COUNSELORS' PERCEPTIONS OF THE MENTAL HEALTH ASPECTS OF INFERTILTY FOR HETEROSEXUAL WOMEN

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ABSTRACT

This qualitative study explores counselors' perceptions of the mental health aspects of infertility for heterosexual women by addressing the following five guiding questions: (1) How do licensed mental health counselors understand the infertility experience for the heterosexual woman client? (2) What is the counselors' experience of working with heterosexual women clients with infertility? (3) What do licensed mental health counselors ascribe as the goal of mental health treatment of infertility? (4) What are licensed mental health counselors' perceptions of appropriate mental health interventions for infertility? (5) What are licensed mental health counselors' perceptions of harmful mental health interventions for infertility?

To address these questions, ten participant interviews were conducted with licensed mental health counselors in the state of North Dakota. Out of the interviews, ten themes emerged which addressed four of the five guiding questions. The fifth guiding question was addressed by using representative participant responses. Themes were substantiated by direct quotes from the participants. An examination of the literature was then conducted to analyze any gaps between emerged themes and the existing literature on the topic. These gaps were addressed in the discussion, which also includes limitations of the study and recommendations for future research.

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DEDICATION

I would like to dedicate this dissertation to my children. Leyton, Teagan, and Tatumn, may you find joy in challenging yourselves one step beyond your comfort zone. You are much loved.

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INTRODUCTION

Context of infertility

The ability to conceive and carry out pregnancy is taken for granted by most, yet according to the American Pregnancy Association, 6.1 million American couples are experiencing reproductive challenges. Society shows some concern for reproductive health in the form of preventing unwanted pregnancies and sexually transmitted infections, however gives less attention to conceiving and successfully carrying out a full-term pregnancy (Rank, 2010). This lack of attention does not minimize the experience of those suffering with infertility.

According to the Center for Disease Control data collected in 2009; 11.8% of women in the United States ages 15-44 have reported using infertility services and 7.4% are infertile (as cited in Paul et al., 2010). Infertility has been defined as the inability to conceive after one year of regular, unprotected intercourse (Brown, 2004; Lykeridou, Gourounti, Deltsidou, Loutradis, & Vaslamatzis, 2009; Paul et al., 2010; Tüzer et al., 2010; Watkins & Baldo, 2004). Infertility can be further classified into primary infertility, which is never bearing a child, or secondary infertility, which is the inability to conceive after one live birth (Gibson & Myers, 2000).

Fertility during adulthood is an anticipated major normative transition. Therefore, infertility constitutes a nonevent transition (Gibson & Myers, 2002) and often requires individuals to redefine their identities (Anderson, Sharpe, Rattray, & Irvine, 2003; Jones, Jenkinson, & Kennedy, 2004; Korpatnick, Daniluk, & Pattinson, 1993; McDaniel, Hepworth, & Doherty, 1992; Ridenour, Yorgason, & Peterson, 2008; Schmidt, 2006). Infertility is a pervasive concern, which invades those who experience it in ways they can't begin to predict. Its effects include economic, physical, social, and emotional hardships, especially for women (Gibson & Myers, 2002; Goacher, 1995). According to a New York Times article dated April 28, 2012, in

vitro fertilization, which is the most common, but also a last-resort, procedure for infertility can be expected to cost between $12,000 and $17,000 per cycle. This financial strain can be stressful for both partners equally, but for other effects of infertility, the stress is greater for the woman (Goacher, 1995). An example of how women experience more stress than men is physically from fertility drugs and treatments (Mastroianni, Morell, Sokol, & Begany, 1997). Another reason for increased hardship for the woman is because her aspiration for a child might play a more dominant role in her life narrative, with fewer available alternatives to stabilize her self-identity (Edelmann, Connolly, & Bartlett, 1994). Goacher (1995) narrowed down five ways women experience more stress than men: (1) waiting for pregnancy test results, (2) time required for treatment, (3) fertility drug side effects, (4) sex on demand, and (5) treatment costs. For these reasons, the present study will focus primarily on the impact of infertility and the mental health treatment of infertility for women.

Literature examines the experience of infertility from the heterosexual, married woman's perspective. In addition to primary and secondary infertility, there is also social infertility, which refers to infertility due to lacking access to all necessary components of conception and applies to gay, lesbian, and single individuals (Rank, 2010). The experience of infertility for heterosexual women can differ from single and lesbian women's experience with infertility. Additional obstacles of infertility for lesbian women that most heterosexual women do not experience include religious objections, moral and ethical determinations, insurance coverage due to inability to be legally married in many states, discrimination, and legal barriers (Rank, 2010). Although many emotional experiences may be shared between heterosexual and lesbian women, there are enough additional obstacles challenging lesbian and single women to

distinguish them as two different experiences. This paper will focus primarily on heterosexual women diagnosed with primary or secondary infertility, not social infertility.

Statement of the problem

According to Boivin & Kentenich (2002), "15-20% of couples undergoing infertility treatments find it so stressful it necessitates mental health counseling" (as cited in Wischmann, 2007, p. 83). While half of those impacted with infertility will likely never have a child (Ridenour, Yorgason, & Peterson, 2008), some find counseling, which includes a mind-body learning component, can increase pregnancy rates (Domar, 2000). For most, the goal of mental health treatment is not necessarily to increase the likelihood of getting pregnant, but instead to lessen the negative impacts caused by infertility (Hammerli et al., 2008). At this point, very little is known about the counselor's understandings of infertility or successful mental health treatment.

Infertility is a social concern, which counselors can be a major source of support if they fully understand all the nuances it entails. Different societal norms can actually impact the level of distress a couple will experience (Vizheh et al., 2013). For instance, if maternity is viewed as the primary role of the woman, and marriage as a means of reproduction, then couples will likely experience greater levels of distress (Vizheh et al., 2013). Social norms run deep and provide a profound stigma toward childlessness. According to Miall (1985), norms prescribe that couples should want children. Therefore, childlessness is a stigmatizing experience. Stigmas judge voluntarily childless couples to be unhappily married, psychologically maladjusted, immature, selfish, lonely, and misguided (Miall, 1986). Often involuntarily childless couples get wrongly attributed with the same stigma as voluntarily childless couples since the only outward symptom of infertility is not having a child. Childlessness often challenges people to rethink their hopes

for the future. This is originally "felt as a crisis, then a disruption and finally a derailment of life dreams" as often a fantasy baby already holds a significant place in their hearts (Shapiro, 2008, p.143), and possibly even in their homes. Counselors can help those with infertility to recognize how societal expectations and pressures are playing a role in their mental health. However, since counselors are a part of society, they could also hold the same misunderstandings about infertility as the society at large.

Need for this study

This paper highlights the plethora of studies available, discussing all the different emotional consequences of infertility. Klonoff-Cohen, Chi, Natarajan, & Sieber (2001) went further to discuss how important it is to regulate the feelings of distress because the more distressed patients are the less likely they are to conceive. This suggested inverse correlation between levels of distress and pregnancy rate validate the importance of interdisciplinary care. While there are a number of different mental health treatments presented in the literature, no research was found addressing the understandings of licensed counselors regarding infertility and the mental health treatment with heterosexual women dealing with infertility. Brown (2004) stressed the importance of mental health professionals being aware of their views regarding infertility as well as making sure the mental health professionals have adequate knowledge to work with the issue of infertility, including causes and treatment. At this point, there is not a very clear picture of what is happening in those counseling sessions and whether or not it aligns with the practices recommended in the literature.

Purpose of this study

The purpose of this qualitative study is to uncover the understandings mental health counselors have of infertility for heterosexual women. Research covers the experience of

infertility for the clients, as well as some recommended treatment approaches; however, this study will address the gap in research regarding what is actually happening in the counseling room when somebody with infertility goes to a local, general counseling practice counselor and presents with infertility. This was addressed by interviewing 10 mental health counselors to address the following five research questions:

1. How do licensed mental health counselors understand the infertility experience for the heterosexual woman client?
2. What is the counselors' experience of working with heterosexual women clients with infertility?
3. What do licensed mental health counselors ascribe as the goal of mental health treatment of infertility?
4. What are licensed mental health counselors' perceptions of appropriate mental health interventions for infertility?
5. What are licensed mental health counselors' perceptions of harmful mental health interventions for infertility?

Researcher lens

Because "the researcher is the primary instrument for data collection and analysis," (Merriam, 2009, p. 15) it is important to understand his or her perspective on the topic of study. These subjectivities can add value to the study by joining personal qualities to the data. The rationale for this study is driven by the researcher's desire to make sure women with infertility are getting served in ways that address their needs, instead of having the counseling room be one more place reinforcing society's misunderstood messages. In order to move in this direction, the first step is to see what counselors' active perceptions are, as those will be emanating throughout

the counseling room and impacting treatment. Depending on what is found from this study, determinations can be made about whether further training for counselors will better serve the clients.

I have been encountering more and more instances of infertility both professionally as a licensed mental health counselor, and personally as a woman in her reproductive years with many acquaintances in their reproductive years. I am approaching this research acknowledging these prior experiences contribute to assumptions toward this topic. One assumption is it is very difficult for somebody without reproductive challenges to fully understand the experience of those with reproductive challenges. Another assumption is that depression symptoms will be the focus of treatment, while some of the infertility-specific experiences might get overlooked. Maybe this is because counselors feel more prepared and comfortable with depression symptoms. In order to keep these assumptions in check, I will be maintaining reflective field notes throughout the research project (Bloomberg & Volpe, 2008). Peer reviewers will have access to the reflective field notes throughout the entire research experience in order to ensure trustworthiness of data collection, analysis and interpretation.

LITERATURE REVIEW

Etiology of infertility

Infertility has gone through an evolution of etiological theories. It was first believed caused by unconscious conflicts, fear, anger, and repression in women. Research has not been able to show a causal link between these psychological states and infertility, so this psychogenic view has diminished in popularity (Greenfeld, 1996). An example of unconscious conflict given by Christie & Morgan (2000) is when people with infertility strongly desire to conceive but continue to harbor ambivalent feelings towards pregnancy.

According to the American Society for Reproductive Medicine (2007), infertility has been increasingly viewed as causing distress rather than as the result of distress. The more accepted psychological sequelae model operates under a similar premise, stating infertility is the cause and not the consequence of psychological distress. According to Greil (1997), this model focuses on the stressful nature of infertility and its treatment, believing it results in emotional consequences such as stress, depression, relationship difficulties, and social isolation (as cited in Jacobs, 2003).

Infertility can be attributed to both men and women. However, only 20-26% of couples seek treatment due to male factor infertility (Evers, 2002). When looking at the cause of infertility considering both men and women 35% is attributed to male infertility, 15% attributed to ovulatory dysfunction, 35% attributed to tubal dysfunction, 5% attributed to other and 10% unexplained. Considering women alone, 40% is attributed to ovulatory dysfunction, 40% to tubal dysfunction, 10% to other causes, and 10% unexplained (Rank, 2010). Kelly-Weeder and O'Connor (2006) stated female factor infertility has increased during the past 10 years in large part due to an increase in sexually transmitted infections (STIs), as well as advancing age,

extremes in body weight, and tobacco and caffeine. Stress has been a commonly blamed culprit of infertility as well. According to Kaufman (1984), most experts do acknowledge that physical dysfunctions causing infertility may be prompted by emotional factors. Brown (2004) stated stress is rarely the cause of infertility; however, high stress may cause infertility-related concerns such as irregular ovulation and fallopian tube spasm.

Meaning of fertility

There are many meanings reproduction can have, including feeling a part of the adult world, fulfilling a biological imperative, and providing a love object (Brown, 2004). Different personality theorists have addressed the issue of fertility as discussed in Brown (2004). For instance, Freud believed the Oedipus complex is when the inner conflict gets resolved for girls; "She gives up her wish for a penis and puts in place of it a wish for a child…. the girl has turned into a woman" (Freud, 1989, p. 676). Impacting a future generation is an important sign of healthy development according to Erikson's stage of generativity vs. stagnation (Brown, 2004). This impacting can be done through biological reproduction or through other activities that nurture the next generation. While women might have a strong yearning to have children, Margaret Mead (1962) discussed how it is hard to differentiate that desire from society's strong expectation of carrying out the caretaker role. This implies women might have just as hard a time grieving the caretaker role created by society as grieving the actual child. Thus, society's expectations of femininity and motherhood not only add a layer of distress for the infertile heterosexual woman, but also dictates what a heterosexual woman ought to desire in order for her life to be meaningful and fulfilling.

Emotional experiences of infertility

The impacts of infertility create an intense amount of distress that some authors have labeled the worst crisis and likened to the level of distress found in cancer, HIV, and heart disease (Domar el al., 2000; Paul et al., 2010; Tarabusi, Volpe & Facchinetti, 2004). This paper further explains emotional experiences as they are related to infertility, while recognizing each individual woman will have her own unique reaction to her infertility experience. This generalized discussion can give practitioners a starting place to build rapport and help the client feel understood.

Sense of self. Kirkman (2001) conducted in-depth interviews with infertile women who described infertility as a blow to their sense of self. This increased the difficulty in establishing a new coherent life story. In order to create, and be excited about, a new life story it has to be more appealing than the old life story. The blow to the sense of self, which would serve as the foundation upon which the new life story would be built, could challenge creating a new life story. Women subjectively rate infertility as more devastating and take greater personal responsibility for the infertility (Greil, 1991). This fragile sense of self combined with the increased sense of personal responsibility lead to fears her partner will abandon her or will resent staying in the relationship (Berk & Shapiro, 1984).

