish to obtain any feedback that this would be made available once the research had been fully completed. Data was then transcribed and analysed following the style dictated by the IPA methodology. Digital recordings were destroyed, and the written data was anonymised, changing or omitting any identifying details from the transcripts (Example transcript provided in Appendix 6).

4.12 Analytic Procedure.

The analytic procedure then took place. Analysis was conducted according to procedures described by Smith, Flower and Larkin (2009) and outlined below. These were used by the researcher as a guideline and aided the structure of the analysis.

1. The first step involved reading and then re-reading each transcript. This allowed the researcher to become immersed and familiar with the data, and only then moving on to the next transcript once full immersion and coding had taken place. Notes that the researcher made during the interview were merged with the transcripts. Including observations about how the participant may be expressing something verbally that does not correspond with the way they are presenting physically. Or how emotive a section may feel that may not be represented in syntax.

2. An initial noting of potential themes followed, these were noted in the margins of the transcripts (example appendix 6). The themes were then given a code and the descriptive, linguistic and conceptual comments or questions of the data were then noted next to the relevant transcript text (Smith, Flower and Larkin 2009).
3. Theme titles were recorded as headings on a blank sheet of paper and verbatim examples from the text were added under each of the headings.
4. As the reading of the transcripts continued, material that was considered to be in support of the identified themes was noted and positioned under the appropriate title heading. An initial list of themes had been identified from the coding of the first transcript. (Example of emergent themes for participant 'Beth'. Appendix 7).
5. If new themes emerged from later transcripts, these were tested against earlier transcripts and any congruent material from earlier transcripts was recorded in the right-hand margin under the appropriate theme title.
6. When each transcript had been read and coded in this way, the segments were recorded under the appropriate theme headings.
7. Each theme was then examined, using the raw material to define the theme more clearly. This involved asking questions, such as; what process is at issue here? under what conditions does it occur? and what are the consequences?

4.13 Ethical Considerations.

Prior to commencing the research, ethical approval was obtained from the University of East London (UEL) Research Ethics Committee (see appendix 6). Ethical considerations are imperative to all research studies and were considered fully within this research due to the sensitive and complex nature of infertility. The ethical facets of the study were discussed with

the Clinical Director and approval obtained for this research. It is important to note that the clinic expressed a wish to remain anonymous and no written information is included that may identify the clinic name or staff involved in the approval process. Ethical consideration was paramount due to the recruitment procedure taking place within a medical context. It was made explicit to the participants that taking part in the study would have no impact on their potential medical treatments and it was clear that the research study was supported by the clinic but independent of it.

I adhered strictly to the UEL Code of Practise and also ensured that the ethical framework governed by the British Psychological Society (BPS) was followed. The four basic ethical principles outlined by the BPS were followed throughout this research. These were: respect, responsibility, competence and integrity. This was primarily achieved by allowing time and space before and after the interviews for questions and reflections. My conscious awareness at all stages of this study regarding the nature of infertility was essential in acting ethically. The struggle of infertility has undoubtedly impacted many different areas of the participants lives and they may not have had an opportunity to reflect on these previously. The participants were informed they had right to withdraw from the study at any time and information was available to them regarding professional support networks, should they require it.

There are further ethical considerations that were addressed in relation to the current study. I am asking the clients to reflect on their own personal experiences of pregnancy, over time. For many women, the relationship with pregnancy begins when they become sexually active. An awareness that there may be some difficult memories that are being revisited was essential and imperative. It was also thought that there may be some difficult emotions attached to their experiences. There is a sexual component to pregnancy which cannot and should not be avoided. Reflections that were sought were indicative of those that could

arguably be part of a therapeutic process. These may normally have been discussed after a number of sessions with a therapist, which would usually begin once a therapeutic alliance had emerged. It was deemed akin to asking the participants to trust the interviewer and to disclose and reflect over a substantial period in their lives in one session of a semi-structured interview. Ethics were therefore paramount to the interview stage. The use of the pilot study ensured a safe implementation of an ethical study.

4.14 Summary.

In this chapter, a case has been made for the use of a phenomenological paradigm to study the subjective experience of women who have been diagnosed with MUI prior to a medical intervention, based on the lacuna of research so far. It has been argued that my close proximity to the nature of the research topic complicates the analytic process but through reflexivity and awareness this can be combatted so as not to subtract from its potential value. A profound awareness of the ethical considerations involved in examining a deeply personal and complex phenomenon have also been discussed. The following chapters concentrate on the data gathered from the study and what this means for the counselling psychologist in terms of informing contemporary infertility research and how this affects clinical practise.

5. Analysis.

Three superordinate themes emerged from the data and twelve subordinate themes represent the subjective experience of MUI.

Table 3. Themes, subordinate themes and a description of their association to infertility.

Superordinate Theme	Subordinate Themes.	Description of the Association to Infertility.
1. The Explanatory Vacuum.	1.1 The Seeking of Answers. 1.2 Turning the Blame Inwards 1.3 Outside Influences. 1.4 Society, Family and Culture.	The impact of no medical explanation for infertility. Self-blame and actions take in the past. Environmental causation. What it means to be part of a pro-natal society.
2. Uncertainty.	2.1 The Intervention. 2.2 Outcomes. 2.2a What if it doesn't work? 2.2b What if it does? 2c. Managing Uncertainty.	A sense of foreboding about the impending medical treatment. The uncertainty of outcomes. Lack of guarantees and predictions of strain. Impact on the relationship dynamics. The interplay between fear and excitement.
3. The Concept of Pregnancy, Past and Present.	3.1 Pregnancy in the Past. 3.2 Ambivalence.	Pregnancy was to be avoided and evoked terror. Idealisation and disconnection from the concept of pregnancy.

6.0 The Explanatory Vacuum.

This theme explores how the participants attempted to make sense of their MUI, where biology and medicine have thus far failed to do so. The first subtheme examines how it seemed apparent in the data that the absence of an explanation led to a sense of seeking one. The explanatory vacuum seemed to have led the women to attempt to assign blame, to both internal, personal factors and external influences, this is explored in the second subtheme. The implication being, if biology isn't to blame, then what is? The third subtheme frames how the women experience their MUI in terms of society, family and culture.

6.1 The Seeking of Answers.

Each of the participants spontaneously expressed a desire to understand why they were experiencing infertility. The interview question that seemed to bring the need for an explanatory framework to the forefront was; “What interested you in this particular study?”. This provided interesting responses, Rachel for example;

I hoped you might have some answers for me! (laughs).

Although Rachel laughed as she suggests the study may lead to “answers”, it could be interpreted that there is an expectation that an answer exists. An answer that has not been qualified by the diagnosis of ‘unexplained’. This seems to have led Rachel toward this sense of seeking, hopeful that the researcher may “have some answers for her”. She seems to be regulating her expectations around this through humour as she laughs as she refers the question back to the interviewer. Jaime also indicates taking part in the study may provide an explanation;

I feel so many people live in the negative constantly. It has to have some impact and hopefully this study will help figure out any connections.

Again, in “looking for connections”, Jaime seems to be seeking a reason in the assumption that there is something to “connect”. Jaime could be looking for an answer and it is inferred

that Jaime expects the connection to come to fruition through this research. Arguably without a causal blame, there is a drive to find one. For Jude, this seems to manifest in frustration.

Frustrated! I want something to blame. There must be a reason – they just haven't found it yet.

Jude's frustration is palpable throughout the interview. Her stating "there must be a reason" seems to suggest that 'medically unexplained' is not answer enough. This seems to be causing Jude irritation that the answer has perhaps been overlooked or missed and she therefore cannot assign it meaning as there is no apparent casual factor. The "must" suggests she is unable to accept the experience and the use of "they" may point to others being at fault. Beth's seeking of answers had led her to question her relationship, when asked how she felt when she was diagnosed with MUI she answered;

I wondered if two bodies as such just are meant to mix and whether this was an indication as to whether my partner and I were a good match and meant to be together.

The implication being that without a medical diagnosis Beth seems to set this up as a test of her relationship. In that, if she is unable to achieve pregnancy, perhaps it is the relationship that is at fault. The process of answer seeking seems to manifest in a propensity toward responsibility, the data seems to indicate the participants looking both internally and externally for cause.

6.2 Turning the Blame Inward.

It emerged that the participants portrayed a sense that MUI, within an explanatory vacuum, can lend toward self-blame. Astra for example;

It's really hard, you start thinking that maybe it was due to the abortion I had. Astra evidences self-blame which pertains to actions taken in the past. The use of the phrase "you start thinking" suggests that she has potentially ruminated around the causality of her current infertility. No research suggests that terminations in the past negatively impact on a

woman's ability to reproduce in the future. Although for Astra it could be argued that her thinking, which she portrays as "really hard", without designation to a specific medical cause have led her to turn blame inward toward herself. For Jaime, she too looks to her body and assigns her inability to reproduce to her physiology.

Hmmm....I do believe internally things aren't right and my body fights constantly. I hardly ever get sick; my immune system fights non-stop with food allergies and constant adrenaline from working too hard.

Jaime expresses without ambiguity that she believes that internally things are not right. Her sense of belief, in opposition to the medically unexplained diagnosis, powerfully indicates the responsibility, from her perspective, is internal. Jaime uses the word "fights" twice, her "body" and "system" are constantly battling, which seems to suggest an internal battle. She explains her body is "working too hard", which may be indicative of her position in society and that as a woman with infertility she may be working too hard to maintain all that is expected of her. The impression is given that her body is worn out and filled with "constant adrenaline". There is a sense of a perpetuating battle or struggle here for Jaime. Jaime also indicates that she had a termination in the past. She indicates that she does not attribute her infertility to that;

I've made peace with that decision. I know it was the right thing to do. Some people may judge it, I have friends who have done the same thing or said they would have done what I did too so...

She explains that she has made peace with the decision, this could indicate that in the past perhaps this reconciliation was not apparent. There is a justification in this extract that her friends would have "done the same thing" or "done what she did too". There is no reason here to suggest that she blames her past actions as causal factor for infertility, but it is included in the analysis as Jaime includes this in her narrative. On reflection this could have

been explored further as to why this may have emerged for her, at the time it was deemed as intrusive. Likewise, Rachel discusses a past termination.

Wondering if something.... something happened when I had the termination and has stopped me from getting pregnant.... Like as in now stopped me.

It seemed to the researcher at the time that this was a difficult admission for Rachel in this section of the transcript, notes were made as to her appearing unsettled with exploring this avenue. Rachel seems to be indicating that a past intervention may have given cause to her current infertility. Previously Astra seemed to blame her infertility on having a termination, Rachel here perhaps blames the termination for her infertility, as though the procedure could be responsible. Rachel exhibits this further as she presents a further insight toward an internal causal factor.

And sometimes you blame yourself. Or... or what or the past.

Like Astra and Jaime there was a feeling that this was a point of rumination, depicted in her use of “or” three times. Again, the vacuum that the unexplained diagnosis has left has been filled with a sense of seeking. This rumination appears to be causing a great deal of suffering, the suffering is dominated by self-blame. Alex goes onto implicate herself in the reasoning for her infertility.

Well, makes me feel like there’s something wrong with me. Even though I know there isn’t the Doctors have said we are both fine. So, I guess I’m confused as to why it isn’t working.

Alex clearly states that she feels there is “something wrong” with her. She recognises the Doctors have ruled out a biological reason, but this has still resulted in “confusion”, it is as though when she refers to “it” not “working”, she is referring to herself as the factor that “isn’t working”. This is also the case for Jude;

I think the fact that I can't get pregnant has upset me... Like there's something wrong with me.

Jude, like the other participants turns the blame inwards. She refers to “I” twice and “me” twice also, there is something inherently self-focused in this extract. Jude recounts that being unable to get pregnant has led to her conclude that there is something “wrong”, which which in turn leads her to feel “upset”. The overarching interpretation here attains to Jude concluding that there is something intrinsically wrong. Likewise for Beth;

I have had health issues from my early twenties which I think have been the major factor in my inability to conceive.

Like all the participants, Beth will have ruled out any medical factors for her infertility, although her narrative here suggests otherwise and seems to indicate that she feels her health matters from the past may have affected her fertility. When asked about it, she replies “

That’s all I can think of for now.

The impression is given that although she understands her health has not had an effect, it appears as all-consuming for Beth as she seems to imply that the fault is intrinsically hers due to her “health issues” but that she is perhaps not willing/able to voice this notion at this stage in the statement “that’s all I can think if for now”.

6.3 Outside Influences.

An external rationale or cause for MUI exists in the data although it is far less prolific than internal cause/ self-blame. A feeling of *seeking* exuded from the interviews, as previously stated, the diagnosis of MUI is seemingly too vacant. If the medical fraternity are unable to attribute their infertility to a cause, the participants are potentially seeking this for themselves. This search for causality is widespread within the data. For example, Beth;

Everything that is put in your food and water and medications we are given that we don't need. It wouldn't surprise me if this was causing us all to be infertile.

In this extract Beth's causality is interesting, the use of the term "us all" could suggest that she feels the problem is more widespread than we know and is seeking environmental causes. Or it could contribute to a feeling of needing to feel part of something, that her diagnosis of MUI feels isolating. Astra also looks toward environmental causes;

.....the food I'm eating and just generally what surrounds us that could be the reason. Everything these days seems to be able to give you cancer so why can't everything affect us to recreate. That's my worry.