Feelings of depression. There is an established relationship between life stress and depression (Paykel, 2001), making accompanying feelings of depression one of the most documented effects of infertility (Anderson et al., 2003; Jones et al., 2004; Lykeridou et al., 2009; Matthews & Matthews, 1986; Miles, Keitel, Jackson, Harris, & Licciardi, 2009; Schmidt, 2006; Tüzer et al., 2010). Chen, Chag, Tsai, & Juang (2004) found that 40% of infertile patients met criteria of anxiety, depression, or both, which sharply contrasts with a community

prevalence of 3%. Some of the identified risk factors of depression include female gender, repeated treatment cycles, unsuccessful treatments, low socioeconomic status, foreign nationality, lack of partner's support for women, previous depression, and two to three years history of infertility (Domar, Broome, Zuttermeister, Seibel, & Friedman, 1992). There is also an association between levels of depression and successful treatment as found by Khademi, Alleyassis, Aghahosseini, Ramezanzedeh, & Abhari (2005) when a before-after study was conducted with 251 women being treated at a university-affiliated teaching hospital for assisted reproductive technology. This study utilized the Beck Depression Inventory scores and found the score rose after unsuccessful treatment and dropped if the treatment was successful. There was a positive correlation with the Beck Depression Inventory score after treatment with pre-treatment scores and duration of infertility.

Isolation. A symptom related to depression is the tendency for those suffering with infertility to isolate. However, this population gives specific reasons for increased isolation. Reasons given to isolate include "avoiding insensitive remarks, misguided sympathy, advice, or unintentional hurtfulness of being in the company of pregnant women or children" (Matthews & Matthews, 1986 as cited in Brown, 2004, p. 33). Revenson, Schiaffino, Majerovitz, & Gibofsky (1991) recognized the double-edged sword regarding social support. Well-intended friends and relatives provide unsolicited advice such as "just relax," possibly doing more harm than good, leading the couple to feel increased frustration and isolation. The lack of social support can also be a source of strain for the couple (Ridenour, Yorgason, & Peterson, 2009, p. 37).

Powerlessness. Brown (2004) found a theme in her interviews regarding issues of control. Many people have learned how to be successful in most areas of their lives by

persistence and hard work; infertility, on the other hand, challenges their previously held beliefs about the role they play in shaping their futures (Brown, 2004).

Grief. Grief is another common experience (Lykeridou et al., 2009; Matthews & Matthews, 1986; Shapiro, 2008), but it is unique with infertility for a couple reasons. With infertility, the losses are invisible and lack the social support people usually receive when their loss is tangible (Bergart, 2000; Volgsten, Svanberg, & Olsson, 2010). Other losses can include losses in self-esteem, security, control, faith (Naish, 1994), beliefs, and values related to relationships, health, status, self-confidence, and being cheated out of important life events (Brown, 2004). According to Volgsten et al. (2010), even after IVF treatment, 30-40% of couples will remain childless; 3 years afterward these couples report feelings of grief, meaninglessness, and emptiness.

Guilt. Guilt (Lykeridou et al., 2009; Matthews & Matthews, 1986; Milden, 1989) is often experienced more in the diagnosed infertile partner. It often entails the partner doubting his or her spouse's affection and fearing his or her spouse will leave him or her for a fertile partner (McDaniel et al., 1992). Additionally, Volgsten et al. (2010) report both men and women express disappointment in not giving their parents any grandchildren.

Stress. The research looks at stress, both in how infertility leads to stress and also how stress impacts fertility (Brown, 2004; Lykeridou et al., 2009; Miles et al., 2009). Domar (1996) states stress levels from infertility can be compared to stress levels experienced from divorce or death (as cited in Brown, 2004). This is particularly relevant because of the many confirmed findings that stress has both direct and indirect effects on pregnancy success (Boivin & Schmidt, 2005; Facchinetti, Matteo, Artini, Volpe, & Genazzani, 1997; Gallineli et al., 2001). The double-edged sword with infertility is that the process of infertility treatment itself is very stressful

including the worry regarding finances, risks of treatment, and how to balance work with treatments (Brown, 2004). According to Brown's study (2004), the treatment is both physically and emotionally exhausting, likening it to a big experiment on the body. Therefore, stress comes not only from the physical treatments but also from the emotional upheavals.

Relationship strain. The research is daunting in regard to the pressure put on the marital relationship when faced with infertility (Anderson et al., 2003; Jones et al., 2004; Levin, Sher, & Theodos, 1997; Schmidt, 2006; Tarabusi, Volpe & Facchinetti, 2004, Vizheh, Pakgohar, Babaei, & Ramezanzadeh, 2013), with sex being one of the most noted stressors as it becomes more of a chore than a pleasure (Hart, 2002; Myers & Wark, 1996; Vizheh et al., 2013). In addition to the strained sex life, couples need to learn empathic reciprocity and mutual empathy to increase their understanding of themselves, their spouses, and the situation (Gibson & Myers, 2000). Vizheh et al. found different genders experience infertility differently, leading to dissociation in couples. Failed attempts at pregnancy are linked with high rates of dispute and divorce in these couples; however, infertility counseling can improve marital and sexual satisfaction. Peterson et al. (2012) suggested counselors should seek permission to address the couple's sexual life directly by providing educational information, addressing myths, and answering questions.

Coping with infertility

The abundance of research about coping with infertility was completed in the 1980s and 1990s and came up with quite similar findings. Callan and Hennessey (1989) defined coping as "an attempt mentally or through some action to master, tolerate or reduce demands that exceed our resources" (p. 343). Strategies to cope with infertility found by these authors include: (1) being mentally prepared, (2) accepting and redefining the situation, (3) keeping busy, avoiding, and denying, (4) seeking information and support, (5) taking action to be a problem solver, (6)

looking to alternative rewards besides pregnancy, (7) calmly accepting emotions, (8) discharging emotions, and (9) resigned acceptance (as cited in Jacobs, 2003). It is critical that those suffering with infertility understand how their coping might be serving for or against their overall mental health.

While most of the literature agrees on the successful coping strategies, there were some noted differences. For example, Menning (1980) likened the phases of grief for couples with infertility to Kubler-Ross's death and dying model, which includes denial, anger, bargaining, depression, and acceptance. Patterson (1986) disagreed and discussed how coping with grief is different and unique for the infertility population; grieving fertility involves unfulfilled hopes instead of memories, infertility seldom has an end point, death involves an irreversible loss instead of recurring periods of hope and loss, death is public and brings social support, and infertility is stigmatized whereas death is not. In order to best assist this population, it could be detrimental to assume their coping and grieving experience could be likened to general grief.

Another contradiction was found between task and emotion-focused coping. Problem-focused or task-oriented coping is defined as "coping that is directed at managing or altering the problem of distress," and emotion-focused coping is defined as "coping that is directed at regulating emotional responses to the problem" (Lazarus & Folkman, 1984, p. 150 as cited in Levin, Sher, & Theodos, 1997). There is also a classification between avoidant strategies, which move the focus away from the stressor, and nonavoidant strategies, which focus on the stressor (Levin et al., 1997). Coping strategies engaged in emotional processing, regulation and expression have been found to be linked with lower levels of depression (Berghuis & Stanton, 2002); however, Levin et al., (1997) found the use of task-oriented coping to be associated with the highest level of marital satisfaction.

Stanton, Tennen, Affleck, & Mendola (1992) found that women dealing with infertility engage in more problem solving coping than their fertile counterparts. Compared to their male counterparts, women are more likely to use avoidance (Hsu & Kuo, 2002; Jordan & Revenson, 1999; Morrow, Thoreson, & Penney, 1995; Prattke & Gass-Sternas, 1993; Stanton et al., 1992), confronting (Prattke & Gass-Sternas, 1993), planful problem solving (Jordan & Revenson, 1999; Prattke & Gass-Sternas, 1993), positive reappraisal (Jordan & Revenson, 1999; Morrow et al., 1995), increasing space (Lee, Sun, Chao, & Chen, 2000), sharing the burden (Lee et al., 2000), storytelling (Keystone & Kaffko, 1992), and social support techniques (Hsu & Kuo, 2002; Jordan & Revenson, 1999; Morrow et al., 1995; Stanton et al., 1992). They are less likely to use distancing and self-controlling coping (Stanton et al., 1992).

According to Miles et al. (2009), 42% of women dealing with infertility reported clinically significant levels of distress. The following coping strategies and factors have been found to increase psychological distress in women: accepting responsibility (Morrow et al., 1995; Stanton et al., 1992), escape-avoidance (Morrow et al., 1995; Peterson, Newton, Rosen, & Schulman, 2006; Stanton et al., 1992), expressive gender role identity (Miles et al., 2009), and male factor infertility (Lykeridou et al., 2009). Lazarus & Folkman (1984) believed gender role identity, career role salience, and societal pressure all influence a woman's cognitive appraisal and therefore distress level.

On the other hand, these coping strategies and factors have been found to decrease psychological distress in women: planful problem solving (Stanton et al., 1992), social support (Gibson & Myers, 2002; Stanton et al., 1992), positive appraisal (Hsu & Kuo, 2002; Stanton et al., 1992), and having paid employment (Bleier, 1994). It is crucial that mental health

professionals assess women's level of distress and try to strengthen these coping mechanisms where possible.

While this paper discusses coping methods associated with greater and lesser degrees of emotional distress in women with infertility, it should be noted that men also experience distress and use different mechanisms than women to cope with the distress. In fact, Morrow et al. (1995) found in a study with 86 men dealing with infertility that 65% were above the norm in psychological distress, and 15% were in the clinical range. Men tend to use the following strategies more than women to cope with their distress: emotional suppression (Stanton et al., 1992), being the best (Lee et al., 2000), denial (Burns & Covington, 1999), distancing (Burns & Covington, 1999; Peterson et al., 2012), avoidance (Berghuis & Stanton, 2002; Burns & Covington, 1999), and withdrawal into themselves (Burns & Covington, 1999).

There appears to be a clear link between coping style and emotional distress. However, exploring how couples can cope successfully can be an intricate process, due to the complexity of individuals and matching coping styles of each partner. When working with women it is important to look, not only at how she is coping, but also how her partner is coping, and how that might be impacting her experience. For example, men tend to use avoidance more than women, however when one partner utilizes this strategy, the other also tends to use avoidance to the same degree (Ridenour, Yorgason, & Peterson, 2008). Also, if a woman is seeking emotional validation from her partner but receives an attempt at problem solving the couple will likely experience distance instead of the sought after emotional connection (Peterson et al., 2012). The next section will address different approaches to successful treatment of infertility, in addition to decreasing the levels of avoidance in both members of the couple.

Mental health treatment of infertility: appropriate interventions and foci of treatment

While the research is exhaustive on the implications and coping strategies for infertility, it seems to be scarcer regarding successful treatment, especially theoretically driven and well-designed interventions with empirical support (Jacobs, 2003). It was noticed during the literature review how the 1980s and 1990s focused heavily on the emotional experiences and coping strategies with very little focus on mental health treatment; in the 2000s, research started focusing on mental health treatment, while research on emotional experiences and coping strategies drastically decreased. The literature that is available for effective coping strategies presents contradictory results.

Mental health treatment is ecological beginning with the individual, then the couple and extending to family, friends, coworkers, and anyone else with whom they interact, including medical professionals (Shapiro, 2008, p.140). When Boivin & Kentenich (2002) interviewed 129 gynecologists, almost 50% believed mental health services are necessary when reproductive treatment fails, whereas 38% believed it should be offered at the beginning of treatment. Interestingly, they also interviewed women going through infertility treatments and found only 24% of them wanted counseling when reproductive treatment was not successful and 32% wanted counseling right from the beginning (as cited in Wischmann, 2007, p.86). Even though the level of distress associated with infertility is known to be great, less than 25% of couples actually seek out help (Vizheh et al., 2013). Greil & McQuillan (2004) were interested in what patients are currently doing to seek support and found the following patterns: 66% of women went to friends and family, 58% went to others experiencing similar circumstances, 60% read articles in popular magazines, 50% read scientific journals, 42% read a book, 24% referenced the internet, 15% contacted a support group, 8% contacted a therapist, 8% contacted a minister or

other spiritual leader, and 16% asked an alternative medicine practitioner about infertility (as cited in Wishmann, 2007, p. 84).

Identified tasks of the counselor working with infertile couples include helping clients cope and move past their grief, offer interventions to enhance the couple's resiliency, exploring alternate pathways to having family (Shapiro, 2008, p. 142), building communication (Hart, 2002), develop interventions that maintain their quality of life and buffer the effects of stress (de Ridder & Schreurs, 2001), move from denial to acceptance, help juggle the feelings of burden and helplessness with active hope and investment in other areas of life (Benyamini, 2003), and finally one of the most crucial counselor tasks is normalizing their strong reactions to infertility (Mahlstedt, McDuff, & Bernstein, 1987). These tasks have been met in individual and couples counseling, support groups, telephone counseling, the Internet, and educational group sessions.

More recent options for people working through infertility include telephone sessions and searching the Internet. Telephone counseling can be helpful especially for educational information (Boivin & Kentenich, 2002) but cannot replace traditional counseling when working through difficult emotional issues (Wischmann, 2007, p.83). This finding was confirmed by Reese, Conoley, & Brossart (2002) when they found "31% of respondents who described feeling very poor reported improvement after telephone counseling, compared to 54% improvement found in face to face counseling" (as cited in Wischmann, 2007, p. 85). The Internet is also becoming more accessible and easy to use for people as a quick place to get information. There are a couple concerns regarding Internet use. One concern noted by Huang, Discepola, Al-Fozan, & Tulandi (2005) was a lack of thoroughness on the fertility clinic websites; often the contents were difficult to determine if credible or if they were advertisements. Another concern is the

correlation with Internet use and increased feelings of depression and lack of support networks (Epstein, Rosenberg, Grant, & Hemenway, 2002). It seems the Internet can be useful for gathering educational information and as one source of support, but it is not recommended to completely replace face-to-face support.

Even though counseling for infertility is not utilized as much as preferred, it seems to be something that is appreciated in retrospect. Monach (2003) did a study and found 72% of participants were very satisfied or satisfied with their counseling services during their period of infertility. Hammarberg, Astbury & Baker (2001) confirmed similar findings when women were asked years after the completion of their treatment if counseling should be an ongoing part of infertility treatment; 90% of the women said yes.

As noted above, all the above methods can be useful resources for a couple with infertility; however, the preferred method of receiving professional assistance is through face-to-face counseling. Many different approaches to treating infertility are found in the literature. Hammerli, Znoj & Barth (2009) did a meta-analysis investigating the efficacy of psychological interventions and found there to be too few studies available for any one treatment strategy to be able to confidently deduce efficacy of any particular intervention. However, they did state psychological interventions were found to improve some patients' chances of getting pregnant. I've grouped different approaches found in the literature into the following four categories: support/intervention groups, constructivist approaches, acceptance approaches, and integrative perspective.

Support/Intervention Groups. Support groups are one of the more common modalities for treatment of infertility. Wischmann (2007) believes counseling and support groups are very efficient and successful and should be offered at no cost to patients at all stages of treatment.

Support groups can vary in their goals, but research has shown groups to increase feelings of belonging, decrease depression, provide education, and help individuals find strength (Shapiro, 2008, p. 141). Schmidt et al. (2003) found that only 10% of women and 4% of men would participate in professionally led support groups (as cited in Wischmann, 2007). Even though there usually is not a significant difference in pregnancy rates between those who do attend support groups and those who do not, those who do attend support groups tend to find them 'helpful' or 'very helpful' (Wischmann, 2007, p.85).

Fertility Group Intervention utilizes structured group therapy for infertility based on Cognitive Behavioral Therapy (CBT) principles. Cognitive Behavioral Therapy focuses the treatment on thought content and helping create useful cognitive change (Kraaij, Garnefski, & Vlietstra, 2008). The goal is to increase the mental health of those suffering with infertility, not necessarily to increase the likelihood of pregnancy (Hammerli et al., 2008). These groups combine educational topics and support over 10 sessions. Relaxation exercises are viewed as integral to the approach. Therefore, each session begins with progressive muscle relaxation and guided imagery. The members give a quick update on their recent medical happenings and then the educational topic is presented with discussion. The topics included are emotion acceptance and tolerance, the wish for a child, coping, enjoy life, medical treatment, self-esteem, meaning, disappointment and hope, waiting, and we are the champions. The session then ends with a go-around discussion of the main points (Hammerli et al., 2008).

Constructivist Perspectives. This approach is suited for those trying to understand a changed life and re-shape a sense of identity (Bridges, 2005). It is called meaning reconstruction because it takes an active approach towards re-negotiation of life rather than a passive approach to going through the stages of grief and returning to normal functioning (Bridges, 2005). This

approach understands that for many people it was decided very early in their lives that pregnancy, birth and raising children was a part of their future; when infertility is established, it poses a major disruption in this engrained life story. Constructivists also believe realities are created by individuals, and it is crucial to understand the personal story of loss for each individual and couple instead of assume a universal reaction to the infertility experience (Bridges, 2005). Becker (1994) discussed how some individuals develop a new infertile self-identity while they were going through this journey, which became a major part of their overall self-concept. The four main processes used to reconstruct meaning according to Gilles (2003) include: sense making, benefit finding, identity change, and continuing bonds (as cited in Bridges, 2003).

Autobiographical narrative therapy (Kirkman, 2003) adds a component that addresses some important barriers to the re-authoring of a narrative, such as the absence of a collective non-mother narrative and lack of meaningful alternative goals. According to this approach, it will not be possible to re-author a narrative until an alternative narrative becomes at least as attractive to the couple as the lost narrative. Also, if the lost narrative included goals perceived to be extremely important, such as mothering, it might be difficult to find goals as important to take its spot. Not only might it be difficult to replace the goal, it may be inadvisable to try to do so before the grief has been resolved from the lost narrative. Sensitivity to timing is required

Acceptance Perspectives. The next couple theoretical approaches have acceptance at the core of healing. Acceptance refers to being willing to admit a problem exists (Scheier & Carver, 2001). The Infertility Resilience Model (IRM) assesses couples' level of resilience specific to infertility. Resilience is contingent on modifying previous views of infertility and acceptance of the infertility situation (Ridenour, Yorgason, & Peterson, 2009). External factors, such as the

social and family environments, are assessed for the social meanings ascribed to childlessness. Education can increase understanding of infertility implications and help eliminate the social stigma (Ridenour, Yorgason, & Peterson, 2009). Pasch & Christensen (2000) stated the interventions of this model were recommended at the couple level and included techniques to increase acceptance, tolerance, and understanding of their spouse. Improved communication, open emotional sharing, and shared decision making responsibilities are also goals of IRM treatment (as cited in Ridenour, Yorgason, & Peterson, 2009).

Another approach is known as Infertility as a Transformational Process. Gonzales (2000) believed mental health providers needed to respond to infertility by interpreting the experience from the infertile person's point of reference. A qualitative study on 25 infertile women revealed five themes: (1) failure to fulfill a societal norm, (2) assault on personal identity, (3) mourning, (4) transformation, and (5) restitution. Failure to fulfill a societal norm included feelings of inadequacy as a woman and loss of purpose in life. They also felt a loss of respect and recognition from others. Assault on personal identity included threats to the self-concept, and this was narrowed down to powerlessness (inability to exercise freedom of choice), stigma (negative interpretations of others' behaviors as cruel and insensitive), alienation (lack of unity with family and peers), and deprivation of ties of descent. Mourning addressed the cycle of hope and disappointment while becoming more aware of the pain associated with the loss. Transformation was when they start to face the reality of their situation that they may never bear a child. Finally, restitution was a process of acceptance and attempting to put the pain behind them. The women were clear this was not a process of resolution but more so of becoming disengaged from the fantasy of becoming a biological mother. Even if a realistic perspective has

been taken and acceptance is under way, it appears that the inability to bear a child always remains a part of the self-identity (Gonzalez, 2000).

The Adlerian perspective, as discussed in Born (1989), looks at neurosis as avoidance of the life tasks of love, friendship, work, self-concept, and spiritual search. The striving for social interest, or connection with the community, is foundational to a person's healthy adult functioning. This perspective applies how infertility affects these different life tasks. The life task of love is impacted through the strained relationship even the healthiest of marriages will experience. Friendship is impacted by increased isolation caused by not feeling normal when compared to peers moving on in family development by having children. Often friends will provide well-meaning but inappropriate advice, such as "just relax," creating a barrier in the friendship (Ridenour, Yorgason, & Peterson, 2009, p. 37). While the person is undergoing infertility treatment it usually becomes the primary issue of focus in the couple's life, and work development gets a back seat. "Infertile individuals often describe themselves as broken, inadequate, unworthy, and not whole" (Born, 1989, p. 453). As a result, they might question their relationship with the universe thinking something similar to, "What happened to the idea if you are a good person then good things happen to you?" Goals of counseling in this approach include assisting the couple in decision making and coping with the emotional impacts of infertility. The tasks of the counselor are to provide encouragement, help balance the need for control with the need to pursue medical treatments, and to help work through couple conflict (Born, 1989).

Integrative Perspective. This perspective was developed with the goals of enhancing the likelihood of conception, decreasing the likelihood of miscarriages, establishing a stronger marriage, and to cope with thoughts and emotions such as the belief that her stress levels kill her baby before it even gets a chance to implant (Katz, 2008). These goals are worked toward using

mind and body techniques, which research has demonstrated can increase chances of conception. Katz (2008) said it is critical that those working with infertility understand the body's responses to the stress and how it might trigger other underlying emotional concerns. An assessment tool was created using the acronym MINDFUL CARE, standing for: mental health and medical assessment, identity and ego functioning, nutrition and neurobiology, developmental issues and drug/alcohol issues, family of origin and functioning, unconscious issues, loving and levity of life engagement, conscious and complementary interventions such as EMDR and guided imagery, alternative interventions such as hypnosis and acupuncture, restoration of health and relationships, exercise and education. The acronym is used to assess current levels of functioning in each of these areas as this model values the disengagement from stress, restoring the physiologic processes, and regaining a sense of balance and control by finding an emotional/body balance (Katz, 2008). Interventions such as body scanning can bring insight into how the body is reacting to and holding the stress; then techniques such as guided imagery, progressive relaxation, meditation, breath work, and reiki are used to help visualize the body relaxing and allowing conception (Katz, 2008). More systematic studies are needed to confidently determine a causal link between pregnancy rates and psychological treatment.

METHODOLOGY

Introduction

The purpose of this basic qualitative study was to uncover the understandings mental health counselors have of infertility and treatment for heterosexual women. Basic qualitative research does not discover meaning as much as it constructs meaning (Merriam, 2009). The current literature examines the experience of infertility for the clients, as well as some recommended treatment approaches. This research attempts to study a gap in literature regarding how general practitioners are approaching counseling sessions with clients facing infertility. A comprehensive understanding of this topic is needed to raise awareness of infertility, and therefore improve counselor's ability to treat clients with infertility. The overarching research question guiding this study is, "How do counselors understand and address infertility issues in female heterosexual clients?" To more precisely address this question, the following five questions were used to guide the research:

1. How do licensed mental health counselors understand the infertility experience for the heterosexual woman client?
2. What is the counselor's experience of working with heterosexual women clients with infertility?
3. What do licensed mental health counselors ascribe as the goal of mental health treatment of infertility?
4. What are licensed mental health counselors' perceptions of appropriate mental health interventions for infertility?
5. What are licensed mental health counselors' perceptions of harmful mental health interventions for infertility?

Rationale for qualitative research

Qualitative research wants to "understand how people interpret their experiences, how they construct their worlds, and what meanings they attribute to their experiences" (Merriam, 2009, p.23). This is interpretive, meaning there is no observed reality, but instead reality is socially constructed, and no two realities are the same (Merriam, 2009). The purpose of this approach is to describe, understand and interpret the meanings people have constructed. The emergent nature of basic interpretive research allows the researcher to take action on the participant's responses by following up with a related, non pre-determined question (Merriam, 2009). This study lends itself to the basic qualitative approach because the primary interest is the experience, meanings and understandings of the counselors with regard to the mental health aspects of infertility.

Research participants

This study included 10 participants, all of whom are Licensed Associate Professional Counselors (LAPCs), Licensed Professional Counselors (LPCs) or Licensed Professional Clinical Counselors (LPCCs) practicing in the state of North Dakota. Of the ten participants, eight of them were female, and nine of them were from urban areas of the state. See Table 3 for more demographic information on all ten participants.

Participant recruitment. Participant recruitment began after IRB approval was awarded (see Appendix A). This study included LAPCs, LPCs, and LPCCs who practiced in North Dakota. The sampling selection was purposive, selecting general practice counselors using the list of licensed counselors provided by the North Dakota Board of Counselor Examiners, which was available online to the public. The recruitment process utilized purposive sampling because

the selection criteria were pre-determined (Merriam, 2009). Psychologists, psychiatrists, social workers, and marriage and family therapists were not eligible to participate in this study.

This study was conducted in a rural Midwest state that had very few specialists and many generalists. The researcher wanted to better understand the experience a client with infertility would have going to a general practice counselor from the counselor's point of view. One way to get this information was by interviewing general practice counselors without providing additional criteria for inclusion. In order to increase the likelihood of obtaining in-depth interviews, selection began with counselors who were acquainted with the researcher but did not have a dual relationship or conflict of interest. The goal of participant recruitment was to conduct face-to-face interviews (Irvine, Drew, & Sainsbury, 2013). Therefore, the researcher consulted the North Dakota Board of Counselor Examiners licensed counselor list and began recruitment with those located within a 50-mile radius. The researcher then reached out to potential participants with a phone call. If the potential participant answered, the researcher followed the oral script for participant recruitment (see Appendix B). If the potential participant did not answer, the researcher left a voicemail stating the first two paragraphs of the oral script and included contact information for the potential participant to call back if interested in the study.

The researcher began interviewing 10 participants who were all recruited during a specified recruitment period. After interviewing the initial 10 participants it was determined from the interview process that data saturation had occurred. Therefore, adequacy of sampling was considered complete, which according to Merriam (2009) occurs when "you realize no new information, insights, or understandings are forthcoming" (p. 183).

When the counselor agreed to be a part of the study, the researcher emailed the participant the informed consent (see Appendix C) and demographic form (see Appendix D) to

be completed. The participants either emailed the forms back or had them completed prior to the face-to-face interview. The participant and researcher set up a mutually convenient time and location to meet for the interview. The preferred location for the interview was the participant's counseling office for privacy and confidentiality. When this option was not available, the researcher's office was utilized. Although in-person interviews were preferred, the researcher completed telephone interviews when face-to-face was not possible (Irvine et al., 2013). When telephone interviews were conducted, privacy was still ensured as the researcher conducted interviews from her office. Prior to the interview, the informed consent was reviewed with every participant. Of the ten participants, five interviewed in person and the remaining five interviewed via telephone to accommodate distance and/or childcare needs. Of the interviews held in person, three of them were held at the participant's workplace and two of them were held in the researcher's home depending on the participant's request. All interviews followed a question guide (see Appendix E). However, the researcher could incorporate additional questions as the interview evolved.