Astra refers to the environment as being detrimental to health. The word "cancer" adds to the gravity of how serious she deems the nature of the environment. This could also be reflective of how a lack of diagnosis is causing her to look at "what surrounds us" causing her "worry". The use of the term "recreate" is interesting, rather than to pro-create. As recreation lends itself to a term associated with fun, pastimes or perhaps being care-free and opposed to her narrative which illustrates a darker side of fertility. This could possibly be examined in terms of societal or cultural expectations placed upon her or indeed to which her and the participants have placed upon themselves. Further examples of this exist in the following section.

6.4 Society, Family and Culture.

The theme of making sense of MUI continues as the participants exhibit their understanding of their infertility in terms of how they are viewed in society, and indeed how they view themselves structured on societal norms. For Rachel there appears to be an expectation;

There is nothing wrong with us, so this should just work out when it is supposed to.

It is interesting that Rachel describes that her fertility will “work out” when it is “supposed” to. This could refer to an expectation she has of herself or how she views a pro-natal society in the supposition that pregnancy is the norm, when there is “nothing wrong” with you. For Rachel, there seems to be a feeling of exclusion to her infertility. For example;

It all just feels a little unfair. Other couples we know seem to be leading fun lives and have no problems at all.

Rachel appears to be excluded from the “fun lives” of those around her. Rachel seems to equate having “no problems at all” with fertility. It is as though once you can achieve pregnancy you become part of a fun, inclusive society and perhaps then experience no problems at all once you have achieved this status which to Rachel regards as “fair”. It was noted by the researcher that there appeared to be some resentment in Rachel's delivery of this narrative and supports the unfair depiction of her fertility status. Astra points to a connection between her MUI and womanhood;

A stigma that I wish didn't exist as it's no different for a woman feeling less like a woman.

Interviewer – that's interesting, what do you mean?

Being barren! Doesn't make you feel very worthy I suppose. Look at everyone just getting pregnant willy nilly.... And there I am... barren! (Laughs).

Astra is seeming to be comparing herself to others around her. Her conclusion being that she feels “less like a woman” and less “worthy”. This seems to portray a key understanding of how Astra views herself in society as less than her fertile counterparts and those “getting pregnant willy nilly”. The use of this phrase could be interpreted as a phallic illustration of infertility and possibly warrants further exploration but also that her language indicates that there is a care free ease to pregnancy for others, as though procreation is recreational. She refers to a social stigma, her inability to reproduce has left her feeling “barren”. A word

denoting emptiness and desolation. Astra also laughs during her narrative, this is possibly to counteract the strong resonance she feels in this section, particularly amplified by her feelings of unworthiness. Beth goes on to amplify the questioning of womanhood in terms of what society expects of her;

I think in some instances pregnancy has become a tick in the checklist of life.... that must be achieved or else you are not a real woman and therefore a failure.

Her use of the term “real woman” here is impactful. Her view of self is framed by how she perceives society views her, in the depiction of a “failure”. It could be argued that self-worth comes from not just her internal and external explanation but is further cemented by a societal view. Beth narrates;

I think the whole issue of pregnancy and having children has changed to the extent that some people want a baby as opposed to a family.

Beth frames her responses in terms of the other. It could be argued that perhaps Beth is regulating ideas of how ‘baby-making’ should be. She continues;

In an ideal utopian world, I would want a baby conceived in love, to a family, not just a baby for the sake of a baby.

It is as though for Beth, baby-making should be chosen and rational. Beth uses ‘ideal’ and ‘utopian’ to illuminate her point. Beth describes the decision process as one encompassing rationality;

Having a baby should be the most considered decision one took in life.

Debatably, Beth has been forced to consider this decision. Her partner and herself have undergone tests to arrive at the diagnosis of MUI and at this stage have attended an initial consultation at a fertility clinic. It seems unlikely that she is questioning her own decision-

making process. This standpoint is further illuminated by Alex, her view on how she perceives her peers and the media impacts her psychological state;

yeah most of my mates have and the media fills me with worry too and how we should already have had our children by 30.

There is a strong sense of how what she *should* have achieved by this time in her life as this is what her peers and society require from her. When this expectation is not met the result is that Alex becomes “filled with worry”. This correlates with Beth’s “checklist of life”. They both critique their infertility through the societal expectation and they’re inability to attain it. Emergent from the data, Alex gives the researcher further insight into her own experience;

I was once in a relationship that had lost passion excitement and some love, but I wanted a baby. This didn't really make sense to me because I wasn't happy, it wasn't until I ended that relationship did I realise I wanted a baby to fill the void of what was missing.

Alex evidences an awareness that, in a previous relationship, she considered having a baby to “fill a void of what the relationship was missing”. Alex seems to be articulating a baby would’ve replaced the “lost passion excitement and some love”. In this way Alex depicts a representation of what role the baby could fulfil. Alex further refers to her parents;

We want our parents to be fit enough to enjoy being grand-parents.

To feel even more love from our families for what we are going to give them. And yes get attention I guess.

Alex conveys the notion that there is an expectation that her parents and partners parents will “enjoy being grandparents”. What is interesting in the extracts is the anticipation of what a baby will bring; “attention”. This could possibly refer back to the previous extract when Alex needed a void to be filled from a previous relationship as, hypothetically, she may have

stopped receiving attention. In this was a baby represents “even more love” and even more attention from her family. Likewise, Alex describes her “worry” in several extracts;

I just worry that I left it too late so that is a worry.

It’s fascinating. Watching the way the body changes. (Mmmm). So clever. I worry about that sometimes though.

I constantly worry about my figure and what I look like.

I worry I will be an hormonal bitch, I will get sick, I could die during child birth, I could miscarry, I will have no energy, I will get fat, get stretch marks, will get hairy.

I’m worried of course about whether everything will be okay with the pregnancy and what will happen if we can’t get pregnant. I guess I am worried too about the effect this will have on my health and my body.

The magnitude of Alex’s worries encompass a sense of running out of time, self-blame, body image, relationship, negative outcomes and change, essentially these relate to worries surrounding femininity, indicative of both fertility treatment and pregnancy. Alex provides unique insight into what underlies her worries relating to infertility, her candid exposure of how this impacts on her femininity is useful in understanding MUI. For Jaime, this is framed through a familial expectation.

I would say that, I think it was an expectation I had, or there was an expectation...

ummm I don’t know how to put it. (Pause). It was always the rite of passage I would meet my husband by the age of 30... as with owning a house and things... As I have learnt - life doesn't go to plan.

Jaime’s account could be interpreted that her social identity has been disrupted by her state of infertility as “life doesn’t go to plan”. Her words are slightly confused and disparate in this

section as she hesitates and corrects herself, it is as though she is finding it difficult to form a coherent representation of her social standing. This is juxtaposed by Jude;

I never really felt the urge to actually be pregnant (no?).... but as I've grown older and people close to me have started families, I've realised maybe I do want to experience pregnancy.

Her extract suggests that she had never really considered pregnancy as a matter of identity fulfilment. Yet as her peers have begun to reproduce, her interest in reproduction has gathered momentum. Furthermore, the fact that she is now experiencing difficulties appears to strengthen her desire for the “experience of pregnancy” and that she should be able to reproduce. Her inability to achieve something drives her desire to want it more. Whether it is the baby or social inclusion at this stage it is hard to determine although it seems apparent that one may serve the other;

Now the fact that I may have problems getting pregnant means that I'm more inclined to want it.

This appears to suggest that even when pregnancy wasn't at the forefront of Jude's goals historically, the impact of a potential societal exclusion leads her toward the decision that should have a family and if she can't the inclination becomes more powerful. It appears that it could possibly be society that seems to be the driving force behind the wish fulfilment of having a baby.

6.5 Summary.

This theme has revealed that how the absence of a medical diagnosis has led to a profound sense of seeking. As though the lack of answers resulted in a sense of rumination regarding alternative resolutions. Which has resulted in a process of assigning blame, whereby the women have found causal factors intrinsically and extrinsically. Ultimately the explanatory vacuum has resulted in a facet that echoes throughout the data; that being the

propensity toward self-blame. Fundamentally, the inability to reproduce seems to be framed by a societal view on what is expected of them as women, when this is not met a profound feeling of failure emerges. However, it is interesting to note that the data does not evidence how society views these women, moreover the failure manifests in how the women perceive they are viewed in society, perhaps one that promotes baby making as the ideal.

7.0 Uncertainty.

This chapter examines, prior to medical intervention, what is at the core of the lived experience of MUI. It emerged that this seems to be governed by uncertainty. The first subtheme examines how the women perceive the possibility of a forthcoming medical intervention and the uncertainty that this evokes. Secondly a sense of uncertainty appears prolific in terms of outcomes, both not getting pregnant but also encapsulating the uncertainty surrounding achieving a pregnancy. The third subtheme portrays an interesting interplay between fear and excitement as a way of perhaps managing the uncertainty.

7.1 The Intervention.

The current research took place prior to a medical intervention, at this stage the women had attended an initial consultation at an IVF clinic and were considering treatment. This subtheme explores how the women perceived the impending treatment. The data elicited a sense of foreboding, salient amongst the participants. Astra asserts the ominous nature of what her future may hold;

It's tough, long and stressful I'm sure.

The thought of IVF seems a bit extreme. Putting my body through all of this.

Astra is expressing an assumption of stress as she is “sure” of the arduous nature of IVF, as something “extreme”. There also appears to be a sense of isolation to her prediction of the future as it is her body that is being “put through all of this”. For Astra, what appears to be causing a sense of stress is the prediction of her impending stress. She goes on to say;

I think it will be super stressful.

Interviewer; In what way?

Stressful on my relationship, for one thing. Stressful financially and I and I yah, I'm not really looking forward to it shall we say..... I just think putting yourself through all of this when there is no guarantee is really difficult to be honest. I feel like its possibly opening up a Pandora's box. But I guess how much you let it all affect you is in your own control. It's up to me to do this or not, I mean up to us. No one is holding a gun to our head! (laughs).

Astra recounts the word "stress" three times in the above extract, she seems to recognise that this is elective, as it is something that is "up to me". The visceral quality to the "gun to the head" implies a sense of danger or could be interpreted as though she feels this is something that she is expected to do. The "opening up of Pandora's box" appears to relate to a number of unknowns. There is an element in this extract that refers to control or perhaps an impending loss of control, in terms of what Astra may postulate is inside of Pandora's box. It could be argued that the not knowing what may be in "the box" also relates to her not knowing what is causing her MUI and furthermore not knowing what the impending medical intervention may reveal or even result in. Astra maintains her control by implying that whilst her infertility is out of her control, how far she is affected by it is not. Interestingly, Astra corrects her assertion of "me" to "us". Ultimately, it is the woman who has to undergo the "super stressful" intervention. Granted, the relationship and financial burden she describes are a shared stress, but the IVF treatment focuses largely on the female, on her body as she referred to. The future for Astra appears looming, and her expression of likely emotions she will confront seem to be framed by isolation, individual physical and emotional stress and possible danger. A further sense of foreboding is apparent in the following expression, Astra;

I think it's important more science goes into IVF, I believe there is still so much we don't know and also the consequences of having a baby through IVF can sometimes

worry me, is my baby not going to be as strong, how can the treatment affect me as a woman in the long run, these are things I worry about.

The use of the word “consequence” here is interesting as it can denote a result or effect that is typically unwelcome or unpleasant. The imminent consequence here appears to be framed by “worry” of how IVF may negatively impact her “as a woman” or her baby. The use of “long-run” implies that it is not just her forthcoming future causing her worry, it includes her forecasted long-term future also. Astra recounts other apprehensions she has around IVF and parenting options;

I think it's a great option for couples or people that are desperate to be able to bare their own child.... But I do wish adoption would be an easier option as so many children out there that need a loving home.

Astra describes IVF as a “great option” for those that are “desperate”. She expresses a sentiment of care for children “out there”. Out there could refer to the fact that they are outside of her, the unexpressed intention could be interpreted that this refers to her own infertility. There is also a sense of abandonment – children “out there” needing “loving homes”. She goes on to say;

It seems to me that there are children in need. And perhaps that is what I should be focusing my energy on.

Astra talks of wanting to have a biological child and adopt a child in need. She has referred to children in need twice in the early section of her transcript, the repetition speaks of this message needing to be heard. Perhaps it is Astra who feels “in need”. There seems to be a sense of questioning for Astra, it is as though she has not yet come to terms with the possible medical intervention and it is her concerns are yet to be heard. For Beth, the possibility of IVF is experienced and expressed in a similar way;

A necessary evil? A means to an end?

Interviewer: Something you're not that keen on? Would that be fair to say?

Ummm, no not that I'm not keen as such. I just think the strain it will on our finances and relationship is a lot.

Beth's narrative is powerful, she suggests that in order to achieve the "necessary" (the baby) she will have to encounter "evil" (the treatment) something to which she expresses she expects to cause "strain". It appears that the interviewer seems to be attempting to understand the strong language that Beth uses, this could have been interpreted by Beth as trivialising, which may have led her to feel judged and therefore discontinued her exploration. This was not the intention of the interviewer but may have been inadequately received. Rachel explains her view of IVF;

Yes, so from a far ummm I think that fertility treatment... on the whole is genuinely amazing.

Because....?

Because it has the ability to give people babies and families.