Participant information. Demographic information was gathered using the demographic form completed prior to the interview (see Appendix D). Information on the demographic form included name, business address, phone number, email, type of license, years practicing, education level, type of practice, specializations, theoretical orientation, number of clients seen weekly, history of seeing clients with infertility, received training/CEUs in infertility, and identification of any fertility clinics in the community serving the mental health needs for patients experiencing infertility. Demographic forms were securely stored, along with the informed consent forms and audiotapes. These items were stored separately from the

transcriptions and field notes, which had no identifying information but instead utilized a numbering system to ensure participant privacy.

Research design

Basic qualitative research involves interviewing the participants to construct their experiences and understandings (Merriam, 2009). This study had five guiding questions designed to describe the overarching research question of, "How do counselors understand and address infertility issues in female heterosexual clients?" Ten open-ended interview questions were used to facilitate the participant's reconstruction of his or her experience (Seidman, 2006) with the topic of mental health aspects of infertility. Because of the emergent nature of qualitative research, the researcher was able to follow up with related but not predetermined questions in each interview. Below is the list of interview questions used to guide the interview.

1. What assumptions or beliefs do you have about the issue of infertility?
2. A heterosexual woman client of yours says she has just been diagnosed with infertility. Please describe to me your understanding of what her experience with that could entail.
3. Can you give me a tour of a session with a client (heterosexual woman) that has infertility? (or potential client)
4. How prepared do you feel to successfully counsel a heterosexual woman with infertility?
5. How comfortable do you feel to counsel a heterosexual woman with infertility?
    a. What experiences have you had to increase your comfort level?
    b. What experiences have you had to increase discomfort?
6. What would you ascribe as the goal of your counseling session with a heterosexual woman with infertility?

7. What are your perceptions of the primary treatment concerns for a heterosexual woman with infertility?
8. What are your perceptions of appropriate treatment approaches to address those concerns?
9. What would harmful treatment look like or entail?
10. Is there anything else on your mind regarding the experience of infertility for your clients or your treatment with the client?

Data collection

Based on the qualitative nature of this study, interviews were used to gather information from the participants. An interview was the chosen data collection method because it allowed the participant to tell his or her story. Seidman (2006) described interviews as a meaning-making exercise designed to understand the lived experience of another with the assumption that his or her story influences his or her behaviors. The interviews ranged from 45 to 90 minutes and were done in person at the researcher's home office, at the participant's office, or over the telephone. The interviews were audio taped using two different recorders. The researcher had a notepad with the interview questions provided. Because of the emergent nature of the research design, the researcher had flexibility to ask additional probing questions based off the participant's responses. After the interview, the researcher left contact information with the participant and asked permission to do a follow-up interview with the participant if needed. No follow-up interviews were held. Permission was also sought to send the transcripts to the participant for review via email. All ten participants agreed to review the transcripts. A thank you note with a ten dollar gift card was given to the participant at this time in appreciation of their contribution to

the study. Permission was received to mail the gift card to the participants who interviewed over the telephone.

Once the interview was complete, it was transcribed using Microsoft Word software. Each interview was transcribed verbatim and in its entirety. Room was left in the margins of the transcriptions for the researcher to provide process notes on the right hand side. Each line was numbered to easily reference the statements during analysis. The participant's name was not used anywhere on the transcripts or field notes. The demographic form and informed consent form, which were secured throughout the study, were the only documents containing participant information. All other documents including the interview notes, transcription, and research paper used the participant's assigned number.

Data analysis

Data analysis was driven by the basic interpretive qualitative methodology. Data management consisted of filing the demographic and consent forms, labeling audiotapes, and organizing transcriptions (Seidman, 2006).

The primary focus of the analysis was to pull together pieces of data to form themes of experiences, thoughts, or feelings. According to Seidman (2006), the first step in breaking down the interview is to read the transcript and mark with brackets the passages that are meaningful. The researcher completed this analysis step by first reading each transcript in full, then going over each transcript a second time using a highlighter to mark the meaningful word phrases, erring on the side of inclusion. A table was then created in Microsoft Word to manage the data. The table had seven columns: the participant number, the data number, the word phrase, context, code, sub-code, and notes.

Table 1.
Data Analysis Example

10	16a	~~I guess I don't have a whole lot of assumptions~~ you know I think it is just a biological each persons body is created differently ~~for some couples it may be what happens in combination of the two of them so I don't as far as if they've done anything or the universe or God is punishing them I don't have any of those kinds of thoughts or beliefs~~	Counselor assumptions	Cause of infertility	Biological	
10	16b	~~I guess I don't have a whole lot of assumptions you know I think it is just a biological each persons body is created differently for~~ some couples it may be what happens in combination of the two of them ~~so I don't as far as if they've done anything or the universe or God is punishing them I don't have any of those kinds of thoughts or beliefs (both laugh)~~	Counselor Assumptions	Cause of infertility	medical	

Table 1.
Data Analysis Example (continued)

10	16c	~~I guess I don't have a whole lot of assumptions you know I think it is just a biological each persons body is created differently for some couples it may be what happens in combination of the two of them so~~ I don't as far as if they've done anything ~~or the universe or God is punishing them I don't have any of those kinds of thoughts or beliefs (both laugh)~~	Counselor Assumptions	Cause of infertility	Not self induced	

Each participant was assigned a participant number, which was used as an identifier instead of the participant's name. This number allowed the researcher to track the transcript from which the word phrase was pulled. Each response the participant gave throughout the interview was numbered, and then every meaningful phrase within that response was assigned a letter (i.e. 1a, 1b, 1c). This made up the second column called data number. The word phrase column included each individual participant response with everything lined out except the identified meaningful word phrase. The context column was a broad description of the word phrase, which helped in the sort process to clump like statements together. The code column included the meaningful phrase's assigned code and the sub-code column was if the code could be broken down into something more specific. For example, the context might be 'client experience,' a code might have been 'cognitive distortion,' and the sub-code might have been 'defective.' The notes column is where the word phrase was either broken down even further than the sub-code,

or when the researcher incorporated any notes that might have been useful while analyzing the data.

After completing analysis of six of the ten transcripts, the researcher went through the data and compiled an alphabetical master code list. While engaging in this process, the researcher went through previously coded word phrases and unified codes that meant the same thing but were worded slightly differently (i.e. thought distortions were all changed to cognitive distortions). Once the data from the first six transcripts were unified, the remaining four transcripts were coded using the same language. After data from all ten transcripts were entered, and codes were assigned, the researcher was able to use the sort function in the Microsoft Word software. The researcher sorted column 4 first, then 5, and then 6. By sorting, the table the codes were then clumped together so the researcher could view the data by looking at the significance of each code and forming themes (Seidman, 2006). The following table demonstrates a sample of the sorted table.

Table 2.
Sorted Data Analysis Example

4	9d	~~Well I imagine why can't I get pregnant, what's wrong with me, what's wrong with my spouse or partner, whats stopping this you know, I imagine sometimes you kindof hear~~ women who are wishing they were pregnant and then they witness someone else who is pregnant and so will wind up why did they get to be pregnant and I don't or you know	Client experience	Social experience	Comparison to Others	

Table 2.
Sorted Data Analysis Example (continued)

5	15	Well even to the degree that in society when you hear about moms that are addicted to drugs and abuse kids and everything else and trying to justify why they are good people that cant have kids while the not so good people or bad people have kids all the time. Try to rationalize that and figure out what that is and what its about	Client experience	Social experience	Comparison to others	
3	12c	: ~~Um I would think why is this happening to me what's wrong with me that this happens~~ why is it happening to me and not somebody else ~~um there might be some of that feeling upset about it and trying to think of things they can do to fix it or figure out options um I don't know trying to kind of reason through it eventually once the shock wears off I would think they would move from a more emotional place to a logical place to try to figure out what route to take~~	Client experience	Social experience	Comparison to others	

Once the themes were created, the analysis process included substantiating the themes with direct quotes from the transcriptions. The researcher addressed "how the research questions are answered by the findings, how the findings relate to the literature, and how the findings relate to the researcher's going-in assumptions" (Bloomberg & Volpe, 2008, p. 76).

Trustworthiness

As a researcher, it is important to confirm the concluded descriptions and analysis accurately represent the reality of the participants (Bloomberg & Volpe, 2008). This will be demonstrated in the discussions on creditability and dependability.

Credibility. Several methods were in place in order to ensure the participants' perceptions and the researcher's interpretations match (Bloomberg & Volpe, 2008). First, the researcher kept brief reflective field notes during and after each interview to monitor subjectivity and assumptions. Second, the researcher engaged in member checks by emailing each participant her transcribed interview so she could test the validity. Last, the researcher used peer debriefing by discussing the reflective field notes with a peer reviewer to facilitate examination of researcher assumptions (Bloomberg & Volpe, 2008). Together, the reviewer and researcher engaged in a search of the transcriptions for rival explanations of the researcher assumptions (Patton, 2002). This was done by thinking of logical alternatives to the findings and checking if they could be supported by the data (Patton, 2002). These cases might lead the researcher to broaden the interpretation, change the interpretation, or doubt the interpretation all together (Patton, 2002). For example, one assumption was that counselors would focus on depression symptoms in clients presenting with infertility. After looking for a rival explanation such as maybe the depression symptoms were put aside to focus on infertility, nothing was found to dispute this assumption, and the interpretation was left unchanged.

Dependability. In order to ensure that one can "track the processes and procedures used to collect and interpret data" (Bloomberg & Volpe, 2008, p. 78) the researcher documented an explanation of how the data was collected and analyzed, including documentation of procedures, interview notes and the field notes. Next, two peer reviewers, one of whom engaged in the search for rival explanations, examined the interview transcriptions and data analysis. Feedback was given from the reviewers. The researcher and peer reviewers then came to a conclusion regarding accurate interpretation of data. The following section presents the ten themes found in the study.

PRESENTATION OF DATA

Introduction

The purpose of the research study was to uncover the understandings mental health counselors have of infertility, including the mental health treatment for heterosexual women. It is the intent that the information gathered in this study will raise awareness and improve counselors' ability to treat clients with infertility. The information presented in this section was gathered from ten participant interviews and resulted in ten major themes, which will address four of the five guiding questions. The fifth guiding question will be responded to after the presentation of the themes. The participants were asked the fifth guiding question directly in the interviews, which resulted in being able to address the question best with direct participant quotes. The ten themes are listed below in no particular order.

1. Counselors believe support systems and strong primary relationships are essential for clients to move toward acceptance.
2. Counselors believe infertility puts a strain on social supports and primary relationships.
3. Counselors frame the infertility experience similar to grief and loss.
4. Counselors believe clients' cognitive distortions and social pressures exacerbate their suffering.
5. While counselors say they are comfortable counseling clients with infertility, they believe they need more training and would be open to receiving the training if there were more opportunities.
6. Some counselors appear to be unaware of personal assumptions and biases with regards to infertility.

7. Counselors help clients with infertility by using basic counseling skills, their prescribed theory, and by establishing a trusting therapeutic relationship to help reach the goals of increased understanding and acceptance.
8. Counselors believe counseling in addition to medical treatment is essential.
9. Counselors believe pursuing alternative options to starting a family can decrease suffering and aid acceptance of the infertility experience.
10. Counselors seem able to empathize with the infertility experience and establish helpful generic interventions but less able to tailor treatment specific to infertility.

Participants

The ten participants of this study were recruited using the contact information from the licensed counselor list found on the North Dakota Board of Counselor Examiners webpage. Even though this sample was not randomly selected, it is believed the findings provide an adequate representation of counselors state wide due to the consistency in responses. Demographic information of the participants can be found in Table 3 below.

Themes

Data will be presented by responding to each of the five guiding questions by describing each theme corresponding to the guiding question. Because the interviews were audiotaped, each theme can be further substantiated using direct quotes from the participants.

Table 3.
Participant Demographic Information

Participant	Gender	ND License	Years of experience	Education level	Type of practice	Theoretical orientation
1	Female	LPCC	15	PsyD	Private	CBT
2	Female	LAPC	1	Masters	Non-profit	undisclosed
3	Female	LPCC	4.5	Masters	Human Service Agency	Eclectic
4	Female	LAPC	1	Masters	Community Agency	Eclectic
5	Male	LPCC	19	Masters	Private	Person centered
6	Female	LPCC	25	Masters	Private	Neuro-biological
7	Female	LPCC	22	PhD	Agency	Eclectic
8	Female	LPCC	27	Masters	Private	Eclectic
9	Male	LPCC	19	Masters	Private	Eclectic
10	Female	LPCC	7	Masters	Agency	Eclectic

Guiding Question #1: How Do Licensed Mental Health Counselors Understand the Infertility Experience for the Heterosexual Woman Client?

In order to understand how mental health professionals would treat the presenting concern of infertility, it is necessary to look at what they understand about the issue. Counselors

were asked open-ended questions about what they know or think about the infertility experience of a heterosexual woman. These questions were designed to give the counselors the opportunity to free associate anything they could think of regarding how they conceptualize the concept of infertility. Table 4 below illustrates the four themes that address the question of how counselors understand the infertility experience in heterosexual women clients.

Table 4.
Guiding Question #1 Table

Guiding Questions #1	Themes
How do licensed mental health counselors understand the infertility experience for the heterosexual woman client?	Theme 1: Counselors believe support systems and strong primary partner relationships are essential for clients to move towards acceptance. Theme 2: Counselors believe infertility puts a strain on social supports and primary relationships. Theme 3: Counselors frame the infertility experience similar to grief and loss. Theme 4: Counselors believe client's cognitive distortions and social pressures exacerbate their suffering.