There appears to be uncertainty as to whether Rachel feels IVF is the right choice, as she describes it "from a far" as "amazing". There seems to be a distancing of the treatment from herself. This is further propagated in the communication that IVF gives "people" the ability to have babies and families, rather than giving her. Jaime had exhibited varying degrees of positivity throughout her account. The prospect of IVF lends to a rare negation of positivity, concerning primarily the uncertainty of outcome, Jaime;

There's just a lot of pressure of all the steps. And I know my AMH is lower so I will worry about my response to it.

Jaime has consistently exhibited positive regard for her future and the uncertainty of her response to treatment is the only point to which were stance wavers. The uncertainty reflected as pressure and a possible lack of control. Jaime's response to IVF is out of her control and unpredictable. She refers to her AMH. This is the Anti-Mullerian Hormone, a protein hormone produced by cells within the ovary. Understanding the AMH level assesses the ovarian egg reserve, a low AMH level can indicate a poor response to stimulated IVF. An AMH level is concrete, whereas MUI is unknown. It could be argued Jaime is attempting to regain some control through a fastidious understanding of the hormone regulation aspects of treatment.

7.2 Outcomes.

Uncertainty gathers further momentum in this theme as there is no guarantee of a definite positive outcome to a medical intervention and insights into the negative outcome of an IVF treatment are explored; as even with an intervention a possible future conception remains uncertain. However, from the data it also transpired that there was additionally a sense of uncertainty around not only not getting pregnant but also, how actualising a pregnancy may affect them, without and without IVF.

7.2.1. What if it doesn't work?

Alex emphasises the lack of certainty with regard to going through IVF;

It's a lot of money isn't it. A lot of whatever putting your body through or whatever. A lot of strain is what I think I'm getting at, especially if the result is negative after all that.

Uncertainty is depicted in "whatever" and the possibility of a "negative" outcome. There is a sense that Alex feels she is taking a risk and the lack of guarantee resulting in "strain" the strain focusing on her body and finances. Jude draws attention to a comparable sense of risk;

I think it seems very stressful... Traumatic... I think it's a very risky business.

The risk in this instance signifies to something beyond stressful, Jude likens it to a trauma.

She goes on to say;

I've been asking myself questions like... What if it doesn't work? And what if I can't afford to take on such a massively financial burden? Or like will my relationship with my partner struggle (pause). Will there be any sense of resentment from my partner if we try and it doesn't work?

A fundamental lack of certainty permeates Jude's fears. It affects her sense of self, blame, financial strain and relationship strain; primarily based on the underlying fact that it may not work. She recounts "doesn't work" twice in this extract pertaining to a sense of fear perhaps born out of uncertainty. The concept of blame, as discussed in the previous chapter appears in this extract as she fears a possible resentment from her partner if she fails to fall pregnant.

This is propagated further by Rachel;

And now, potentially we can go through IVF, but what if that doesn't work? What if having a baby isn't meant to be for us? It's too sad to even think about!

For Rachel, the potential of the process not working is "too sad to even think about". The sadness and disappointment are arguably sustained by the lack of a guaranteed outcome. The fear being that if IVF doesn't work, perhaps a baby isn't meant to be. It is as though this is an overwhelming consideration for Rachel, and "too sad to even think about". There is something concrete and final to her assertion, it is as though it is her worst fear that will perhaps be realised. Rachel provides further insight into her emotional state;

Ummm I guess it's what I want. Well, what we want, as a couple. However, every month I do try not to get too excited or to be too positive as I worry the disappointment and sadness will be too much when it doesn't work.

Like Astra previously, Rachel corrects “I” to “we” portraying a sense of isolation, although her tone here is indecisive which could be derivative of whether she believes it is something that is desired by the “we”. Yet, it is the foreseen expectation of an unsuccessful month that inhibits Rachel’s emotional expression. Her fear could be that if she allows positivity, the result may be “disappointment and sadness”. There is a sense here of a lacking and an absence of hope for the future. During the interview process, the interviewer expressed to Rachel that it had been noticed that Rachel had looked sad at this interchange, Rachel replied to this with an apology. It is as if Rachel consistently tries to repress any emotional expression, as if she feels she has something to apologise for. Rachel appears to manage this by explaining often that she “tries not to think about things”. When asked why, she explains;

Cause I guess it would be too sad. And I want to try to keep positive, as much as I can

The sense of anticipating an anxiety around loss for Rachel and each of the women permeates the accounts. The strain of the present, dominated by the expected or anticipatory anxieties of the future based on a very real fear that a treatment does not guarantee a successful outcome. However, further insight emerged from the data surrounding the eventuality that pregnancy may be realised.

7.2.1. What if it does?

The participants revealed that the facet of uncertainty still reigned within the possibility of a positive outcome of pregnancy. For Astra, the uncertainty manifests in her concern over the future child’s health. She explains;

Yah, I think it is different yah, but in the end, it comes down to creating a baby that is healthy. I would worry about that anyway, even without the IVF thing.

Well as anyone I think it's just about creating a healthy baby, I will worry about that a lot.

Well, I've been pregnant before and it didn't work out. So, I'm worried that its related to that, perhaps.

These extracts are taken from different sections of the transcript evoking that Astra's fears over the health of her baby are pervasive, with and without a medical intervention. Again, uncertainty is a cause of worry for Astra. She echoes a sense of uncertainty regarding the safety of IVF and long-term effects. It also appears that Astra has experienced a negative outcome to pregnancy in the past and this adds to the gravity of the uncertain nature of pregnancy. There is further insight in to the complex emotional expression Alex is experiencing as she began to explore how a baby may impact her relationship;

I've come to realise that and massively fear that mine and my boyfriend's relationship will change dramatically.

Alex relays that she has realised a "massive fear" of how the dynamics of her relationship may "change dramatically" through the introduction of a baby. She describes a friend's relationship;

They were so close before and so similar to mine and (boyfriend) relationship. (Mmmm). They were a team. But now with the baby they seem tense and agitated with each other. The baby was constantly bloody crying (Laughs). She said they still haven't had sex (Pause). It's been months now. She has no time for (her partner) now, all her attention is on the baby. (sure). I don't want that. I adore my life with R. I don't want a baby to ruin that, as selfish as that sounds.

There is a sense that the fear for Alex is that a baby may negatively impact her relationship. This is unlikely to be secondary to the MUI, it is more representative of Alex's vicarious experience. A baby has caused an agitation in the relationship of her friends and a withdrawal of intimacy. Alex states that the female in this narrative is less interested in the partner as all

of her attention is now on the baby. It is more likely that Alex fears not that she will give the baby all of her attention and not her boyfriend but more that she may experience a withdrawal of attention from him. She further explains;

Also, what if he loves the baby more than me? I couldn't handle that seriously
(laughs). I would be jealous of my own baby!

In this extract Alex refers to jealousy and a fear of her partner loving the baby more than her. She is regulating these ideas with her laughter, as though she is worried how she may be perceived by the interviewer. Alex presented as vulnerable in this part of the interview but continues to explore this idea and provides interesting insight into why she may feel this way;

Maybe its cause I didn't have a great relationship with my mum and think that I will be like that with my children.

For Alex, this clearly indicates a sense of trepidation based on her own early experiences. Providing a sense that the role of the baby in MUI could be understood in terms of the women's own early experience, which now impacts on Alex's emotional state. In the following extract, Jude discusses some of her worries;

Primarily losing the baby. Especially after all this trouble conceiving. I think I would be a very nervous pregnant lady and be constantly worried about any movement non-movement, going on busy transport (laughs).

Jude uses laughter perhaps to regulate her fears. The primary fear appears to be the anticipatory loss of a child. It could be argued that what she is experiencing now in her infertile state is akin to loss, for Jude her connection to fear is in the future, not in her present. Her narrative circumnavigates the possibility of no pregnancy at all or even the IVF process. Her fear is a very strong sense of an anticipatory anxiety. Thus far, the participants have exhibited their fears for the future, which seem to be fuelled by uncertainty. Underlying the

uncertainty, the data exposed a feeling of overwhelming emotions. The focus of the next subtheme is how the fears seem to exist in an interesting interplay with excitement.

7.3 Managing Uncertainty.

Different emotional expressions of uncertainty have linked to one another in the in the data so far, in an ominous expression of the future and the prospect of not getting pregnant and also actualising pregnancy. Throughout the transcripts, it is as though the participants are trying to manage their fears around IVF, uncertainty and pregnancy by evoking excitement.

For example, Astra;

And giving birth. That idea.... Yikes. Makes me shudder... it will be worth it though I'm sure.

Astra highlights that what she desires incites anxiety and causes her body to “shudder”. The fear Astra depicts somewhat visceral, it is reactive and physical. During the interview as Astra stated this word her body displayed a shudder, suggesting that she wanted to shake off the anxiety that had been provoked, a non-verbal communication of anxiety (Foley and Gentile 2010). The use of the word “yikes” is employed articulated to denote fear. She justifies the physical pain with a psychological form of comforting in this case “it will be worth it”. Astra seems to be indicating that the fear will be neutralised in terms of what she desires, she re-assures herself in “I’m sure”. The relationship with this fear is managed by the excitement around having a baby;

But would hope a happy time too as have something exiting to look forward to.

Happy, exited, nervous I guess that's the only way I can explain how I think I would feel.

For Astra, her image of the pregnant self is derivative of the interplay between fear and excitement. It is as though her desire helps to neutralise the fear and expectation of nerves. Her pregnant self is “happy”. Alex further depicts her fears around pregnancy and childbirth;

I could die during child birth....

The pregnant me is happier than I've ever known, more excited than I've ever felt in my whole life and more terrified than I've ever felt before.

Death is a concept that Alex is connecting with the birth. Unambiguous anxiety exists in her extract, what is interesting is how these intense fears exist alongside the notion that Alex will be “happier and more excited than she has ever been her whole life” whilst also “more terrified”. Fear and excitement existing in a binary relationship. The complexity exists not just in the absence of a child but in the anxiety and fear attached to the prospect of both not becoming pregnant and in fact, being pregnant. There is also a suggestion that the birth of the child will lend toward more happiness than she has felt her “whole” life, this could be interpreted as though the pregnancy and birth will amount to Alex feeling whole. The interplay between fear and excitement resonates within Jude’s narrative as she explains;

I'm actually quite frightened by the prospect of it.

Jude, like the other participants overtly expresses the desire to have a child throughout her narrative. Her analysis of what it may take to achieve this desire is conflicted by fear, trauma and risk. For example;

I feel myself trying to dismiss my worries and concerns and any negative feelings I have towards it. I hope that if I do get pregnant it will feel natural and like its meant to me and I'll embrace the changes to my body and to my lifestyle.

Jude seems to want to dismiss her worries, perhaps she is trying to protect herself from the eventuality that an IVF treatment may not be successful. In order to manage her possible

fears, she talks of embracing change and hope, as though it were meant to be which perhaps speaks of it being outside of her control. Jude goes to display the complex relationship she has with pregnancy;

Well its obviously difficult because of the physical problems, pain, life style changes and its inhibiting maybe. But at the same time, I imagine the pain and suffering is counteracted by the fact that you have created a life.

Of course, there are the more unpleasant physical aspects and inconveniences but predominantly, I know that the love I develop for the child whilst I am pregnant, and knowing I am taking care of him or her in the best way I can will outweigh any negative pregnancy symptoms.

The fears expressed are apparent in the “physical aspects” and “inconveniences”, she refers to “pain” and “suffering” which she describes as “inhibiting” and “difficult”. Yet the relationship is complex as independently Jude attempts to resolve this conflict in the “best way she can” by counteracting the negative factors with positive facets including the development of “love” and the knowing that you have “created a life”. There is a further sense of “knowing” to her narrative, which is interesting as she has described it as uncertain previously. The complexity of said relationship is vital in understanding the subjective experience of MUI. Jude seems to have begun to attempt to resolve her pain autonomously, counteracting the fear with what Jude seems to be pertaining to, that being hope. The complexity is apparent in Jaime’s narrative also, when she asked about the birth she explains;

Just a bit scared of the pain!!! (Laughs)

For Jaime, the “pain” that she refers to with regard to the birth was experienced in the interview as powerful. It was noted that her face grimaced and she grabbed her stomach, the

non-verbal expression of pain was palpable, in the room and Jaime attempted to laugh off her response, yet the significance of this communication was not muted. The dualistic relationship for Jaime is expressed below;

The fact that I am facing that is both daunting and exciting.

The expression in this transcript elicits both the negative “daunting” which denotes fear and the positive, “exciting” indicating hope. Perhaps this lends to a coping style adopted by Jaime, as it appears to function as a resolution of conflict. This is further propagated by Beth. Previously, Beth described IVF as a “necessary evil”. The primitive quality to such a description seemed to pertain to a fear. She refers to the birth;

The pain. Would I be alright? Would the baby be alright?

Interviewer: and this worries you?

Well of course it does yes. I have heard some terrible stories. A friend of mine just went through IVF and had to abort at 12 weeks because the foetus was so badly deformed. I think that would be too much for me to handle.

I have seen that whilst pregnancy can be a wonderful experience for some women it can be full of difficulties and even a danger to their health for others and that includes the births also as they seem to vary between women.

Beth’s anxieties are as with all the participants built on some rationale and in this case, experience. It is not to say that anxiety around childbirth is not to be expected or that it is unreasonable, it is more to gain insight into specific fears that may or may not be present in MUI. Within this narrative it appears to pertain to the tangible expression of fear and “danger”. For Beth, what is being exhibited here appears twofold. There is an anxiety surrounding the pain of birth coupled with an apprehension that has been shaped by a recent experience of a friend. The concern expressed is that it would be “too much” for her to cope

with. The existence of a dualistic relationship is present in the Beth's narrative in the form of a metaphor, describing how others may feel when pregnant;

Also, how women feel when pregnant, some feel like the traditional Earth Mother and enjoy the state of being pregnant whilst others feel like a beached whale and hate it.

Earth mother and beached whale are interpreted as the symbolic representations of the dichotomous relationship with pregnancy that Beth is arguably experiencing and expressing through metaphor in the form of extremes, indicative of both fear and excitement. This seems to apply to Rachel, manifested in the following extract;

I should probably be more worried about being pregnant, but I'm not really. I feel like once I have become pregnant, I'll have a baby and everything will be fine. (Yup). It will have taken so long, it wouldn't be fair for something to go wrong surely!

It could be interpreted that the worry for Rachel feels too overwhelming and therefore she denies any. This fairly reasonable statement contradicts the way in which Rachel presented, her anxiety in the interview superseded her narrative, when she states, "it wouldn't be fair for something to go wrong" is experienced as pleading rather than concrete. The dualistic relationship in this instance applies to what Rachel is saying and how she is saying it, which do not appear congruent as whilst her narrative displays a sense of excitement her presentation was more suggestive of fearful. Complex emotions, fear and uncertainty anxiety have been expressed in the subthemes so far.

7.4 Summary.

This chapter has highlighted the uncertainty present in MUI and how this uncertainty pertains to the participants expectations and summations of the impending future. The data has also exhibited that where the uncertainty manifests in the possibility of not becoming pregnant there are also fears around achieving pregnancy. Interestingly the women seem to

have begun to manage the uncertainty autonomously by counteracting the fears with excitement.

8. The Concept of Pregnancy, Past and Present.

This chapter specifically addresses the concept of pregnancy, and how it is conceived by the women in this study. Diagnosed with MUI, these women are driven by their desire for pregnancy. The following chapter highlights that this has not always been the case, the participants concept of pregnancy in the past contrasts with how they feel about pregnancy in the present. The first subtheme depicts how throughout these women's teenage years and early twenties, pregnancy was epitomised as that to be avoided; radically contrary to their current objective toward pregnancy. The second subtheme illustrates what appears to be a two-sided perspective, encapsulating an idealised version of pregnancy and contrasted with a disconnection from pregnancy.

8.1 Pregnancy Past.

This subtheme highlights how the participants view of pregnancy has evolved over the participants lifespan. Interestingly, a consistent facet throughout the data appeared. That being that pregnancy in the past was adverse and measures were taken to ensure pregnancy was avoided. Astra explained;

As a teenager and early 20s I for many years I did not want children.... was not on my agenda and even remember saying to family it was not my thing.

Astra quite affirmatively expresses how in the past she did not want children, a view she recalls sharing with her family. This attitude appears to be salient for Astra for "many years". When Astra was asked how she remembers the teenage her felt about getting pregnant she responded;

That would never had been an option, I knew I was definitely not ready for a child at that age and thankfully live in a country where abortion is a possibility.

Astra asserts strongly that for her teenage self, pregnancy was never an option. The words that Astra uses are particularly emotive. She uses “never, not and abortion”, there is no ambiguity in her stance. This is further propagated by Beth whom also refers to a contrast between past and present;

Having had it always instilled in me that I shouldn't get pregnant it now comes as a shock to do a full 360 degree turn around and it comes as a shock that there is now difficulties in conceiving. It's a difficult mind set.

Beth describes the contrast as a “360 degree turn around” and a “difficult mind set”, indeed her attitude to pregnancy has dramatically changed. She depicted that an outside influence; potentially her family and/or society “instilled” within her the attitude that she should not get pregnant, which now translates as a “shock that there are now difficulties in conceiving”.

Like Astra, Beth recounts her attitude from the past as a stark opposition to her present. Beth further explains;

Having come from a Catholic educational background and catholic parents my whole time, like I am sure many others at the time despite their religion, was spent trying to avoid pregnancy.

Beth mentions religion and how this “like many others at the time” could have possibly shaped her attitude toward pregnancy, that being; something to “avoid”. Beth continues to describe a time whereby she thought she was having a miscarriage;

Bit shocking.... But I didn't give it much thought. But again, at that age it would've been a catastrophe. That's a bit strong, it would've been an unpleasant surprise.

The use of the word “catastrophe” within this extract is strong and denotes an event causing great and usually sudden damage or suffering. In Beth’s narrative, she corrects it to be an “unpleasant surprise”, which is clearly not as impactful as her primary assertion of catastrophic, yet the foundation of a negative force was evident. This does not appear congruent to her description of “I didn’t give it much thought”. For something to be “shocking” and perhaps “catastrophic” implies that it held meaning for Beth. Alex confirms the idea of avoidance in the past;

As a young woman, I had no interest in babies or getting pregnant I did what I could to not fall pregnant.

In this extract Alex explains a lack of interest in babies and getting pregnant and this is further highlighted by her active intent in doing what she “could to not fall pregnant”, which is now the opposite of her current objective. When asked to recount her experience with pregnancy prior to trying, she stated;

Apart from trying not to get pregnant!

Again, this statement highlights her previous attitude towards avoiding pregnancy and in opposition to her present attitude and motivation of becoming pregnant. As a teenager Alex recalls the occurrence of pregnancy left her feeling;

Terrified.

Pregnancy evoked terror in the past for Alex. Her past relationship to pregnancy represents a powerful resonance in her transcript. Once more, we see evidence of avoidance in the past through the narrative of Rachel, as she refers to a previous pregnancy;

Yes, like it was the worst thing in the world and when it happened, it was! It was a problem to fix.

Yeah I think during my teens, twenties and even now in like my early thirties, becoming pregnant was something to be actively avoided.

Yes! I thought of it as something terrible! That should be avoided at all costs!

Rachel elaborates on the paradigm. Her past experience of pregnancy resonates with something “terrible” a “problem”. Her language is weighty, as pregnancy was something to be “avoided at all costs”. The way she explains her experience is without justification or reason. The avoidance in Rachel’s case seems to run parallel with the depiction of all participants, including Jaime;

It was the last thing on my mind and wouldn't happen till I was old (laughs).

It isn’t to say that Jaime is consciously avoiding the thought of pregnancy in this extract. Its more as though there wasn’t a need for it to enter her consciousness until she was “old”. Now that she is “old”, unfortunately Jaime is now struggling to achieve pregnancy. It could be argued that this creates a disparity in what she avoided in the past compared to what she wants the most in the present/ future. She goes on to say;

I... I.... ummm I think the teenage me was terrified of getting pregnant.

The use of the word “terrified” suggests there was more than just an acceptance that it wasn’t for then it would just happen later. It suggests more that there was indeed a conscious decision to avoid pregnancy, primarily due to its terrifying nature. It is unclear what Jaime is specifically referring to, yet the portrayal of terror is powerful and arguably significant, as this has featured on several occasions in the data. She goes on to say;

I now see it as such a gift. To fall pregnant and bring a child into the world is so special.

The suggestion that Jaime “now” sees it as a gift, opposed to the terror she previously spoke of exhibits a shift in her concept of pregnancy. A further complex relationship with regard to pregnancy is further evoked in this theme, the notion being; I avoided pregnancy all my life, now pregnancy avoids me. The impact of this is explored in the following subtheme.

8.2 Ambivalence.

Emergent from the data there appeared to be a sense of an idealised view of pregnancy, amalgamated with a disconnection from the concept of pregnancy. This could be interpreted as ambivalence, defined as a state of having simultaneous conflicting reactions, beliefs, or feelings towards some object (Armitage and Conner 2000). The two-dimensional perspective that emerges exposes two separately positive and negative paradigms toward the concept. The positive in this case seems to be idealised, whilst the negative side results in a distancing from pregnancy.

8.2.1 The Idealised Pregnant Self.

The data uncovered several expressions of pregnancy idealisations. The final question on the interview schedule asked the participants to describe “What does the pregnant you look like and feel like?”. The rationale for this question was based on the researchers experience of patients with infertility, in a therapeutic setting. The question had often yielded interesting answers that had led to a greater understanding of the patient’s subjective experience of infertility and pregnancy. In this setting the question reveals that the participants seem to be presenting an idealised concept of their pregnant selves. Alex for example;

Being pregnant to me I feel will be a magical and incredible experience.

This portrayal of a “magical and incredible experience” reveals a possible idealisation.

The use of the word magical in particular relates to something extraordinary or mystical.

At the same time Jude also displays to a future child as she depicts her child as;

A soul... a whole person who is going to have their own life and experience (laughs).

Jude often presents an idealised version of pregnancy. The suggestion that the baby is a whole person could be interpreted that the baby will make her a whole person. She goes on to say;

I want my partner to be able to touch my belly and us all feel safe and within an untouchable unity that cannot be felt with anyone else. It would be our world and our little life to take care of and love and cherish.

Jude demonstrates how the pregnancy symbolises a feeling of being whole. The representation of is “unity” between her, her partner and her unborn baby. The unity then becomes “untouchable” and is determined as “safe”. The expression here is of an idealised version of pregnancy, that it “cannot be felt with anyone else”. The sense is of completeness, in their “own world”. In this way, the pregnancy exerts a type of bond, the completion of a triad. Jude seems to idealise her feelings of needing to feel whole into the fruition of her baby. Her pregnant self is safe and untouchable. Beth describes her pregnant self in the following extract;

Having been overweight all my life the pregnant me feels like I have been on a massive binge without the enjoyment of any bingeing as I have been very sensible regarding diet and exercise, but I am also in wonder at what the human body can do and how it can produce a hopefully happy and healthy human being (pause) albeit a very small one.

Beth refers to being overweight all her life but that her pregnant self has not enjoyed the “binge” that is the prelude to pregnancy. There is a sense of wanting and a sense of restriction in her narrative. However, hope seems to be present, albeit perhaps a “small one”. She continues to explore;

Ideally a baby in my opinion, should be conceived in love, planned or at least not unplanned, unwanted or unexpected and by that I mean that even if one was not married the parents were planning to get married or in a relationship that was stable enough to deal with all that a baby needs i.e. a safe loving environment, ideally with two loving parents and if not well off financially stable enough to provide the basic necessities, shelter, food, clothes, warmth assuming that love is a pre requisite.

Beth describes an ideal once more, using “ideally” twice in the extract. She frames it in terms of the other and appears to regulate this ideal, as perhaps her ideal utopia has been shattered through the MUI. Her ideals are framed by an assumption that “love is a pre-requisite”. There is a sense of sadness in this extract, the fact that love should be a pre-requisite but seems to exist on an assumption – placed outside of her ideals. Jaime describes her pregnant self;

Glowing and feels wonderful!!

Jaime’s depiction of herself is glowing, and overarchingly positive. It could be argued that the depiction of glowing is based on a traditional view of what mothers are expected to encounter in pregnancy and therefore could be somewhat idealised. However, when the negative side of the ambivalence is encountered this appears to result in a disconnection.

8.2.2 Disconnection.

This subtheme attempts to highlight how there appears to be a relative disconnect from the concept of pregnancy, based on what emerged through the analysis of the data and on the researchers notes whilst conducting the interviews. For example; Jude explains how she has viewed pregnancy in the past and how that impacts on her position now;

Whenever friends or family members have been pregnant it's always felt quite 'not-real'. Like it's something for them to have and not me.

Jude explains the concept of pregnancy as something that is “not real”, that it is perhaps distant or hypothetical. Her depiction of “them” to have rather than her compounds the feeling of distance she is evoking. The overall feeling in this section is that Jude is distancing herself from pregnancy or feels distant from. The way she conceives pregnancy appears disconnected. She continues;

It always seemed so far away (laughs). My friends and I would joke about who would be the first to get pregnant. I always knew I really really wanted children but again, like I said, the pregnancy part itself seems very scary and surreal and always has done.

Distance continues to resonate in this extract as Jude uses “far away” to denote a pregnancy. Although it appears that Jude is able to connect to the wanting of a pregnancy, although it is expressed in humour, her congruence with this is emphasised in “really really wanted children”. The disconnection exists in the “pregnancy part itself”, it appears that the concept of pregnancy is “scary and surreal”, This is what seems to fuel the ambivalence for Jude, she laughs and uses her friends “jokes” as ways of managing the negative side of the ambivalence. She goes on to say;

Now I have been actually trying I feel really very scared. (Mmmm) Life will change if it actually happens. (Pause) Obviously, my body will change which is worrying - I don't know how I feel about getting big and having a life growing inside me. (Sure). I think that it's something you can't ever really prepare yourself for - such a surreal phenomenon.

Jude recounts “actually” twice, as though she is attempting to bring reality into the narrative. This reality leaves Jude feeling “scared”. When she describes a life growing inside of her she states she is unsure of how this makes her feel. It seems more that she is describing that she is

scared and perhaps overwhelmed. The concept of pregnancy being something that feels “surreal” and that she is unprepared for, this speaks to a sense of being overwhelmed. One such factor that appears to be overwhelming to Jude is change and how pregnancy will impact on her body. It is important to note that during this part of the interview, Jude felt very anxious. The anxiety seemed to grow the more she connected with the reality of pregnancy. Therefore, it could be argued that for Jude, a sense of disconnection works to protect her from feeling scared and perhaps overwhelmed. Beth evidences a similar disconnection. It is as though Beth finds it difficult to confront her infertility. The process of the interview proves difficult to encourage Beth back to the subject of her own infertility; as she is able to discuss pregnancy in terms of the other, and by doing so may be trying to keep the difficult and painful emotions at a safe distance, for example;

I feel that fertility treatment can be a good option for some people but in my opinion it is obviously not a simple single issue that stands alone.... but I do believe that it has turned into a bit of a business and its successful for many people but it can perhaps give false hope to others.