Theme 1: Counselors believe support systems and strong primary relationships are essential for clients to move towards acceptance. When asked to describe the infertility experience for a heterosexual woman, many participants framed the experience as one that requires outside support in order to move through it in a positive direction. Only one of the ten participants spoke of infertility as an issue best dealt with alone. In fact, the common belief is

that if a woman tries to cope with infertility by holding it in or being private, that behavior will lead to greater suffering and might initiate seeking support from a mental health professional. Participants also spoke of how seeking support from others would help them not only decrease suffering, but also help them accept their current life situation. Research supports the importance of support systems in helping clients move through infertility in a positive direction. Paul et al. (2010) suggests infertility can provide opportunities for personal growth. However, an important variable in a person's ability to achieve personal growth is availability and satisfaction with social support systems. Therefore, social supports appear not only to be important in minimizing distress, but also valuable in moving toward personal growth. The following quotations speak to theme one.

> "Well I think the support if a person has friends and family, and they lean on those friends and family, I think that the experience can be a lot less difficult than if they just keep it to themselves."
>
> "I think people are more susceptible to needing counseling support when they don't have outside support because I think a lot of people who have an open relationship with partners, parents and siblings and can openly communicate and get that support may not need the counseling support. They may not be stuck they may naturally be able to work through that process on their own, which is the hope for everybody, but that isn't the case so I think quite often people that do come in for counseling are those that don't have that level of support. That's why they need the counseling support."

Theme 2: Counselors believe infertility puts a strain on social supports and primary relationships. While participants spoke about the importance of their support networks in healing, they also believed support networks could be a double-edged sword, sometimes getting

strained and potentially causing more suffering to the woman. Literature supports the double-edged sword nature of support systems (Revenson, et al., 1991). Participants referred to husbands, friends, and family members as support networks. At times the strain in relationships is caused by no fault of the support systems, but as a consequence of inadequate coping strategies to cope with the painful emotions of infertility. For example, if a support person is pregnant or has children, the woman suffering with infertility may not know how to cope with the emotions elicited and begin instead to isolate or become resentful. Other times, support systems might be doing something causing distress, not knowing the impact of their behaviors. Examples of hurtful behaviors from support networks include friends moving on with their lives not realizing how much pain the woman is still struggling with, or husbands using different coping techniques leaving the woman feeling unsupported and invalidated. And yet other participants spoke of relationship strain originating from behaviors of the woman dealing with infertility, including guilt and blame. Below are some examples of ways participants spoke about support systems being strained.

> "It also can cause a lot of relationship issues if one partner is has been diagnosed to be more the issue with infertility. You know, the blaming piece or assuming the other person blames you, and the other person if they choose to stay in the relationship will also not be able to have a biological child, and all of that piece could entail the worry if that person wants to leave because of that."
>
> "Which I think can bring up some anger and maybe not wanting to spend time with those friends because those feelings might be pretty strong at certain points, um, feelings of resentment and possibly isolation themselves from friends who have children."

"I try to help these clients focus and learn independent coping skills because they tend to turn to their spouse for support and coping and often get let down because their spouse can't understand."

"That I think is interesting because again I think at the beginning of things everybody is l ike ya and kind of rallying around them, but as everybody's lives go on its like ok really (laughing) you talk about it, and talk about it, talk about it like I've seen some of that, and then their experience is very negative and they probably feel even more isolated from other people."

"I've heard that anywhere they go all they see is that everybody else is pregnant, which is painful, so they isolate because its hard to be happy for them."

"Other people are accomplishing what they see as their lack of accomplishment, and they just want to isolate, or they are angry because their best friend is having a baby and they are not."

Theme 3: Counselors frame the infertility experience similar to grief and loss. Many participants framed infertility as a grief experience. If they did, they were asked if the grief was similar to grieving other losses or different. Responses often mimicked common grief milieu that women should work through the stages of grief toward accepting the infertility and close that chapter to move on with a new life. In this way participants view the grief experience like other grief experiences where once the client moves through the stages of grief they can put those emotions behind them and move on. However, research often contradicts this message saying women might be able to come to terms with infertility as their new life story, but many struggle to re-narrate a new life story that includes childlessness without feeling emptiness and grief (Miall, 1986). While participant responses mimic what one would expect to hear with grieving,

they seem to underestimate the essence of loss associated with infertility because of its close link to self worth and purpose for many women (Volgsten et al., 2010).

Some responses highlighted the differences of grieving infertility to include lack of societal support and not grieving an actual death. While some participants were on the fence about whether it was the same or different than other grief and loss experiences, most participants conceptualized infertility as a loss. Below are different responses highlighting the way participants linked infertility to grief.

> "Which I think is important is really really key in any grief process. Is that ok this is the end of this chapter, but it doesn't have to be the end of all chapters, and some really great things can come out of this…and to help that person open their eyes to what those positive things might be um and to figure out what their life story is going to be from this point on."
>
> "Individuals with infertility have very kinda complicated grief. Umm, like not really something they have a person to grieve over like the loss of a child, but they are not able to conceive a child so, until they come to that point of acceptance, they are always kind of in that state of loss…umm, or feeling lost"
>
> "Any time you deviate from what you consider normal if there is such a thing and normal would be being able to have children. To me that is a sense of grief and loss because you are grieving a loss of normalcy. Its not normal in society unfortunately its not looked at as normal not being able to have kids is the abnormality so it's a change of what you expect out of your life; it's a change of how you perceive things. It certainly affects numerous things including self esteem and a bunch of different things so I guess for me it is kind of a grief and loss process"

Theme 4: Counselors believe clients' cognitive distortions and social pressures exacerbate their suffering. Common internal dialogues associated with infertility that participants usually found relatively easy to name included women feeling defective, feeling they are being punished, self-blame, and feeling worthless. Participants believe these thoughts were not helpful to the healing process, which the research supported (Becker, 1994). Participants were able to provide little elaboration into the origination of these types of thoughts but were quickly able to list them as common cognitive experiences for those dealing with infertility. One participant was able to identify a thought pattern of rigid thinking, which might hurt the progression of the healing process.

Other participants conceptualized certain cognitive experiences such as 'things may not work out' as harmful cognitive distortions, when the women living through infertility might conceptualize those same cognitive experiences as rational and not distortions. Counselors might be tempted to reframe certain realities of the client's experiences, but doing so might invalidate the realities of the client's cognitive experience.

Participants also mentioned societal pressures exacerbating the suffering of infertility because it provides an additional layer of alienation. Societal pressures could include indirect social norms or more direct verbal cues received from others such as, "So when are you going to finally have kids?" The literature also discussed the detriments of societal pressure (Miall, 1986). Below are some examples of responses from participants reflecting on the impact of cognitive distortions and societal pressures.

> "I think a lot of thought distortions can go along with 'Is there something wrong with me?' 'Am I a bad person and this is why this is happening to me?' I think would be real common."

"They live with families they live in a community where people are getting pregnant and having babies. There are messages that a marriage is about starting a family so there really is no escaping it for them and then also the pressure you know people asking when are you going to have a baby and do they tell do they not tell."

"Well I think if a person is a very rigid thinker and their plan for themselves was to have four kids and now they have these infertility issues and not being able to have any children. They may be an all or none thinker a rigid thinker and it's just well that's that then. That cognitive process might hurt their progression."

Guiding Question #2: What is the Counselor's Experience of Working with Heterosexual Women Clients with Infertility?

The second guiding question aimed to describe the counselors' experience providing counseling services to clients presenting with infertility. Their experience is made up of their level of comfort, level of confidence, level of training, conflicts of interest, or personal biases they bring into the counseling room. Table 5 below illustrates the themes that respond to this question.

Table 5.
Guiding Question #2 Table

Guiding Question 2	Themes
What is the counselor's experience of working with heterosexual women clients with infertility?	Theme 5: While counselors say they are comfortable counseling clients with infertility, they believe they need more training and would be open to receiving the training if there were more opportunities. Theme 6: Some counselors appear to be unaware of personal assumptions and biases with regards to infertility

Theme 5: While counselors say they are comfortable counseling clients with infertility, they believe they need more training and would be open to receiving the training if there were more opportunities. It was a very common response for participants to report feeling comfortable working with clients with infertility, but they would also report having no training on the topic and feeling they would benefit from more education. This response indicates counselors are basing their comfort level working with infertility on something other than their knowledge or competence on that issue. Kruger & Dunning (2009) look at the relationship between confidence and competence suggesting the more unskilled a person is in a task, the more unaware they are in their skill deficits. Therefore, increased perception of comfort does not necessarily mean increased competency but may instead indicate a greater need for skill development. Comfort level was increased based on a couple different factors.

Counselors feel more comfortable working through the familiar issues but less so working through the infertility. One participant demonstrated how working through familiar things such as cognitive distortions might be the way treatment will go when the more emotionally sensitive areas emerge by stating, "Well it is just a lot more difficult for me. I am ok with working through cognitive distortions and irrational thoughts but when somebody is having numerous miscarriages and dealing with that it seems to be more of a struggle because I just feel so bad." The same participant later said, "I think I feel pretty comfortable working with these clients."

Participants also correlated their level of comfort with behaviors of the client. For instance one client stated, "I get less comfortable working in couples counseling when the woman looks to the man for support and understanding and the man just has nothing to offer." Another participant also based comfort level on the client's behavior stating, "I think I feel pretty

comfortable with that because they were pretty, umm, pretty open about talking about things. Umm, now there might be other women who are more resentful to the fact that if they knew I have a child, you know, they would really, it would be difficulty for them to talk to me because they feel like, 'You don't know what I'm talking about.' I can't say I've had that experience so I felt pretty comfortable in that situation. Umm, I think if the couple is motivated and they were ready to take…if they were educated about it themselves. If they were actively speaking with doctors and taking the chance to work towards their goal of having a child rather than the blaming, and we've been trying and haven't been able to conceive, so we are done, you know."

Participants felt the greatest need for further education regarding the medical components of infertility treatment, even though they acknowledge the medical component is out of their scope of practice. According to Peterson et al. (2012), workshops have been created to facilitate the collaboration of medical and mental health professionals working with infertility. Efforts should continue to be made to meet the educational needs and desires of counselors by providing training in a convenient and useful way. Below are some examples of how participants discussed their desire for more training.

> "I would like one that, um, is multidisciplinary. You know, where there is, um, an MD specialist in this area or maybe mental health counselors of some sort who have specialized in it."
>
> "There isn't a lot out there either. You have to seek it and be looking for it."
>
> "Well I do somewhat [feel comfortable], but I never see any opportunities out there to get more training. It doesn't seem to be a topic that is covered in trainings."
>
> "It would be nice to have some trainings offered to better help clients deal with some of these issues."

Theme 6: Some counselors appear to be unaware of personal assumptions and biases with regards to infertility. When the participants were asked if they knew of any personal assumptions or biases they had about infertility, the answer was something along the lines of "No, none that I know of," with all ten participants. This indicates either the participants were currently unaware of any preconceived ideas about infertility they would bring into the counseling room, or they were too uncomfortable to disclose personal biases about the topic. It does not necessarily mean the participants actually have no personal assumptions or biases about infertility, as later responses in the interview usually illustrated such biases. As with any topic, it is important for counselors to gain self awareness into their personal assumptions or biases they have or they could negatively impact the counseling process (Brennan, 2013; Brown, 2004).

One assumption mentioned in the interviews was, "Encourage them that there is a time that it will happen one way or another if you are just open to that." This idea might be presented to try to facilitate the client to move toward letting go of control and trusting the process. However, not only does it instill a guarantee that can't be guaranteed, it also insinuates if it doesn't happen it is because the client wasn't open to it. This idea might be a commonly held belief of people who have had children very easily without complication and who have never faced the reality they might not be able to have a child. Many people struggling with infertility are also struggling with the reality it might not ever happen for them (Gonzales, 2000). No matter what they do there is no guarantee.

Another commonly held misconception is that people don't get pregnant because they are stressing out or worrying too much, and if they would not stress out and just relax it would probably happen. Bringing this assumption into the counseling room could very possibly

increase self-blame for any failed attempts at pregnancy. This assumption is illustrated in the following quotation.

> "I could say that I witness they always say that people are trying, trying, trying, and they can't get pregnant, can't get pregnant, and then they start to try doing all this other stuff to try to get pregnant. Once they've stopped putting all that effort in, a lot of times I see relatives getting pregnant at that point so there is that part of me that says well don't stress yourself out, you know what I mean, because that is probably leading to a lack of whatever it is you are hoping for"

Another participant presented with a bias that people going through infertility should have no problem being around other people who have kids. This participant stated, "Just because they don't have kids doesn't mean that they can't be around those that have kids and that I don' t belong with people that have kids because I'm different I'm strange, that kind of thing." The research stated it is very common for women going through infertility to isolate and struggle being around people with kids (Brown, 2004). If a client presents with this concern to a counselor who holds this bias, it would be possible to increase the shame experience of the client without acknowledging the impact of the bias.

Another commonly held assumption is that once people quit infertility treatment and adopt a child they will conceive. Again, this belief could be detrimental to the counseling process if stated in the counseling room to a client actively engaging in infertility treatments. One participant reflected on this assumption by stating, "There is the possibility because we all have heard stories about people who have adopted because they thought were infertile and then conceived a child."

Guiding question #3: What do licensed mental health counselors ascribe as the goal of mental health treatment of infertility?

The third guiding question looks at what counselors hope to accomplish in their treatment of infertility. A common response was to let the client take the lead in determining goals of mental health treatment.