It could be argued that Beth is not simply expressing a view of the nature of IVF as a business, as her use of “false hope” and “stands alone” have a powerful resonance to them, suggesting a sense of isolation, disconnection and lack of hope, perhaps her own lack of hope. She continues;

I think the whole subject is massive and cannot really be a single issue separated from many of the other changes that have taken place in society over the last 25 years and more particularly with regard to women, pregnancy and motherhood.

Beth’s depiction of pregnancy is again distant and disconnected, in particularly the concept of her own pregnancy. She goes on to explain her experience of pregnancy has been vicarious;

My experience to date of pregnancy is vicariously through friends and family members that have had children (pause). From observing these pregnancies, I have seen that whilst pregnancy can be a wonderful experience for some women it can be full of difficulties and even a danger to their health for others and that includes the births also as they seem to vary between women.

Beth's narrative again attempts to distance ideas of her pregnancy away from her awareness. She talks about the experiences of her friends ambivalently and without affect, perhaps keeping herself distant from her lack of pregnancy. Likewise, Rachel describes a lack of worry over her MUI;

I should probably be more worried about being pregnant, but I'm not really. I feel like once I have become pregnant, I'll have a baby and everything will be fine.

Rachel's seems to maintain a sense of disconnection throughout her interview, she appears to be trying to convey an attitude that she isn't worried and that "everything will be fine" which, on one level may be a reasonable perspective. However, this is directly incongruent to her presentation in the interview. As she appeared anxious and unsettled. Rachel continues;

Yes, I'm just thinking that as fertility treatment moves closer to ummm a reality, to my reality, I am starting to question, in my own mind ummm whether or not it is the right path for us as a couple.

Interviewer: Sure. Can you say why?

Well, it's not something I want to rush into. There is nothing wrong with us, so this should just work out when it is supposed to.

Interviewer: You mean getting pregnant when you're supposed to?

Yeah.

Interviewer: without an intervention?

Yeah, when its meant to be....

In this exchange, the researcher persists to penetrate Rachel's expression. Her denial is robust and whilst her narrative comes across as acquiescent, it is incongruent to the anxiety she presents with during the interview. As she states, "when its meant to be" she is attempting to convey that she is accepting of her infertility and that it will potentially resolve when the time is right or perhaps when fate intervenes, but it feels more as though she cannot allow the thought of infertility to exist, as this becomes part of her "reality". As the interview continues, Rachel provides some insight into her emotional state but continues to maintain a disconnected stance;

I just try not to think about it.

In this extract, the dissonance she presents with is purposeful. In that she potentially has an awareness of how to protect herself from the "reality" she mentions. As previously discussed, Rachel disclosed that she had a termination in the past. It seems as though a disconnection is evident discussing how this impacted her;

I viewed it is a problem that had to be dealt with quickly and without fuss. Very few people know and I didn't, I mean I prefer to think that it never actually happened. It was so long ago that it now feels like it didn't.

Rachel refers to the past as a problem that needed fixing, these extracts imply that that she has fixed it by disconnecting from it. The pregnancy in the past was a "problem" that required "fixing without fuss". Her lack of pregnancy in her present now potentially requires a medical intervention, therefore the disconnection can be read as an overwhelming feeling that "fuss" will occur. Ambivalence is also apparent in Jaime's data;

Yes. Definitely. I think it's a matter of timing. It's not my time now, I believe that it must be for a greater reason... like its someone else's time... but I it will be (laughs).
I'm keeping positive.

Jamie maintains positivity and holds this tension by asserting “reason” and rationalises this through the supposition of a higher power. She goes on to state;

But also that the mind is such a powerful tool and also can stop a pregnancy.

There seems to be a feeling that if she were to get in touch with any of the negativity associated with pregnancy during the interview process or otherwise, this may result in an unfavourable outcome. It is as though she must remain positive or her “mind” may “stop a pregnancy”. Jaime attempts to remain in the positive aspect of her ambivalence and reject the negative side, perhaps it is the disconnection from the fearful side of her ambivalence that is present. Furthermore, Jaime explains;

Like when you believe something and then it happen (pause). Whether it’s good or bad.

Ummmm I believe that good, like good things will happen, so they will. If people focus on negative things then, maybe, I think they are more likely to happen

Jaime seems to want to distance herself from negative side of the ambivalence. It is as though if she were to connect to that, or to “focus on negative things” they may be “more likely to happen”. Jaime’s ambivalence seems to be working adaptively in maintaining a positive external reality. It could be argued that this may not be sustainable long-term.

8.3 Summary.

This chapter has illustrated how the women in this study had dramatically changed their mindset toward pregnancy, over time. Pregnancy in the past was to be avoided and in some cases was viewed as terrible, evoking terror. It emerged from the data that the women in the present exhibited an ambivalence towards pregnancy in the present. This seems to have

manifested in a complex relationship with pregnancy. It is as though they may be struggling with concepts of pregnancy much like their struggle to conceive.

9.0 Discussion.

This chapter will summarise the findings of the study and explore the emergent themes, relating them to the existing findings in the field of infertility. Consideration of the contribution to counselling psychology and the implications for practice are also reviewed. This chapter aims to provide a critical analysis of this study by re-visiting the research aims and strengths, limitations and possible areas for future development are discussed.

9.1 The Explanatory Vacuum.

MUI is diagnosed when a couple has been unsuccessfully trying to conceive for twelve months or more. As well as the inability to fall pregnant, unexplained diagnoses have ruled out all other known explanations and a thorough investigation of the infertile couple is required prior to a diagnosis of unexplained infertility. Therefore, whilst specialists may have ruled out several undesirable causes for infertility, there remains an explanatory vacuum as to why infertility persists. This chapter presented how the women in this study tried to make sense of the medical mystery that seemed to encapsulate their MUI. The sense making emerged from the data from four positions; the seeking of answers, turning the blame inwards, outside influences and how this was structured in terms of a society, family and culture.

9.1.1 Seeking.

While there are plenty of unanswered questions about the nature and cause of MUI, there seems to be no question that these participants are suffering. As Bell (2013) suggests

“for the women who had been given a reason or reasons for infertility, there was comfort at least in having some information as to why natural conception was proving elusive”. Without diagnosis or definition what seemed to emerge was a profound sense of seeking.

It is as if the absence of a reason failed to give designation to a sense of the unknown, this seems to have resulted in rumination and a seeking of answers, ‘finding answers’ being the most prolific reason the women were attracted to this study. The participants seemed to have an expectation that an explanation existed but was yet to be uncovered or that something had been missed. Perhaps the bio-medical approach to infertility influenced this. MUI is less tangible than say an ovulatory disorder or tubal dysfunction, the explanatory vacuum seems to leave the unexplained, unexplainable. It is as C. S Lewis describes: it is easier to say, “My tooth is aching” than to say, “My heart is broken”.

The lack of diagnosis has resulted in frustration and the women seem to be ruminating over potential causes for the infertility. It is most likely that this is an attempt to create meaning and order in a painful, chaotic experience. The sense of seeking resonates throughout this theme and throughout the study. Who or what is to blame is the very question dominating their mental life and for Beth she even seems to frame this by questioning whether her relationship was meant to be. It could be argued that these sorts of thoughts and feelings are inevitable. As rational beings, humans have an innate tendency to assign meaning, cause and blame to negative life events, even to events that are largely out of their control (Bernard 2010). It is as though, for these participants they are desperately seeking a way to understand and build a new ontological framework. In MUI, this seems to indicate a special vulnerability to turning the blame inwards upon themselves.

9.1.2 Turning the Blame Inward.

The seeking seems to result in a conclusion salient amongst the participants; when medicine and biology cannot be held accountable, the responsibility is turned inwards. The

data evidences a sense of the women attributing their MUI to actions taken in the past (such as terminations or health issues). Klock (2011) defines; “Women often assume that they are the cause of the infertility and search their past for a potential cause. Women who have had a sexually transmitted disease or previous abortion may be convinced that the infertility is a result of those events”. This tendency exists alongside the sense that when no medical explanation exists, the conclusion that is sought is that they are the problem. It seems as though the self-blame is compounded by a sense of shame. Sorenson (2016) believes that “Unlike guilt, which is the feeling of doing something wrong, shame is the feeling of being something wrong. When a person experiences shame, they feel ‘there is something basically wrong with me.’”. The data elicits powerfully that the women believe there is something intrinsically wrong with them. Lewis (2007, pg 135) defines shame as an “intense negative emotion that is elicited when one experiences failure relative to a standard, feels responsible for the failure, and believes that the failure reflects a damaged self”. The damaged self in this instance seems to be the inability to achieve or maintain pregnancy, the participants believing that they are the failure.

9.1.3 Outside Influences.

Environmental and lifestyle factors may be playing a large role in decreasing fertility rates in industrialised countries (Nargund 2009) and there is increasing concern about the effects of environmental contaminants on reproductive health (Fujimoto, Giudice, Fujimoto and Giudice 2009). While there is limited clinical data regarding most chemical exposures and human reproduction, studies in laboratory animal models and wildlife under- score the vulnerability of the reproductive system to many environmental insults at different times of development and across the life cycle (Fujimoto, Giudice, Fujimoto and Giudice 2009).

For the participants in this study the explanatory vacuum has resulted in the women looking for cause, with both Beth and Astra indicating there may be answer in the environment. Certainly, there is cause for concern as further research seems to indicate other, outside reasons for MUI such as Marci et al (2016) who indicate a possible reason for MUI may be the presence of a hidden viral component found in the endometrium. Likewise, Roberts (2001) describes aspartame, the sweetener found in diet drinks and chewing, as the “main destroyer of human fertility”. Additionally, Freeman (2010) points to a possible link between celiac disease and unexplained infertility. It is beyond the scope of this study to ascertain what environmental causes maybe involved in MUI, it is more to amplify the sense of seeking that is generated when a lack of answers exists. Ideas around who or what is to blame seem to be nourished by cultural expectations.

9.1.4 Society, Family and Culture.

This study aimed to investigate the experience of MUI not as a medical pathology but as the absence of a socially desired role. Society and family expectations seem to maintain the sense of blame, failure and arguably shame for these women. This theme strongly evidences that for the participants it seems less important how society views them, moreover the failure manifests in how the women view themselves in society; their infertility carries a hidden stigma borne of shame and secrecy (Whiteford and Gonzalez (1995). This is important because the role of health beliefs in psychological adjustment has been widely researched. How people feel about their illness or condition, shaped by their beliefs about themselves has been shown to influence the way they manage and cope with it. (Morgan, Villiers-Tuthill, Barker and McGee 2014). Therefore, to understand MUI comprehensively it is imperative to firstly understand the individual’s view of the world, and their view of their place in it. This is in accordance with the view that the experience of infertility is profoundly shaped by varying degrees of pro-natalism (Parry 2004; Greil, McQuillan and Slauson-

Blevins 2011). Women especially are said to suffer and to bear the brunt of infertility problems (Dyer et al., 2002; Dyer et al., 2004; Inhorn, 1994; Inhorn and van Balen, 2000). This claim appears to be based mainly on the idea that women are usually blamed for infertility (Inhorn, 1994, 2003, Gerrits et al. 1997; Papreen et al., 2000). This view seems to be maintained and moreover, propagated by the participants themselves.

The women measure themselves against their peers and feelings of isolation and exclusion are clear in the data. Williams (1997) found a sense of isolation to be one of the most salient features of psychological consequences of infertility. The highly problematic nature of infertility is usually attributed to the social importance of childbearing and strong social norms to reproduce (Dyer et al., 2002), as the participants point toward a sense of social exclusion around their MUI. To refresh the earlier supposition that; “The social construction of health and illness is perhaps even more striking in the case of infertility than it is for other conditions” (Greil, Slauson-Blevins& McQuillan, 2010) gives context to the present subtheme. They go on to say, “... no matter how medical practitioners may define infertility, couples do not define themselves as infertile or present themselves for treatment unless they embrace parenthood as a desired social role”. In society, a woman’s childbearing ability can often be closely linked to her status as a woman, so that when a woman is infertile she may feel unfeminine (Sultan & Tahir 2011) this was emergent within the data, characterised by the femininity worries of Alex.

As Kirkman (2001) suggests, infertile women must deal not only with the blow inflicted by infertility to their sense of self, but also with the difficulties of presenting a simple and coherent life story in the social world, this seems to relate to the narratives in this theme. As to make sense of something where there is no sense to be had, is nothing but senseless.

9.1.5 Clinical Implications.

There has been an interest in people's beliefs about illness causes for years and a growing concern that people's everyday understandings of illness are silenced by the 'voice of medicine' (Mishler, 1984; Lawton, 2003; Prior, 2003; Riessman, 2002). This thesis maintains that women with MUI or indeed infertility are not unwell. However, their understanding and beliefs about why the experiencing this difficulty in conceiving is integral to understanding them psychosocially. The idiographic nature of this study focusing specifically on MUI, rather than infertility as a construct has shed light on where the psychological impact appears to surface. This chapter evidenced how women largely blame themselves in MUI, which may manifest in shame. Shame embodies a painful sense of self-blame which if it does not resolve or if it cannot seem to be diminished or altered, then this can become a cause for clinical concern (Van Scoy 2016). It is not the clinical concern that embodies the findings of this theme, it is more that as counselling psychologists we try to understand and empathise with the layered and complex psychosocial burden manifesting in MUI.

Furthermore, cultural assumptions about women's reproductive responsibilities have shaped medical science and the medical system (Barnes 2014). Although male infertility is as common as female infertility (HFEA 2014), the women in this study seem to focus largely on themselves, which is perhaps governed by the voice of medicine and its focus on the female. With that in mind, the experience of MUI should not be silenced, instead the emotional pain and suffering must be given voice; to understand how in a pro-natalist society, women are viewed as 'less' than their fertile counter-parts and sadly as 'less' by themselves.

9.2 Uncertainty.

This theme explored how uncertainty is prevalent in MUI and provides suggestion of where the uncertainty appears to be fostered and subsequently maintained. The data and

analysis uncovered that the uncertainty the women were currently experiencing was largely due to the forthcoming possibility of a medical intervention. However, uncertainty for the women in this study is twofold. Firstly, there is an abundance of uncertainty as to why there is a failure to conceive, the medical fraternity have been unable to provide reason. Secondly, there is no guarantee or definite positive outcome to a medical intervention. A future conception is therefore, in no uncertain terms; uncertain. There is also emergent data regarding the impact not only of what it means to fail to conceive but also what it means to these women should conception become successful. It further materialised that the women seemed to be managing their uncertainty through an interplay between excitement and fear.

9.2.1 The Intervention.

The findings suggest that the uncertainty for the participants is fostered by a prediction of stress in their imminent future, regarding a possible medical intervention. The participants had attended an initial consultation at a fertility clinic and the possibility of an intervention was approaching. The literature review highlighted that of all the psychological factors thought to be involved in infertility, stress is possibly the most salient (Williams, Marsch and Rasgon, 2007). Due to this study being conducted prior to a medical intervention it has emphasised how stress inducing the possibility of treatment can be. Henning, Strauss and Strauss (2002) argued that the many of the previous infertility studies do not allow the separation of the psychological consequences of infertility from the possible consequences of the infertility treatment. What emerged from the data in this study is a greater insight into what the treatment means to the participants, independent from what infertility may mean to them. A sense of indecision emerged, it may be as Mapani (2015) explains “Many infertile couples still continue to delude themselves that they have a "minor" problem which is "easy to solve" and does not require "big-gun" therapy”. It may be that the beginning of infertility treatment is frequently a difficult decision for the couples as it is connected with the stress

associated with the inability to conceive naturally and the giving up of control over their own bodies (Malina and Pooley 2017). The data supports this notion as a loss of control was resonant, particularly for Astra. However, there was an additional sense that a ‘strain’ was predicted. This took form in terms of a sense of isolation, relational and financial strain but seemed to resonate quite powerfully in the lack of certainty. Malpani (2015) states that “a major mind-block is the fear that if IVF fails then they will have no further treatment option left to explore”. Therefore, it may be as Rachel described “too sad to even think about”.

9.2.2 Outcomes.

The lack of guarantee regarding the outcome of an intervention was prevalent in the data. Malpani (2015) describes that “dealing with a negative result can be one of the hardest things to cope with during IVF treatment - especially if it's the first IVF cycle”. The impact of the non-fulfilment of a wish for a child has been associated with anger, depression, anxiety, marital problems and feelings of worthlessness (Deka and Sarma 2010). As outlined in the literature review, the research on the psychological impact of infertility has been vast and the data in this study evidenced complex emotional expression which included trauma, loss, guilt and blame; the lack of guarantee adding to the already pervasive uncertainty.

For couples who have trouble conceiving IVF can be the key to starting a family. However, IVF treatment does not guarantee pregnancy. The IVF live-birth rate per egg retrieval for younger patients has doubled in the past decade to approximately 40% (HFEA 2014) although many women do not conceive on their first attempt, and it is impossible to guarantee any medical outcome with the technology (Adamson 2004). The lack of guarantee and perceived burdens of the intervention permeate the women’s accounts and intensify the uncertainty that exists. Uncertainty regarding the consequence of IVF and what this means in terms of it failing and also what it may mean in terms of success.

Pregnancy is a complex bio-physical and psychosocial process (Côté-Arsenault, Brody & Dombeck, 2015) which is more than likely further complicated by MUI. Therefore, an understanding of what the unborn baby may represent could be an important resource for individuals who are facing infertility (Amir, Horesh and Lin-Stein 1999). Alex explored the potential impact of having a baby and began to connect her own early experiences with what her unborn baby represents to her. Maternal representations of, and relationships with, the unborn baby appear to be associated with psychological health in pregnancy and beyond and might play an important role in identifying women who need additional support, as well as providing an arena to develop positive pregnancy experiences (Walsh, Hepper and Marshall 2014). Prenatal and perinatal psychology explores the psychological and psychophysiological effects and implications of the earliest experiences of the individual, before birth (prenatal), as well as during and immediately after childbirth (perinatal) (DeMause 1982, pg 244). The theory of prenatal attachment posits that a unique relationship develops between parents and fetus long before a child is born (Brandon et al 2009). As Alex has demonstrated, a relationship seems to already be forging and expanding upon these ideas could perhaps be a unique opportunity to contribute to the evolution of fertility counselling as described in section 1.5.

9.2.3 Managing Uncertainty.

It was suggested in the literature review that with MUI it is the ambiguity that is at the root of the distress (Paul et al 2010). This is indeed evident in this study and reflected in the abundance of uncertainty. What is interesting here is how the women have begun to autonomously neutralise their uncertainty in an interesting interplay with excitement. It appears that in this study excitement is the antidote or defence against fear. It is reasonable to suppose that many mothers to be will experience excitement in relation to pregnancy and starting a family and it is not unreasonable to expect that they should. However, it is

interesting in this particular study as it gives rise to a sense of hope. One that can perhaps be built upon in a therapeutic intervention.

9.2.4 Clinical Implications.

The process of IVF has high financial costs and demands a strict and intense regime of medication use, constant monitoring of hormone levels and intrusive procedures in order to retrieve eggs and after fertilisation to place them back into the woman's uterus (Kaliarnta, Nihlén-Fahlquist, Roeser 2011). This thesis has demonstrated that the participants already have a strong sense of what an IVF intervention demands and that the stress provoked by a possible intervention is, arguably, as stressful as going through the intervention. Campagne (2006, p. 1651) advocated for early and concurrent psychosocial support during the use of assisted reproduction services. As counselling psychologists, we should perhaps recognise a possible two-way process. It is recognised stress and anxiety effect outcomes of IVF (Domar, Zuttermeister, Seibel, Benson, 1992. Panagopoulou, Vedhara, Gaintarzi and Tarlatzis 2006. Williams, Marsch and Rasgon, 2007), and this thesis highlights that stress and anxiety are in essence provoked not by the IVF intervention alone, but additionally by the possibility of it.

It has been suggested that the emotional trauma of the MUI diagnosis has repercussions on a number of levels including intrapsychic and interpersonal (Raphael-Leff 1986). As this chapter has begun to indicate, the baby that is invented by the prospective mothers, may be representative of their own experiences. Therefore, MUI could perhaps be understood in the wider-frame of pre-natal psychology. In that that parenting is the process of becoming a parent to the unborn child, that which begins even before pregnancy (Deave et al 2008). It may be that the uncertainty, present throughout the data, could be reduced through a therapist's understanding of the women's own early experience and this could potentially be an important resource for individuals who are facing infertility. In this case, it is imperative

that counselling psychologists view the women with MUI not only as prospective parents but as daughters of parents too.

Recent evidence indicates that stress and anxiety in pregnancy can have harmful effects that may continue throughout the infant's lifespan (Mueller and Bale 2008; Talge, Neal and Glover 2007). While postnatal psychological distress has been widely studied for many years, particularly with a focus on postpartum depression; symptoms of maternal depression, stress, and anxiety are *not* more common or severe after childbirth than during pregnancy (Kinsella and Monk 2009). Therefore, the prenatal relationship between mother and baby is pertinent at all stage of conception. The data seemed to give insight to the participants inner world. For Beth, she framed her responses continually from an 'outsider's perspective', indicating isolation, referring to love several times. Jude exhibited a sense of the baby making her feel whole and seemed to list 'inclusion' as a factor to main parts of her often-idealised narrative around pregnancy. Astra refers to children in need and sense of abandonment. Whereas Jaime seems to reflect a positive early experience, but this is perhaps reflective of the familial and societal impact she discussed openly although there is a strong element of idealisation depicted in her narrative combined with a disconnection from the negative. Alex evidenced her own insight toward her anxiety based on her experience with her mother. This chapter could arguably begin the work of a therapeutic treatment. One that aims to resolve internal conflicts that may be present, encourage tolerance of uncertainty and build upon the hope and excitement displayed.

9.3 The Concept of Pregnancy, Past and Present.

The participants in this chapter, give insight into how they conceive a possible conception. It was illustrated that the desire to have a baby was not always present, in fact it was previously viewed as an unwelcomed event and in some cases terror evoking. The participants perspective toward pregnancy dramatically shifted over the course of time. The

mindsets of the past distinctly differing from the present. The second subtheme aimed to demonstrate how, in the present, the participants exhibited ambivalence toward the concept of pregnancy, suggesting a two-sided perspective. The positive arousing idealisations and the negative providing a disconnection from the concept. These will now be examined in further detail.

9.3.1 Pregnancy Past.

This study highlights how the participants relationship with pregnancy has shifted over time. Interestingly, a theme that emerged, consistently throughout the data was that pregnancy in the past was adverse and measures were taken to ensure pregnancy was avoided. Faced with being unable to conceive in the present, a complex paradigm is evident. Beth describes the contrast as a “360 degree turn around” and a “difficult mind set”. It is perhaps meaningful to revisit Turner and Robinson (1993) who found people’s reasons for having children include; that children are an extension of the self or a source of personal fulfilment and satisfaction and children enhance their identity. They also explained that people look forward to the companionship that youngsters will bring and that they want to nurture, motivate, and help children become happy and mature. Furthermore, they want to give their children what they themselves never had. Additionally, many couples want children because society expects it of them; it is what married people do. Certainly, this study has highlighted the societal impact of wanting to start a family. Implicit in the construction of parenthood as the natural order is the obvious corollary that those who do not reproduce remain outside the natural order (Thorsby 2004). This underlies the portrayal in the media of women living without children as selfish and child-hating — characteristics that are precisely opposite those of the idealised "mother" (Morell 1994: 55). It is important to note that it is the ideology of motherhood, rather than practice of motherhood. However, in this studies data we

do not see evidence of how or why a shift in perspective has occurred; what we do see is, that it has.

Numerous studies have examined factors affecting unplanned pregnancies and on adolescent pregnancies, but few researchers have asked women with a planned pregnancy what made it the right time to become pregnant. Thus, the typical, healthy woman's perceptions of when to conceive are not known (Montgomery et al 2010). Anecdotally, this phenomenon has commonly been called the “biological urge,” and it’s seen as part of women’s biological instinct to have children. Biology is at play when women are pregnant (Sloane 2002, pg 336). Oestrogen and progesterone kick in at conception and continue through pregnancy, along with the neurohormone oxytocin, which fires at the time of delivery. Furthermore, biology is at work once the baby is born, including how the mother’s brain responds differently to different baby behaviours (Broad, Curley and Keverne 2006). However, it is important to underscore that there is no real evidence to support the notion that there is a biological process that creates that deep longing for a child (Carroll 2012).

The data indeed indicates that a shift took place and it may be an interesting area of future research to look at this more in-depth. However, perhaps it could be interesting to consider that if the former construct of pregnancy can be defined as a memory, serving as a connecting link between an object (the baby) and feelings or thoughts towards that object (avoidance and terror). It could be argued that the unpleasant intrinsic feelings may remain, unconsciously, causing less than favourable associations with the object, which may be automatically activated, for example, later in life when the object is no longer adverse and is instead desired. This does generate the further discussion as it seems to have manifested in a complex relationship with pregnancy. The notion being; I avoided pregnancy all my life, now pregnancy avoids me.

9.3.2 Ambivalence.

The complexity of MUI is further evident in the ambivalence the women seem to display. The ambivalence, although perhaps similar to the previously discussed duality of uncertainty, seems to present in an unlike manner. Where uncertainty was characterised by fear and excitement, ambivalence suggests a complex relationship between idealisation and disconnection. This speaks to the complexity abundant in the narratives. The participants displaying each of these facets at separate intervals in the data, suggesting both opposing and overlapping experiences, where the former is laced with emotion the latter appears less so. The ambivalence that emerged will now be critically analysed.

Early studies on the relationship between psychological factors and infertility, rather than reproductive function, generally focused on the female personality characteristics and ambivalence for motherhood as the cause of medically unexplained infertility (Griel 1997). These studies have since been rejected (Griel 1997, Wischmann 2003). However, it does appear that an ambivalence exists. Haynes and Miller (2003, pg 66) discuss that ambivalent feelings about producing children are, of course, universal, and are currently heightened for western women by their increasing freedom to seek higher education and careers, and their increasing success in these areas. They go on to say that what is possibly contributory to lower fertility levels is a rejection of the negative component of ambivalent feelings, when these feelings are warded off from conscious awareness, and its return prevented by a defensive idealisation of the prospect of pregnancy and an idealised image of the baby. Without supporting or denying this supposition, an important finding within this data is the ambivalence as described.