Table 6.
Guiding Question #3 Table

Guiding Question 3	Themes
What do licensed mental health counselors ascribe as the goal of mental health treatment of infertility?	Theme 7: Counselors help clients with infertility by using basic counseling skills, their prescribed theory, and by establishing a trusting therapeutic relationship to help reach the goals of increased understanding and acceptance.

Theme 7: Counselors help clients with infertility by using basic counseling skills, their prescribed theory, and by establishing a trusting therapeutic relationship to help reach the goals of increased understanding and acceptance. The participants often stated their counseling approach with infertility clients would be the same as any other counseling session they would facilitate. Many stated they would build rapport with the client by using their basic counseling skills. They also stated they would fall back on their prescribed theory which was often Person Centered Approach and Cognitive Behavioral Therapy.

> "Cognitive behavioral therapy, in terms of helping them get to their core assumptions, and identifying their thinking patterns that maybe causing problems in how they feel about themselves or their partner."

"I do tend to fall back on CBT quite a lot, so a lot of going through the thought process of what are you thinking about yourself, how can we identify if this is good or not, and how can we identify a better way for you to go through your day? Then a lot of just empathizing and probably spending a lot of time at the beginning on the rapport. I imagine it's a really private issue, I don't imagine those people want to just start telling you everything that has ever happened to them in terms of their infertility."

The participants believed the goal of mental health treatment should be for the client to reach an increased understanding and acceptance of their situation. The research confirmed these goals for the treatment of infertility. For instance, Paul et al. (2010) agrees with the importance of clients reaching an understanding of their experience because without an explanation individuals often reach lesser degrees of personal growth, since she instead spends time trying to search for reasons which often leads to self blame and alienation. Hammerli et al. (2008) also discussed goals of mental health treatment being more to lessen the negative impacts of infertility than to increase the likelihood of getting pregnant. Below are quotations that highlight the participants stated goals of mental health treatment of infertility for the heterosexual woman client.

"I think, you know, a lot of it would be helping them clarify for themselves their thinking about it, their beliefs, being able to identify the feelings, and getting them to a place where they feel they understand themselves in the process."

"So to me it's a matter of coming to a level of acceptance as much as I can of, 'This is just a fact of my life,' and then I go from there."

Guiding question #4: What are licensed mental health counselors' perceptions of appropriate mental health interventions for infertility?

Participants were asked what they felt would be helpful mental health treatment interventions for women with infertility-related concerns. It was common for participants to discuss medical treatment and alternative options for achieving a family. These themes will be discussed further below.

Table 7.
Guiding Question #4 Table

Guiding Question 4	Themes
What are licensed mental health counselors' perceptions of appropriate mental health interventions for infertility?	Theme 8: Counselors believe counseling in addition to medical treatment is essential. Theme 9: Counselors believe pursuing alternative options to starting a family can decrease suffering and aid acceptance of the infertility experience. Theme 10: Counselors seem able to empathize with the infertility experience and establish helpful generic interventions; but less able to tailor treatment specific to infertility.

Theme 8: Counselors believe counseling in addition to medical treatment is essential. Many participants acknowledged the heavy medical component to infertility. Participants seemed to understand their role as one who refers any questions regarding attempts to get pregnant to medical specialists; at the same time, participants felt it was important as the

mental health provider to have a better understanding of the different medical procedures involved. Only one participant discussed how clients sometimes get so involved with the daunting medical procedures they often overlook any emotional components to infertility stating, "The infertility experience gets so physical they don't realize the emotional impact until later with the technology." In the end, participants understood there is an important place for both mental health and medical professionals when helping clients through infertility. Below are some quotations highlighting their perceived importance of interdisciplinary care, which research could support (Hart, 2002).

> "I guess I would just say they should see a fertility specialist and follow their advice."
>
> "I'm a holistic thinker so I think it's a mental, emotional, physical experience."
>
> "You have to take time to go down the road to educate on the physical components and connect them up with people that can help them on the physical side and still support them emotionally to find that resolution."

Theme 9: Counselors believe pursuing alternative options to starting a family can decrease suffering and aid acceptance of the infertility experience. When participants were asked about helpful treatment interventions for infertility many responses included exploring alternative options for having a family. The literature also discussed alternative options for obtaining a family. It was noted, though, that there are ways to incorporate this into treatment in a helpful way and ways that would be hurtful to treatment progress depending on variables such as timing and exploring related issues (Peterson et al., 2012). Specific related issues include third party conception, unusual family composition, fears the biological parents will form a stronger bond with the child, and processing how to explain the nature of conception with the child (Peterson et al., 2012). There are no scripts regarding how to share information with future

children, but according to Peterson et al. (2012), it is important for counselors to check in with clients about these specific infertility concerns. While many participants were easily able to list some alternative options, none of them brought up any of the above listed related issues, nor did they mention how they need to be sensitive to where the clients are at in their infertility journey. Clients just starting their doctoring process might not find discussing alternative options very helpful, whereas clients getting ready to terminate medical services might be more ready to explore these options. Participants seemed to use exploring alternative options as an intervention earlier in the process of treatment as one participant stated, "After the faulty thoughts are examined then we look at what their alternative options are."

Participants also seemed to minimize the grief a client might be facing by believing if they pursued alternative options then the grief feelings should be resolved. The risk in presenting this mentality to the clients, especially early in the treatment process, is the clients might feel invalidated in the level of despair they might be feeling. Below are some quotes where participants discussed alternative options in such a way the client might interpret as, 'You can't have a biological child, that's ok, just adopt.' Participants also never discussed how difficult foster parenting may be and how hard the adoption process may be, all things counselors need to consider when presenting these options to clients.

> "The one good thing about infertility is while someone may be mourning the possibility of having a biological child, there are still options for family. So if a person is grieving the idea of having a family there is still hope for family through other options."
>
> "Ya and there are many options. The obvious one is adoption or foster care, but others do other things. They may work in a daycare center. Some get involved in church work, they may teach Sunday school, work in the nursery, or they can offer themselves as daycare

and babysitting for other people and so they feel they invest into people's lives and of course the parents of the children as well."

Theme 10: Counselors seem able to empathize with the infertility experience and establish helpful generic interventions but less able to tailor treatment specific to infertility. When participants were asked about specific interventions they use in their counseling sessions to work through infertility they often gave vague answers that could be used when working with any topic. It appears the participants had more confidence talking about the experience of infertility than they did talking about how to treat the mental health consequences of it. Below are some quotations that demonstrate the tendency to talk vaguely about interventions.

"Helping clients see themselves in a more positive way often through journaling."

"Definitely her self image and looking at faulty thoughts. Trying to help her have a more positive outlook on herself and her situation."

"My goal would probably be whatever their goal would be, but, umm, I'm I think probably a lot of support. Umm, maybe some skills helping them build skills to communicate how they are feeling. The feelings of loss or the things we talked about right away that they may be feeling."

"I don't think with infertility it would be any different than any other issue somebody would bring into the office."

"Well there would be some exploration through talk therapy. There would also be some exercises I would give them like some paper and pencil types of things they can take home to get them to notice certain things or look at certain things in a different way. Um, so I guess I utilize homework to a certain degree. I utilize activities within the session to

get them to explore even different ways. Um sometimes I have people that use drawings and things such as that, again I utilize a bunch of different ways or techniques."

The literature confirmed the importance of incorporating infertility specific interventions to the counseling sessions. According to Vizheh et al. (2013), infertility specific counseling should begin with a definition of infertility, and other psychoeducation such as etiology, prevalence, impact on personal life, and sexual satisfaction. Specific interventions geared toward infertility could also include coping with the two-week wait period and repeated semen analysis (Peterson et al., 2012), body scanning, guided imagery, progressive muscle relaxation, and meditation (Katz, 2008). None of the above were mentioned anywhere in the data collection.

Another important discussion is the decision to terminate medical attempts to conceive (Blyth, 2012; Peterson et al., 2012). While a few participants brought the issue of terminating medical treatment up in their interview, most then referred that conversation to be held in the medical doctor's office and overlooked the important emotional component. Terminating medical treatment is an important phase for counseling because up until this phase counselors are likely working toward things like fostering hope, stress management and coping, and maneuvering through the medical procedures. Then counselors shift toward processing the hard decision of when to quit trying. This decision is becoming increasingly difficult due to all the new technological advancements (Hart, 2002). Once the decision to quit trying is made, then counselors work toward re-narrating the client's future story (Bridges, 2005). Once counselors have worked with the clients through the previous phases they can begin to explore alternative options (Hart, 2002). None of the participants discussed the importance of timing when discussing terminating medical treatments and making sure not to process it too early. Also never

mentioned was the sequential nature of the infertility experience and coordinating mental health services; instead it appeared exploring alternative options to starting a family would be something that would occur early on in the treatment before the clients have even decided to stop with the medical treatments.

Peterson et al. (2012) also discussed the usefulness of certain assessment measures such as the Positive Reappraisal Coping Intervention, the FertiQoL, and the SCREENIVF; it is of note that no participant mentioned any tools or instruments as a possible intervention. The SCREENIVF is an instrument designed to identify patients who would benefit from mental health services. If they have a positive pre-medical treatment score, they are more likely to experience higher levels of distress throughout their medical treatments. The Fertility Quality of Life Tool (FertiQoL) is designed to assess the fertility problem's impact on different life domains including personal, social, and relational. The Positive Reappraisal Coping Intervention was designed to assist in coping with the two-week waiting period. Blyth (2012) went on to list other topics of importance to include potential for multiple pregnancies, sexual problems, and anxiety of a future pregnancy.

Guiding question #5: What are licensed mental health counselors' perceptions of harmful mental health interventions for infertility?

Once the participant discussed what they would do in the counseling sessions, they were asked what they would make sure not to do. Many participants stated they would not give the client advice, they would not push them beyond where the client is comfortable, they would not act like a medical doctor, they would not place blame, nor would they minimize the problem. Below are examples of what the participants believe would be harmful to incorporate into mental health treatment of infertility.

"Um, well I'm thinking of acting as if I know what they need, or minimizing the problem. Um, discounting their feelings, supporting beliefs that are really detrimental to them, things along those lines."

"I think its important not to push them too early."

"I would definitely not point blame on the client, or ask if they've done this or tried that to get pregnant. I also wouldn't give any medical advice since I'm not a doctor I would constantly refer them to ask their physician."

"Well I don't really think I would ask, I would make them feel they aren't doing all they can do as far as medically because that's not really my place to decide what they are supposed to be doing, like have you talked to your doctor about this and this and this, umm, because I think they would feel more blamed and shameful than anything. And I wouldn't exclude the partner from the discussion especially if it was couples counseling and just focused on her because I think that many clinicians do. Ummm. and I don't think that if sometimes, like especially with you know some religions and cultures, I don't think I would discard the fact that this is not having a child is a bigger issue than what they feel it is, like I would make them feel like oh its not that big of a deal just because you can't have a child just because you are this culture you know I mean that is just or just to put that off or minimize that.

"Telling them what to do in any capacity. Umm, putting judgments on them like if you did this then this would, or if you didn't do that then. You know you don't want to pull any of that kind of harsh words on them, and probably like I said do all the talking and trying to make it seem like you know what's happening or understanding them when you don't and can't understand their experience until they tell you."

The participants discussed infertility with varying degrees of familiarity and understanding. Some participants appeared more experienced working with clients through infertility, while others stated they are very unfamiliar with this topic. It was beneficial to this study to have the varying levels of experience in order to get a more comprehensive understanding of counselors' understandings of the mental health aspects of infertility. The next section will critically compare and contrast the participants' interview data to the current literature on infertility to analyze areas that might need additional training.

DISCUSSION

The following section discusses the researcher's additional thoughts and questions that emerged throughout the literature review, data collection and data analysis process. Completing this research helps confirm the need for specialized mental health treatment for infertility. By looking at counselors' perceptions of the mental health aspects of infertility in heterosexual women, important information was brought to light regarding the current mental health practices of infertility.

Summary of results

The ten emerging themes of this study address four of the five guiding questions posed by the researcher. The fifth guiding question explored what participants believed were hurtful mental health interventions for infertility. To respond to the fifth guiding question, different participant statements were provided, which were representative of the participants' responses as a whole. The below table summarizes the 10 themes and four guiding questions posed in this research study.

Table 8.
Themes

Guiding Question	Themes
How do licensed mental health counselors understand the infertility experience for the heterosexual woman client?	Theme 1: Counselors believe support systems and strong primary partner relationships are essential for clients to move toward acceptance. Theme 2: Counselors believe infertility puts a strain on social supports and primary relationships.

Table 8.
Themes (continued)

	Theme 3: Counselors frame the infertility experience similar to grief and loss. Theme 4: Counselors believe clients' cognitive distortions and social pressures exacerbate their suffering.
What is the counselors' experience of working with heterosexual women clients with infertility?	Theme 5: While counselors say they are comfortable counseling clients with infertility, they believe they need more training and would be open to receiving the training if there were more opportunities. Theme 6: Some counselors appear to be unaware of personal assumptions and biases with regards to infertility
What do licensed mental health counselors ascribe as the goal of mental health treatment of infertility?	Theme 7: Counselors help clients with infertility by using basic counseling skills, their prescribed theory, and by establishing a trusting therapeutic relationship to help reach the goals of increased understanding and acceptance.

Table 8.
Themes (continued)

What are licensed mental health counselors' perceptions of appropriate mental health interventions for infertility?	Theme 8: Counselors believe counseling in addition to medical treatment is essential. Theme 9: Counselors believe pursuing alternative options to starting a family can decrease suffering and aid acceptance of the infertility experience. Theme 10: Counselors seem able to empathize with the infertility experience and establish helpful generic interventions but less able to tailor treatment specific to infertility.

Overall, participants have a general understanding of the mental health consequences of infertility. The following sections address additional information that might be helpful for the counselor to be aware of in regards to the infertility experience and its mental health treatment.

Suggestions for being a more knowledgeable and proficient practitioner

The below paragraphs highlight additional topics mental health professionals should consider when working with a client going through infertility. Some participants might have mentioned parts of the following ideas. However, some of the ideas were not discussed at all by any of the participants. The ten participants did not present any of the information below extensively enough to constitute a theme, suggesting there is incomplete training to be fully informed practitioners.

Infertility and society. Margaret Mead (1962) discussed how some women might be grieving carrying out the caretaker role more than grieving the actual child because it is so engrained into society, which makes it hard to differentiate the source of the suffering. Individuals going through infertility get direct and indirect messages from society frequently. These societal pressures influence the cognitive appraisal of the infertility experience and are correlated to increased distress level (Lazarus & Folkman, 1984). Society creates norms for various things, including parenting (Vizheh et al., 2013). Unfortunately, there is a stigma around childlessness, both voluntary and involuntary. If a woman chooses not to have children she might be judged as unhappily married, psychologically maladjusted, immature, selfish, lonely, and misguided (Miall, 1986). If a woman is unable biologically have a child, people might believe it is because she is doing something wrong (Shapiro, 2008). Either way, if a woman feels these societal messages it will not help her cause or her emotional healing. Part of successfully treating women with infertility is to normalize their feelings about these societal messages, not to minimize them or to reframe them. If a woman is expressing distress from messages received from society, it should be taken at face value and normalized instead of treated as a cognitive distortion (Mahlstedt et al., 1987)

Women might even receive messages from their political leaders that in-vitro is morally wrong. Constitutional Measure No. 1 (Senate Concurrent Resolution No. 4009, 2013 Session Laws, Ch. 519) on the current North Dakota ballot seeks to enact a new section to Article I of the North Dakota Constitution. If the measure passes November, 4th, 2014, then "The inalienable right to life of every human being at any stage of development must be recognized and protected" (https://vip.sos.nd.gov/PortalListDetails.aspx?ptlhPKID=4&ptlPKID=1#content-start). This measure has been controversial because of the unknown impacts it may have due to

the statement, "…at any stage of development." Some are concerned it will present complications with advanced directives; others are concerned in-vitro fertilization would no longer be available in the state of North Dakota. At this point it is not written in definite terms what the impact would be on future in-vitro fertilization cases. The opponents of this measure believe reproductive specialists would no longer practice in the state because the fear of criminal prosecution makes liability too high. The supporters of Measure No. 1 say the measure was created with the mission to protect against abortion only. People in society who believe in-vitro fertilization is morally wrong might say something to a woman with infertility such as, "So what are you going to do with any unused embryos, kill them?" Statements such as these are likely going to contribute to the client's negative experience with infertility. No participant in this study discussed these types of societal or political messages.

Many participants in this study referenced another socially held belief. One such participant stated, "We all have heard stories about people who have adopted because they thought were infertile and then conceived a child." The reason counselors need to challenge this potential biased belief system is because of the message it might be communicating to the client, mainly the reason they aren't able to have a child is because she is worrying about it too much. A counselor working with women going through infertility needs to be sensitive to the fact she is likely dealing with self-blame or guilt, and the counseling process should not exacerbate those feelings (Becker, 1994). Counselors need to take great care to make the counseling room a safe place for these women to explore whatever feelings they bring to the process. Along similar lines, it is commonly believed that if a woman is not able to have a child it's not that big of a deal because she can just adopt. This mentality minimizes some women's long-standing narrative of being pregnant and carrying a biological child. It also minimizes how difficult of a

process adoption has become. Adoption is not for everyone who wants to be a parent. It should be noted that no participant in the study discussed these potential implications with adoption.

Infertility and grief. Many participants discussed how infertility is a form of grief, possibly even complicated grief. Some participants discussed how grief with infertility is unlike other forms of grief because it lacks a concrete loss. Grieving fertility, however, has other differences as well. Infertility does not have definite time frames and seldom has an end point (Patterson, 1986). When a woman is grieving fertility it usually means grieving unfulfilled hopes, whereas other forms of grief typically involve memories. Because the grief is over unfulfilled hopes, it doesn't usually come with the type of social support death of a loved one would (Patterson, 1986). For some women, what they might be grieving most is their lost biological mother narrative, feeling a part of the adult world, and the perceived respect and recognition from others that comes with being a mother (Brown, 2004; Gonzales, 2000). Other forms of loss the participants did not mention include loss of self-esteem, security, control, and faith (Naish, 1994). It is important for counselors to understand each client's personal story of loss instead of assuming a universal grief reaction (Bridges, 2005).

When counselors work with grief the end goal is usually to reach acceptance (Menning, 1980). With infertility, it's important for the counselor to know that the woman's grief might not ever get resolved, but instead she moves toward disengaging from the fantasy of becoming a biological mother. Often the fantasy will never disappear, and the grief is never gone, but instead she works toward being able to engage in other life dreams (Gonzalez, 2000). Some clients might not be able to relate to discussion of acceptance and resolution of grief. Participants didn't speak about acceptance the way the literature did. Participants seemed to equate acceptance with resolution or finding peace with the loss, whereas the literature explained acceptance as being

willing to acknowledge a problem exists and then being able to disengage from the problem (Scheier & Carver, 2001).

Clients might pursue alternative means of obtaining a family. Counselors need to understand that the clients will likely love their adopted child, foster child, or child through surrogacy just as much as 'their own' child; however, when a person goes through this process it doesn't take away from the grief they are feeling over the loss of whatever idea they had in their minds for how they were going to start a family (Brown, 2004). Also, counselors need to acknowledge the power of language when discussing this issue with clients. An adopted child should not be referred to any differently than 'their own' child. 'Their own' is in quotes as often people don't know how to verbalize the difference between a child conceived in congruence with society's perceived natural way of conception versus another means. Often clients might also go through a period of redefining things in their own minds because they might have always assumed they were going to have a child the way society expects them to. A child brought into a family from another path should not be thought of as a second choice to starting a family. One participant stated, "Some will choose to adopt at that point so they cope by substituting in somebody else's children that they then begin to parent and raise as their own." People who have never come into close contact with infertility may have never had to challenge some of these messages present in society.

Infertility and depression. Domar et al. (2000) likened the level of distress that comes with infertility to cancer, HIV, and heart disease. Knowing this, counselors can expect the clients to present with depression symptomatology. While it might be helpful to treat some of the depression symptoms, it likely will not assist with the grief that comes with the infertility. Participants spoke the most of implementing cognitive behavioral therapy to work with the

clients' cognitive distortions. While this might be helpful if the client is presenting with cognitions such as, "This is happening to me because of something I did," it likely will not help with thoughts such as, "I may not ever be a mom, and then I don't know what I will do." The latter example is possibly a reality for the client and not a distortion and would require narrating a new life narrative. Also, if a client is experiencing sadness it might not be helpful to reframe the sadness as one might do with CBT for depression because this sadness is likely a normal grief reaction. The literature on mental health treatment has very little emphasis on treating cognitive distortions; even the cognitive behavioral therapy-based ones focused more at emotion tolerance (Hammerli et al., 2008). Additional research is needed in order to look deeper into the relationship between infertility and depression treatment. None of the participants discussed these differences in their interviews.

Infertility and relationship with self and partner. Participants discussed how women with infertility might experience negative thoughts about themselves such as, "There's something wrong with me." What participants didn't discuss is how some women with infertility often experience an extreme identity crisis and feel their identity changes as a result of infertility (Becker, 1994; Gonzales, 2000; Kirkman, 2001). Their identity was likely grounded in getting married, becoming pregnant, and then having children. The stronger their identity was grounded in such narratives, the more of a struggle infertility will be (Edelmann et al., 1994; Greil, 1991). If a woman never had biological children as part of her core identity then infertility would not be something that shakes her to her core. Also, the more her identity is grounded in being a biological mother, the less likely she has any non-mother alternative narrative to move forward with. She might feel inadequate as a woman and lack any alternative goals that compare in levels of importance to being a biological mother (Kirkman, 2003). If the alternative goal isn't as

meaningful or more to the woman's life purpose, then it will not provide a sufficient pull to the client and she will continue to feel a loss of purpose in her life (Edelmann et al., 1994). It is important for counselors to explore each client's personal identity narrative instead of assume infertility will affect each one the same.

Participants also discussed how marriage might be affected when infertility is presented but provided little detail about how or why the marriage would be impacted. One participant discussed how the woman might fear abandonment from her partner because she is feeling inadequate, unworthy, and unlovable. Berk and Shapiro (1984) also found the fragile sense of self combined with feeling personally responsible for the infertility could lead to fears of partner abandonment. Participants did not discuss how marital struggles often stem from differences in coping styles between the two individuals (Peterson et al., 2012). Research discussed how women have their tendencies in copies strategies, and men's tendencies are often different. When one partner utilizes emotional coping tendencies and the other partner utilizes task oriented coping tendencies, then marital struggle is more likely (Levin et al., 1997; Peterson et al., 2012). Participants often lacked details into the types of coping strategies used and how important it is for the relationship for each partner to understand and accept the differences in coping. It will also strain the relationship if the husband does not understand the depth of pain the woman is experiencing (Gibson & Myers, 2000). The counselor can provide relief by normalizing the strong reactions to infertility (Mahlstedt, et al., 1987).

Infertility and the future. Kirkman (2003) discussed how it is important to assess how important the mother narrative is to each person because if it is extremely important it might be hard or impossible to recreate a new narrative to take its place. If this is the case, it is inadvisable to try to work toward re-narrating a story before the client has been able to process the loss of the

old narrative. However, it is advised to take an active approach toward re-negotiation of life rather than getting stagnant in working through the stages of grief in order to return to normal functioning (Bridges, 2005). An added level of complexity in renegotiating a new narrative for a woman with infertility is maneuvering through how infertility has impacted her belief about her role in shaping her future (Brown, 2004). Infertility challenges one's beliefs about how much control one has in shaping their future (Katz, 2008). With infertility it doesn't matter how much one does to move toward a goal, sometimes the goal is just not going to work out. People often receive messages from early on in their life that if you work hard enough you can achieve your goals. Infertility is a hard exception to that rule. In moving forward, it can be helpful to re-establish a sense of control and freedom of choice in shaping their future (Katz, 2008), while simultaneously developing interventions that buffer the effects of stress (de Ridder & Schreurs, 2001).

Limitations

A potential limitation in this study was in the sampling method. The researcher was interested in understanding the experience of general practice counselors. This is due to North Dakota's lack of specialists, which increases the likelihood that someone seeking counseling for infertility would go to a generalist counselor. Because sampling does not exclude participants who do not "specialize" in infertility there were some cases that were not as information rich as others. This issue, however, also provided the researcher with valuable information regarding the level of experience working with infertility. This study's findings are not intended to be transferable to counselors specialized in infertility.

Also, there might be a potential limitation in the participation recruitment process. While these findings likely provide a rich description of counselors across the entire state, participants

were only found out of two main parts of the state, leaving one half of the state not represented at all by a participant. In addition, participants were mostly from the urban areas of the state, with only one of the ten representing rural demography. While the ratio of male to female participants is representative of the statewide population, it might be a limitation to not have male counselors more represented in the study.

The location of the interviews was not consistent with all the interviews, which might have had an impact on how much a participant was willing to share. Being over the phone versus face-to-face might also have impacted a participant's interview. In the future, it would be beneficial to broaden this study to include other states and more participants. It would also be interesting to replicate this study with mental health professionals who specialize in working with infertility. The following section discusses other potential areas for future research.

Recommendations for the future

Study clients' perceptions of mental health treatment. Gynecologists believed mental health treatment was more important to receive than clients did, and yet those who did receive treatment largely believed it to be beneficial (Boivin & Kentenich, 2002). Clients' perceptions of mental health treatment and their need for it might be the greatest barrier to seeking help. It would be helpful for mental health counselors to understand the clients' perspectives regarding the treatment process. There are studies available regarding the clients' experiences with infertility but not specific to the mental health treatment process. What do they find helpful or hurtful in the counseling room? Do they feel the counselors understand their experiences? Do they feel safer in the counseling room versus discussing this topic with friends? Why is there such a low participation rate in support groups (Wischmann, 2007)?

Study efficacy of clinical interventions, especially different studies confirming efficacy of a particular intervention. A challenge for counselors who desire to perform evidenced-based practice is a lack of valid and reliable research regarding intervention efficacy. The lack of literature regarding interventions makes it difficult to reach the desired outcome of confidently deducing efficacious treatment strategies (Jacobs, 2003; Hammerli et al., 2009). Vizheh et al. (2013) agreed there was a lack of research on effectiveness of treatment interventions, stating the research that was out there mostly focused on the mental-emotional characteristics of infertility such as depression and anxiety.

Develop, implement, and evaluate a training program for licensed mental health practitioners. This study highlights an important need for mental health professionals to receive training on the unique dynamics of infertility. The information accumulated from this project can assist in the formation of the program. Some examples of important aspects to incorporate in the training program include: psychoeducation, societal implications, appropriate timing of interventions, grief and infertility, finding purpose from re-authoring a new life story, and acceptance as it relates to infertility.