The process of transition to parenthood appears to be different among previously infertile women and involves higher levels of anxiety, avoidance behaviour, and lack of

preparation for taking home a new-born (Kennell, Slyter and Klaus, 1970). This has led some authors (Fisher Hammarberg and Baker 1., 2008; Hammarberg et al., 2008) to the hypothesis that pregnancy and parenthood might be idealised by IVF couples. The supposition being that in pregnancy after ART, parenthood might become idealised and this may then hinder the adjustment to the reality of looking after a baby and the development of a confident parental identity (Hammarberg, Fisher and Wynter 2008). However, no study has ever attempted to investigate this. The subtheme seems to suggest that there is an element of idealisation present even prior to conception. The opposite side to this seems to be a warding off of the negative side of the ambivalence. It is as Raphael-Leff (2010) describes “To sustain this idyll, any negative feelings and resentment must be suppressed”. Edelman, Connolly and Bartlett (1994) believe whilst individuals go through IVF treatments, behaviours involving unrealistic optimism, idealisation and denial are coping mechanisms. This seems reasonable to assume prior to a medical intervention the women in this study are attempting to cope with their MUI and the complexity of their views on pregnancy past and present, and how this may impact their future.

9.3.3 Clinical Implications.

Precise information related to behavioural patterns of infertile couples is limited (Papreen et al 2000). This chapter has given light to how coping mechanisms manifest in MUI. With the intention that these ‘adaptations’ can be explored in therapy; as patients deploy various coping configurations to manage their relationship with their perspective to pregnancy, past and present. Essentially, moving away from the traditional medical discourse apparent in treating infertility (encompassing MUI) and toward a humanistic and empirically defined phenomenon created through early experience and defence of the self; and all of its complexity and structure. Psychodynamic approaches might examine how feelings of loss provoked by infertility reawaken past losses, whereas cognitive behavioural

approaches might want to focus on modifying maladaptive thinking patterns. Despite theoretical and methodological differences, it seems apparent that the ultimate goal would be to help the patient achieve a better quality of life.

9.4 Summary.

The research thesis aimed to explore the lived experience of women with MUI, prior to a medical intervention. The research aims will now be re-visited and critically analysed in terms of how they may have effectively contributed to this field of research. Limitations and recommendations for future research follow.

Firstly, the literature review evidenced that infertility had both psychological and societal consequences. Although the impact of these had largely been examined through quantitative methods and the traditional bio-medical approach, rarely outside of a positivist epistemology. The modification of the epistemological stance in this study has provided a more in-depth insight in to MUI, giving voice to the complex issues which seem to span biological, psychological, social and cultural domains. The complexity of how these women view themselves and their MUI has provided a commentary on how complex MUI is and how beneficial psycho-social support could be to these women.

Secondly, it was argued that traditionally any exploration of MUI has been conducted within an infertility study that has not excluded the MUI sample from the biologically impaired sample. MUI is patently different when there is no designation or cause, and therefore will be experienced differently. This study has given voice to the idiographic group in the hope that counselling psychologists, fertility clinics and allied professionals recognise that at the core of this experience is unexplained. To explain a thing you feel but have no control over seems to be taking its toll on the women in this study, and perhaps silently in many more women who share the same unexplainable existence.

The third aim attempted to illustrate that previous infertility research, in many studies, has been approached as though there is a presence of disease as opposed to the absence of a socially desired role. The phenomenological approach has offered the researcher the opportunity to develop an idiographic understanding of participants and what it means to them within their social reality. The experience of MUI is multifaceted and deserves to be heard, and not muted by the voice of medicine and the traditional lens from which it has been previously viewed. It was only very rarely, if at all, that women laid claim to a biological drive to reproduce, articulating their desire for a child not in terms of drives, but in terms of a wider, externally-determined role of societal expectation, which they are as yet unable to fulfil. The pathologising of infertility does nothing more than to pathologise the whole woman, defining her by her inability to reproduce.

The final aim illustrated that previous studies have largely failed to account for the experience of women with MUI prior to a medical intervention, which suggests we may not completely understand how infertility impacts individuals, as the experience has potentially been contaminated by a medical intervention. This study has given rise to how the possibility of a medical intervention is indeed a cause of stress, prior to engagement with it. The sense of the foreboding in terms of a medical intervention and its uncertainty could direct fertility clinics toward an understanding of how ominous and anxiety provoking treatment appears. Perhaps highlighting the need for psychoeducation or, indeed, psychological support prior to treatment.

9.5 Limitations of The Study.

It could be argued that the demographics of this study lack diversity, as the cultural representation apparent in this study is limited, however it is reflective of the demographic of those seeking infertility treatment in private clinics in London. The participants were Caucasian, English-speaking women with medium to high socio-economic status from a

single centre. The research aims could be further addressed in multicultural and multicentre studies, perhaps focusing on those not able to afford the costly private treatment. The study could be expanded outside of the private sector to build upon these findings and explore the subjective experience further. This thesis, and indeed largely within the current academic literature, motherhood is not represented outside of the discourse of the family, meaning that it has been characterised by heterosexual marriage. This is based on a more general principle of “heteronormativity”. Further research regarding less heteronormative representations of society could lead to develop the ideas around the cultural impact of MUI.

Some revisions were made to the interview schedule as the pilot interview resulted in feedback which caused the participant to feel overwhelmed and I wanted to avoid recreating this, possibly due to my lack of experience as a researcher. However, the data reported remains rich and useful and I do not feel that this has impacted the research negatively.

During the course of the interviews I noted that I had always attempted to end the interview on a positive note, asking the participants to visualise their pregnant selves. This is indeed an assumption of my own, being that a visualisation of pregnancy lends toward hope. However, this is built on being immersed in the world of fertility for several years, as both a nurse and counselling psychologist in training. This question yielded some interesting answers and it seemed to complete the interviews with a sense of hope. With respect to this, I noticed that I didn't probe this question. As soon as a positive answer was produced, I ended the interview. Reflecting on this, I wondered if I may have wanted to leave the participants feeling hopeful and not distressed or perhaps my inexperience as a researcher caused me to feel the need to end the interviews succinctly and positively. In this way it caused me to consider whether I was attempting less to contain their anxiety regarding MUI or my anxiety as a novice researcher. Further reflection led me to feel that I ended the interviews in this way to ease my own anxiety about investigating such a personal and sensitive experience but

perhaps more than this I too had been guilty of inadvertently reducing women to the “baby-making machines” I had tried to argue against doing. This question could generate more ideas about how the women feel about pregnancy; in terms of impact on the bodies and sense of self. Therefore, a limitation exists in the way this question was not fully explored and even more so, how I as the researcher found hope in the conclusion that a baby would be achieved in order to manage my own anxiety.

9.6 Recommendations for Future Research.

This research has opened many other avenues for further study. As a research project which only focused on women’s views and experiences, it would be interesting and beneficial to explore men’s perceptions too. Having argued that infertility treatments focus almost exclusively on women, I too have been guilty of doing so; in asserting women as the focus of this study and therefore a study like this would benefit all involved in treatments. Including men and furthermore couples including same sex couples and single mothers and fathers.

Furthermore, the study generated an idea that has yet to be studied academically, that being that a shift occurs in pregnancy over time. It seems unlikely that this is purely a biological drive and it would be interesting to determine how and when this shift occurs as it would give us further insight into women as more than baby-making machines, that are reduced to a view of mal-functioning in the face of MUI and infertility.

9.7 Concluding Remarks.

This research provided an in-depth snapshot of the experiences of a small number of women diagnosed with medically unexplained infertility. The results from this thesis highlight the value of qualitative research methods using in depth interviewing techniques as opposed to the previous traditional approach often used to examine infertility. The conclusions drawn support the premise that conceiving a possible conception with MUI is a

complex phenomenon and one distinct from infertility. The research has generated new questions, afforded a unique insight and provided directions for future research.

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Appendix 1. Participant Invitation Letter.



UNIVERSITY OF EAST LONDON

School of Psychology
Stratford Campus
Water Lane
London E15 4LZ

**Proposed project to explore the experiences of women who have been diagnosed with
medical unexplained infertility**

Dear Fertility Friend,

Thank you very much for reading this letter, which is to ask if you would consider participating in a research study investigating the experiences of women whom have been diagnosed with medically unexplained infertility. Prior to undertaking any medical interventions, such as IVF treatments. The research is being conducted by a team of researchers at the University of East London and has received a favourable opinion of the University Ethics Committee.

As part of this research, we would like to conduct individual interviews with women who are considering undergoing medical intervention for fertility.

We are hoping to gather information on people's views and experiences of infertility and to identify any common themes in the understanding of the experiences that have led you to the point of seeking medical help with fertility. Together with your help we hope to compile evidence to gain a greater understanding in to the experience of women prior to undergoing treatment. Your experience and understanding would make an invaluable contribution. The individual interviews are expected to take approximately 1 – 1 ½ hours.

I am attaching the Participant Information Sheet and if you would like to, please could you contact me: Louise Goddard-Crawley, Doctorate Student, at ***** or on ***** (Mon - Fri, 9am-5pm).

Please include the following information:

- Contact information.
- Which of the following days of the week would be most suitable for you.
- An indication of your geographical location and whether you would prefer to be interviewed at home or at UEL, Stratford campus.

If you have any questions about the research, please do not hesitate to ask.

(Should we receive an unexpectedly high number of positive replies, we may not be able to take up all offers of participation.)

We look forward to hearing from you.

Yours sincerely,

On behalf of the University of East London,

Louise Goddard – Crawley

Professional Doctorate Student.

Department of Psychology.

University of East London.

Appendix 2. Participant Information Sheet.

UNIVERSITY OF EAST LONDON

School of Psychology
Stratford Campus
Water Lane
London E15 4LZ



The Principal Investigator(s)

Louise Goddard - Crawley
Contact Details: u1330923@uel.ac.uk

Consent to Participate in a Research Study

The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate a research study. The study is being conducted as part of my Doctorate in Counselling Psychology at the University of East London.

Project Title:

Conceiving Conception: A qualitative examination of women's subjective experience of medically unexplained infertility, prior to medical intervention.

Project Description

The project wishes to explore the experiences of women who have been diagnosed with medical unexplained infertility. The evidence to date suggests psychological symptoms may interfere with fertility and the success of fertility interventions. However, these studies focus on the psychology and medical well-being of the infertility-patient during and after fertility treatment. These studies do not focus on the cognitions, emotions and behaviours of the patient before treatment begins. Interviews would be used to gain a better understanding in to subjective experiences and beliefs in relation to pregnancy. You will be asked to reflect retrospectively on your own experiences prior to undergoing medical interventions.

Confidentiality of the Data

All participants will be emailed an information sheet in which the nature of the research will be further explained and participants will be required to sign a consent form prior to the interview. If you decide to partake in the research you will have the right to withdraw up to

two weeks after the interview without disadvantage to yourselves and without any obligation to give a reason. After the two weeks have passed, the interviewer has the right to use their anonymised transcripts. Participants who withdraw within the two-week time frame will have all their collected information destroyed.

Participants and any individual mentioned in the interview will be allocated a pseudonym. In addition, any identifying references will be removed or changed. All information will be kept on a personal computer that will be password protected and all documents will themselves also be password protected. Data will be coded and anonymised. All paper documents such as consent forms will be stored in a locked filing cabinet.

The recording will be erased at the end of the research and all anonymised transcripts and consent forms will be erased after 5 years.

Participants will be informed in the information sheet that my Director of Studies and examiners will have access to extracts from the anonymised transcript.

Due to the sensitive nature of the research, participants may experience unpleasant emotions that could, even though unlikely, cause distress. As such, all participants will be provided with an information sheet prior to interview, in which the nature of the research will be explained, highlighting potential emotional reactions. In addition, participants will be informed that they have the right to terminate the interview at any stage.

Once the interview has taken place the participant will be given the opportunity to reflect on the experience and any concerns that this may have raised.

Location

The interviews can be carried out at your homes if you feel this is more convenient or we can arrange to have a quiet room at the UEL Stratford Campus.

Remuneration

Unfortunately, there wouldn't be any financial reward for taking part in this research.

Disclaimer

You are not obliged to take part in this study and should not feel coerced. You are free to withdraw at any time. Should you choose to withdraw from the study you may do so without disadvantage to yourself and without any obligation to give a reason. [Include if relevant to you: Should you withdraw, the researcher reserves the right to use your anonymised data in the write-up of the study and any further analysis that may be conducted by the researcher.

Please feel free to ask me any questions. If you are happy to continue you will be asked to sign a consent form prior to your participation. Please retain this invitation letter for reference.

If you have any questions or concerns about how the study has been conducted, please contact the study's supervisor [Dr. Irina Anderson, School of Psychology, University of East London, Water Lane, London E15 4LZ. [REDACTED]. i.anderson@uel.ac.uk]

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mark Finn, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Tel: [REDACTED]. Email: m.finn@uel.ac.uk)

Thank you in anticipation.

Yours sincerely,

Louise Goddard - Crawley

Appendix 3. Consent Form.

UNIVERSITY OF EAST LONDON



Consent to participate in a research study

Conceiving Conception: A Qualitative Examination of Women’s Experience of Medically Unexplained Infertility, Prior to Medical Intervention.