Advocacy for the mental health needs of infertility with medical professionals. This study discusses the importance of interdisciplinary care for clients with infertility. A first point of contact for women dealing with infertility is often a medical professional. The research provides convincing reasons to present to the physicians on the importance of collaborating with mental health professionals. Not only can physicians be made aware of different mental health services available, but they may also be interested in receiving education on the different screening assessments and mental health implications of infertility to ensure quality services are provided.

Conclusion

This research study is relevant because it not only highlights the unique needs of those seeking mental health services for infertility, it also confirms the importance for mental health counselors to be properly trained in order to provide the best services possible. This research project was possible because of the ten licensed counselors who were willing to share their experiences working with infertility. All ten of the participants stated they had very limited, or no, training in this area but are very interested in receiving training for this increasingly prevalent issue. Because these counselors lacked professional training on infertility one would expect their level of compassion and knowledge on the topic to mimic that of the general population. Unfortunately, research has not been done on the general population's understandings of infertility, so this comparison cannot be confirmed. Participants were able to label many different thoughts, feelings, and experiences a woman with infertility likely faces. However, the participants' interviews did not demonstrate understanding of the complex intricacies of infertility, which one might not expect to find without either personal experience or professional training with infertility. This study confirms the need for mental health professionals who specialize in treating infertility to provide trainings to others interested in working with this population in order to increase the likelihood that a woman with infertility will get the care she needs when seeking out mental health services.

As the conductor of this research project, I found the results interesting and informative to my future work. I believe this valuable information would be beneficial for any counselor working with the adult population to acquire, which is why I would like to use these results to prepare counselor trainings. I am excited to continue my practice working with women and couples struggling with infertility, as I believe I am more prepared as a result of conducting this

research. I hope to use the knowledge I've gained throughout this process to practice sound, evidence-based counseling practices and conduct effectiveness research on the interventions provided. And lastly, I hope this study makes all people who experience infertility one step closer to getting the quality service they need in moving through their journey.

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APPENDIX A. IRB APPROVAL

NDSU NORTH DAKOTA STATE UNIVERSITY

Institutional Review Board
Office of the Vice President for Research, Creative Activities and Technology Transfer
NDSU Dept. 4000
1735 NDSU Research Park Drive
Research 1, P.O. Box 6050
Fargo, ND 58108-6050

701.231.8995
Fax 701.231.8098
Federalwide Assurance #FWA00002439

May 31, 2012

Jill Nelson
School of Education
SGC C121

IRB Approval of Protocol **#HE12208**, "**Counselor's Perceptions of the mental health aspect of infertility for heterosexual women**"
Co-investigator(s) and research team: **Michelle Westbrock, Janelle Stahl Ladbury, Jennifer Boeckel, Jennifer Obinna**

Approval period: 5/31/2012 to 5/30/2013 **Continuing Review Report Due: 4/1/2013**

Research site(s): **varied** Funding agency: **n/a**
Review Type: Expedited category # 7
IRB approval is based on original submission, with revised: protocol, recruitment documents, and consent (received 5/29/2012).

Additional approval is required:

- prior to implementation of any proposed changes to the protocol (*Protocol Amendment Request Form*).
- for continuation of the project beyond the approval period (*Continuing Review/Completion Report Form).* A reminder is typically sent two months prior to the expiration date; timely submission of the report is your responsibility. To avoid a lapse in approval, suspension of recruitment, and/or data collection, a report must be received, and the protocol reviewed and approved prior to the expiration date.

A report is required for:

- any research-related injuries, adverse events, or other unanticipated problems involving risks to participants or others within 72 hours of known occurrence (*Report of Unanticipated Problem or Serious Adverse Event Form*).
- any significant new findings that may affect risks to participants.
- closure of the project (*Continuing Review/Completion Report Form*).

Research records are subject to random or directed audits at any time to verify compliance with IRB regulations and NDSU policies.

Thank you for cooperating with NDSU IRB procedures, and best wishes for a successful study.

Sincerely,
Kristy Shirley

Kristy Shirley, CIP
Research Compliance Administrator

Last printed 5/31/2012 1:13:00 PM

APPENDIX B. ORAL PARTICIPANT RECRUITMENT SCRIPT

Hi, my name is Michelle Westbrock. I am a graduate student in the College of Human Development and Education at North Dakota State University, and I am conducting a research project to look at counselors' perceptions of the mental health aspects of infertility in heterosexual women. It is our hope, that with this research, we will learn more about counselors' understandings of the infertility experience as well as appropriate mental health treatments.

Would you like to hear more about our study?

[If yes,]

You are invited to participate in this research study. The only criteria for participating in the study are that you are a general practice Licensed Associate Professional Counselor, Licensed Professional Counselor or Licensed Professional Clinical Counselor and you are currently seeing clients. Your participation is entirely voluntary, and you may change your mind or quit participating at any time, with no penalty; however, your assistance would be greatly appreciated in making this a meaningful study.

If you decide to participate, we will set up a time for an interview. The interview should take between 45 and 90 minutes to complete and I will ask questions about your professional experiences with, and understandings of infertility. We can meet in your office, my office, or we could do a telephone interview if you prefer. I will audiotape the interview to ensure accuracy. You may also be invited to complete a shorter follow up interview. Once the research project is complete, I will erase the audio recordings. I can email you the demographic form and informed consent for your preview before we meet if you like.

When writing about the study, your information will be combined with information from other people taking part in the study; we will write about the combined information we have gathered. You will not be identified in these written materials. We may publish the results of the study; however, we will keep your name and other identifying information private.

Feel free to ask any questions about the study now, or contact me later at *701-471-9054,* michellewestbrock@gmail.com. You may also contact my advisor, Dr. Jill Nelson at 701-231-7415, jill.r.nelson@ndsu.edu. If you have questions about the rights of human participants in research, or to report a complaint about the research, contact the NDSU Human Research Protection Program, at (701) 231.8908, or ndsu.irb@ndsu.edu.

Thank you for your participation in this study. If you wish to receive a copy of the research results, please email me at Michellewestbrock@gmail.com or call 701-471-9054.

APPENDIX C. INFORMED CONSENT

NDSU North Dakota State University

Human Development and Education

SGC Building

1919 N University Dr.

Fargo, ND 58108-6050

701-231-7921

Title of Research Study: Counselors' Perceptions of the Mental Health Aspects of Infertility.

This study is being conducted by: Michelle Westbrock is a doctoral candidate and can be reached at Michellewestbrock@gmail.com or 701-471-9054. The advisor of this research project is Dr. Nelson. She can be reached at jill.r.nelson@ndsu.edu.

Why am I being asked to take part in this research study? You are being invited to participate in this research study as a Licensed Associate Professional Counselor, Licensed Professional Counselor, or a Licensed Professional Clinical Counselor. The researcher's desire is to better understand practicing mental health counselor's experiences and understandings of the mental health aspects of infertility for heterosexual women. If you are a practicing, general practice, licensed counselor at an LAPC, LPC or LPCC level, then you can be a great contributor to this study.

What is the reason for doing the study? The purpose of this basic qualitative study is to uncover understandings mental health counselors have of infertility for heterosexual women. This understanding can help counselors better understand clients' experiences with infertility and the counselor's role in helping.

What will I be asked to do? After you agree to participate, you will be asked to complete a demographic form which includes some general information about you and your counseling practice. This informed consent form also will be asked to read and verbally consent to if you understand and agree to its contents. Once this is done you will be asked to participate in an approximately 45-90 minute audio recorded interview which will ask you questions about your perceptions of the infertility experience and appropriate mental health treatment of a heterosexual woman with infertility. By consenting you are agreeing to be audio recorded and letting the researcher use this recording to transcribe the data. The researcher will then ask if you agree to a potential follow up interview in the future, if needed. The researcher will also ask for your permission to send you your interview transcript to verify its accuracy shortly after your interview. The researcher will send out the themes from the research data for you to be able to review and verify.

Where is the study going to take place, and how long will it take? For convenience, an in-person interview can take place in your counseling office. If this is not preferred by you, the interview can take place at the researcher's office in Bismarck, ND with the cost of travel being accrued by the participant. If you are closer to Fargo, it is possible to conduct the interview on the NDSU campus. If you prefer, a telephone interview can be arranged. Interviews will take about 45-90 minutes of your time.

What are the risks and discomforts? The level of risk involved in this study is minimal due to the nature of the study. There is, however, a chance that the topic under investigation will be a sensitive one for you, and therefore elicit emotional distress. If this is your experience, you can choose to skip a question or withdraw from the study all together. The researcher will take great care to minimize any potential emotional distress by providing a comfortable and accepting

interview environment. The researcher will also take great care to ensure your privacy is protected and anonymity remains in place. It is not possible to identify all potential risks in research procedures, but the researcher(s) have taken reasonable safeguards to minimize any known risks to the participant. If new findings develop during the course of this research which may change your willingness to participate, we will tell you about these findings.

What are the benefits to me? As a result of participating in this study you could develop a more comprehensive understanding of your treatment approaches and perceptions of infertility. You will be given the opportunity to reflect on your understandings and beliefs, which ultimately can enhance your treatment with clients. However, this is not guaranteed and you may not get any benefit from being in this research study.

What are the benefits to other people? As a result of your participation in this study, the counseling field will have a better understanding of what is happening in the world of mental health treatment for infertility. This will provide a basis for moving forward with additional counselor trainings if needed. The other benefit is to the people suffering with infertility. This study will help them get the treatment their unique experience requires, as well as help them feel comfortable pursuing mental health treatment for infertility.

Do I have to take part in the study? While your contribution to this study is valuable, your participation in this research is your choice. If you decide to participate in the study, you may change your mind and stop participating at any time without penalty or loss of benefits to which you are already entitled.

What will it cost me to participate? There will be no cost to you as the participant to be in this study, unless you choose an interview site that requires travel for you. If, however, you pursue follow-up processing with a counselor or other professional it would be at your own cost.

What are the alternatives to being in this research study? Instead of being in this research study, you can choose not to participate.

Who will see the information that I give? We will keep private all research records which identify you. There are IRB trained and approved peer reviewers participating in the research that will go over the transcripts and the researcher's analysis of the data, however no identifying information will be provided in the transcripts. In the analysis process, your information will be combined with information from other people taking part in the study. When we write about the study, we will write about the combined information that we have gathered from all ten research participants. We may publish the results of the study; however, we will keep your name and other identifying information private. We will make every effort to prevent anyone who is not on the research team from knowing that you gave us information, or what that information is. For example, your name will be kept separate from your research records and these two things will be stored in different places under lock and key. During the interview and analysis process you will be referred to as a participant number or pseudonym instead of your name. You should know, however, that there are some circumstances in which we may have to show your information to other people. For example the law may require us to show your information to a court or to tell authorities if we believe you have abused a child, or you pose a danger to yourself or someone else.

Will I receive any compensation for taking part in this study? As a token of great appreciation, the researcher would like to gift a ten dollar gift card with a thank you note to each participant after the interview.

What if I have questions? Before you decide whether to accept this invitation to take part in the research study, please ask any questions that might come to mind now. Later, if you have any

questions about the study, you can contact the researcher, Michelle Westbrock at 701-471-9054 or Dr. Jill Nelson at 701-231-7415.

What are my rights as a research participant? You have rights as a participant in research. If you have questions about your rights, or complaints about this research you may talk to the researcher or contact the NDSU Human Research Protection Program by:

- Telephone: 701.231.8908
- Email: ndsu.irb@ndsu.edu
- Mail: NDSU HRPP Office, NDSU Dept. 4000, PO Box 6050, Fargo, ND 58108-6050.

The role of the Human Research Protection Program is to see that your rights are protected in this research; more information about your rights can be found at: www.ndsu.edu/research/irb .

Documentation of Informed Consent:

You are freely making a decision whether to be in this research study. Agreeing to this form means that

1. you have read and understood this consent form
2. you have had your questions answered, and
3. you have decided to be in the study.

APPENDIX D. DEMOGRAPHIC FORM

Demographic Form **Participant # _____**

Name: _____ Gender: Male/Female

Business address: _____

Phone number:_____

Email: _____

Type of license:_____

Years practicing: _____

Education level: _____

Type of practice:_____

Specializations: _____

Theoretical orientation: _____

Number of clients seen weekly:_____

History of seeing clients with infertility:

_____

Have you received training or CEUs related to infertility? _____If yes, what kind and how many hours?

_____

Is there a fertility center in your community? _____ If yes, do they serve the mental health needs of patients?

_____

APPENDIX E. INTERVIEW QUESTION GUIDE

(1) What assumptions or beliefs do you have about the issue of infertility?

a. How do you perceive these assumptions/beliefs impacting the counseling experience?

(2) A heterosexual woman client of yours says she has just been diagnosed with infertility; please describe to me your understanding of what her experience with that could entail?

a. Emotional experience

b. Cognitive experience

c. Coping process

d. Social experience

(3) Can you give me a tour of a session with a client (heterosexual woman) that has infertility? (or potential client)

a. What was the session like for you? (or would be)

(4) How prepared do you feel to successfully counsel a heterosexual woman with infertility?

a. What has helped prepare you?

b. What would help you feel more prepared?

(5) How comfortable do you feel to counsel a heterosexual woman with infertility?

a. What experiences have you had to increase your comfort level?

b. What experiences have you had to increase discomfort?

(6) What would you ascribe as the goal of your counseling session with a heterosexual woman with infertility?

(7) What are your perceptions of the primary treatment concerns for a heterosexual woman with infertility?

a. What are your perceptions of appropriate treatment approaches to address those concerns?

(8) What would harmful treatment look like or entail?

(9) Is there anything else on your mind regarding the experience of infertility for your clients or your treatment with the client?