I have read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw, the researcher reserves the right to use my anonymous data after analysis of the data has begun.

Participant’s Name (BLOCK CAPITALS)

.....

Participant’s Signature

.....

Researcher’s Name (BLOCK CAPITALS)

.....

Researcher’s Signature

.....

Date:

Appendix 4. Interview Schedule.

1. How do you view fertility treatment?
Prompt; what about it do you think could be challenging?
2. How do you think your perspective on pregnancy and being pregnant has changed over your lifetime?
Prompt; remembering back to how you used to view pregnancy.
3. When you were in your teens and early twenties how did you view pregnancy?
Prompt; how did the teenage you feel about the prospect of a pregnancy?
4. Why do you believe that you may be experiencing difficulties in conceiving?
Prompt; what types of reasons have you thought that may be responsible?
5. What was it about this particular study that interested you?
Prompt; what attracted you to partaking in the study?
6. Have you ever been pregnant before?
Prompt/ disclaimer; please only answer if you feel comfortable doing so.
7. How long have you been trying for?
Prompt; when did you realise there may be difficulties with fertility.
8. What is your experience with pregnancy prior to trying?
Prompt; perhaps through friends or family.
9. How do you think your partner feels about it?
Prompt; it's a difficult thing to talk about, how do you feel he is effected?
10. Is there anything in particular about pregnancy that worries you?
Prompt; in terms of the pregnancy itself or after the pregnancy.
11. What is your preconception of being pregnant?
Prompt; how do you view pregnancy and being pregnant?
12. What was your feeling when you were told there wasn't a biological reason for infertility?
Prompt; can you remember what the diagnosis of MUI felt like?
13. Can you remember how the teenage you felt about getting pregnant?
Prompt; if you were to imagine the teenage you were with us; how may she respond to these questions?
14. What does the pregnant you look like and feel like?
Prompt; imagine you are pregnant now, how do you feel?

Appendix 5. Debriefing Material.

Conceiving Conception: A qualitative examination of women's experience of infertility, prior to medical intervention.

Dear Participant,

Thank you once again for taking part in the research. Your answers are very helpful to us and we appreciate the time and effort you have put in. Please be aware that BPS guidelines have been adhered to.

Your answers will remain confidential and your anonymity will not be breached in the presenting of the findings.

You are under no obligation to take part in this study. If you feel you would like to withdraw from the project please note that if you do so within two weeks from the interview date, the interview and all data will be destroyed. If however, you withdraw after the two week period the researcher maintains the right to use the data collected.

Thank you & Best Wishes

Louise Goddard – Crawley

U1330923@uel.ac.uk

If you are unhappy, or if there is a problem, please feel free to let us know by contacting If you have any questions or concerns about how the study has been conducted, please contact the study's supervisor Dr. Irina Anderson, School of Psychology, University of East London, Water Lane, London E15 4LZ. [REDACTED] or email i.anderson@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mark Finn, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Tel: [REDACTED]. Email: m.finn@uel.ac.uk)

Appendix 6. Ethics Review Decision Letter.

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

SUPERVISOR: Irina Anderson

REVIEWER: Melanie Spragg

STUDENT: Louise Goddard - Crawley

Title of proposed study: Conceiving Conception: A qualitative examination of women's cognitions, emotions and behaviours prior to medical intervention for medically unexplained infertility

Course: Professional Doctorate in Counselling Psychology

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.
2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below): In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.
3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below): In this circumstance, a revised ethics application must be submitted
4. and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY

(Please indicate the decision according to one of the 3 options above)

Minor amendments

Minor amendments required *(for reviewer)*:

I wondered if the title could be re-thought about 'conceiving conception'. Also is the study about experience in general rather than specifically thoughts, feelings and behaviours? There are some minor typos and some sentences are a bit muddled (data sources or

participant section particularly). The research questions are too long and quite difficult to understand – (what are underlying mechanisms for example). These should be framed in a consistent manner with the chosen research methodology. Should the participant receive the information sheet before agreeing to take part to help inform their decision? There may also be ethical implications of interviewing in participants' homes and this needs to be agreed with the supervisor in case there are any recent changes in regulations. Should the participants have the right to withdraw at any time or at least longer than two weeks? There is some repetition about confidentiality and data storage. Why is distress considered to be 'unlikely' for the participant?

Major amendments required (for reviewer):

Confirmation of making the above minor amendments (for students):

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name Louise Goddard-Crawley
Student number: u1330923

Date: 02.01.16

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

ASSESSMENT OF RISK TO RESEARCHER (for reviewer)

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

- HIGH
- MEDIUM
- LOW x

Reviewer comments in relation to researcher risk (if any):

Low

Reviewer (*Dr Melanie Spragg*):

Date: 02/12/2015

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

PLEASE NOTE:

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, travel approval from UEL (not the School of Psychology) must be gained if a researcher intends to travel overseas to collect data, even if this involves the researcher travelling to his/her home country to conduct the research. Application details can be found here: <http://www.uel.ac.uk/gradschool/ethics/fieldwork/>

Appendix 7. Example Transcript. Participant 'Alex'.

I – Ive turned on the recorder now. So I'll start with the questions if that's okay?

P – Yes, sure. (laughs)

I - How do you view fertility treatment?

P - Fertility treatment is pretty incredible. I allows struggling woman and couples to achieve pregnancy and a family, which I think is incredible.

I – okay, you feel its incredible. Thank you. Anything else you would like to say about that?

P – well I guess if the outcome was guaranteed it would be more positive.

I – what do you mean?

P- it's a lot of money isn't it. A lot of whatever putting your body through or whatever. A lot of strain is what I think Im getting at, especially if the result is negative after all that.

I – yes of course. How do you think your perspective on pregnancy and being pregnant has changed over your lifetime?

P - As a child I don't think I ever thought about pregnancy? Just watching adults and family with babies made me want a baby of my own to play with. As a young woman I had no interest in babies or getting pregnant I did what I could to not fall pregnant.

I – Such as?

P - you know the normal teenage things – contraception, morning after pill... you know. I was once in a relationship that had lost passion excitement and some love, but I wanted a baby. This didn't really make sense to me because I wasn't happy, it wasn't until I ended that relationship did I realise I wanted a baby to fill the void of what was missing.

I – so at one point you considered a having a baby to fill the void of a relationship you say?

P – yeah I know, sounds bad don't it. (laughs).

I – No, no

P - But I knew it wasn't the right thing to do but I just was like at the time, I just wont take my pill or whatever and then just see what happens. (Mmmm). Luckily for me now, nothing happened. Now I am in the most loving relationship of my life, I'm content and incredibly happy, (yes) we are financially secure and my career is not of much interest to me anymore. We are at an age and a position where we want to start a family. We want our parents to be fit enough to enjoy being grandparents.

I – sounds nice. Thank you. Next question. When you were in your teens and early twenties how did you view pregnancy?

P – Well like I said it was the last thing I wanted. I was always a really good teenager though... never really went through that wild stage like some of my friends did. There were a few pregnancy scares and stuff with them but nothing ever for me luckily.

I – so you kind of experienced it through them almost?

P – yeah. I took my mate for an abortion once. I think we was 19. We never told her mum or my mum and it was well hard for her.

I – Mustve been hard for you too, going through it with her?

P – I think it was yeah. But it just made me think even more about not sleeping about or having casual sex. I never wanted to have that reputation either. At my school some of the girls did. And I hated it. Glad I didn't fall into that.

I – Sure, yes. So,

P – And

I – sorry yes, go on...

P - Seeing pregnant woman has always fascinated me but at my age now i think it is beautiful and cannot wait to experience that for myself one day, feel that baby growing and bond even more with my partner and fall in love even more for what we are going through together. To feel even more love from our families for what we are going to give them. And yes get attention I guess. Being pregnant to me I feel will be a magical and incredible experience.

I – to get whose attention?

P – Our families.

I – it sounded before like you, when you were younger associated casual sex or being wild with being pregnant?

P – yeah, I think so yeah. Well its true though aint it. The more risk you like put yourself in.

I - So, why do you believe that you may be experiencing difficulties in conceiving?

P - I stopped taking the contraception pill a year ago and have still not got normal cycles and periods so this concerns me.

I – this is normal after you stop the pill?

P – yeah it is yeah... but still seems a bit off to me. Also my age concerns me, I'm 31 now. Think I should've had a baby or family by now.my partner had some health issues when he was younger but that's all been sorted now.

I – your partner had health issues?

P – well he had some problems with his testicles when he was a teenager. Its all sorted now. Hes been checked and everything is fine.

I – and do you think you should've had babies before now?

P – yeah most of my mates have and the media fills me with worry too and how we should already have had our children by 30.

I – do you believe that?

P – I think I do a bit. But I wasn't ready before, relationship wise and financially wise. I just worry that I left it too late so that is a worry..... even though I know it shouldn't be. My mum had me when she was 20 so I guess that I thinking about that too. Actually (R) mum was in her 40 when she had him. So that's good. I think I don't know now you know.

I – that's okay. What was it about this particular study that interested you?

P - erm.... That's a hard question. I don't know you know. I saw it and thought yeah why not. Nothing to lose.

I – Sure. Have you ever been pregnant before?

P – No.

I - How long have you been trying for Nicole?

P – since I came off my pill, so about a year... just over.

I - What is your experience with pregnancy prior to trying?

P – Apart from trying not to get pregnant! (laughs) And then that time when I thought that is what I wanted – but realised luckily it wasn't right at the time. I don't have any experience with pregnancy apart from family members and close friends being pregnant.

I – and whats that been like?

P – its fascinating. Watching the way the body changes. (Mmmm). So clever. I worry about that sometimes though.

I – About?

P – well.... About getting fat.

I – why?

P – I don't know if this is relevant but I have some like body issues. Always have done. Was a bit of a fat teenager and never want to go back there.... So I constantly worry about my figure and what I look like.

I – is this something in particular that worries you about being pregnant?

P – (laughs) I know ill get fat when im pregnant. But ill have an amazing reason too. Now its cause Im a greedy bitch!!

I – ooh that's harsh.

P – im only joking. (Laughs).

I – anything else about pregnancy that worries you?

P - . I worry I will be an hormonal bitch, I will get sick, I could die during child birth, I could miscarry, I will have no energy, I will get fat, get stretch marks, will get hairy.

I – that is a lot of worries....

P – I know. Im being dramatic. It will all be worth it I know. I cant wait to have a family with R. (Pause).

I -Is there something else?

P – Well, yeah kind of.... I think, I think after speaking to close friends who have recently had a baby (yeah). Ive come to realise that and massively fear that mine and my boyfriends relationship will change dramatically.

I – How so?

P – They were so close before and so similar to mine and Rs relationship. (Mmmm). They were a team. But now with the baby they seem tense and agitated with eachother. The baby was constantly bloody crying (Laughs). She said they still haven't had sex (Pause) Its been months now. She has no time for S now, all her attention is on the baby. (sure). I don't want that. I adore my life with R. I don't want a baby to ruin that, as selfish as that sounds.

I – I understand.

P – also, what if he loves the baby more than me? I couldn't handle that seriously (laughs). I would be jealous of my own baby! And what if I get post natal depression. Lack of sleep. Stuck with a screaming baby all day. He will walk through the door and I will just nag and moan at him. Everything could change massively.

I – well I think everyone has these fears don't they...

P – is this normal?

I – well.....

P – maybe its cause I didn't have a great relationship with my mum, and think that I will be like that with my children.....

I – maybe.....

P – I know what im like, I can be such a bitch sometimes.....

I - How does R feel about it all?

P - I think he is slightly concerned too but only because of his testicle issues in the past otherwise he just keeps saying everything will be fine, he wants to start a family almost as much as me. But I don't think men have the same feelings as woman.

I – the male factor for IVF has been ruled out though?

P – yeah yeah all is working fine I just get a feeling he blames himself.

I – you say women don't have the same feelings as men?

P – we are made different. They don't have emotions like us and in regard to fertility I think some men do feel pain (Mmm) and heartache along with their partners but they will never know how truly painful it is cause its not their body (Mmm). They don't have maternal instincts like women. Their bodies don't ache for it like a womans.

I – that is really interesting, Nicole what is your preconception of being pregnant?

P - My preconception of pregnancy is that it is a wonderful life changing experience you go through with the person you love more than anyone else in the world.

I -Of course.... and.... What was your feeling when you were told there wasn't a biological reason for infertility?

P - This worries me as no one in my family ever struggles to fall pregnant so I wrongly assumed growing up I would be fine.

I – sure. And what is that like for you?

P – well, makes me feel like theres something wrong with me. Even though I know there isn't the doctors have said we are both fine. So I guess im confused as to why it isn't working.

I - Can you remember how the teenage you felt about getting pregnant?

P – Terrified.

I – yes I think we covered this earlier., last question - What does the pregnant you look like and feel like?

P - The pregnant me is happier than I've ever known, more excited than I've ever felt in my whole life and more terrified than I've ever felt before.

I – theres a mixture of feelings there hey?

P – I know I want a family. I know I want that and I want to have a family with R. Im worried of course about whether everything will be okay with the pregnancy and what will happen if we cant get pregnant. I guess I am worried too about the effect this will have on my health and my body. But ultimately this is something that will make us happier than we already are (laughs)

I – and I think that’s a good place to finish. If that’s okay with you?

P – yes. Sure. Thank you.

I – thank you.