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Infertility as a lonely struggle?

Coping stories of previously infertile women

In this narrative study, we explored the meaning infertile women attribute to social support in coping with their infertility-related challenges. Written accounts and episodic interviews with 26 previously infertile Finnish women were used as data. Two different coping story types emerged: coping alone and coping with support. In the coping alone type women neither sought nor received support. Their coping appeared as a lonely struggle. In the coping with stories, women turned to their spouses, peers, or professionals, but still emphasized that they would have needed more support. Based on our findings, we underline the need for individually tailored support.

Keywords: coping; fertility treatments; infertility; motherhood; narrative study; social support

Infertility is a highly prevalent global challenge, especially in developed countries, (Inhorn & Patrizio, 2015). It has remained especially for women a social burden (Inhorn & Patrizio, 2015; Lehto, Sevón, Rönkä, & Laakso, 2019) that can cause feelings of social stigma, isolation, and defectiveness (Greil, Slauson-Blevins, & McQuillan, 2010). Infertility itself, the exceptionally invasive and disruptive medical interventions used in its treatment, and the emotions these arouse (Bradow, 2012) may challenge a woman's perception of herself as a "proper" woman (Paul et al., 2010). Many researchers consider infertility one of the most emotionally stressful and demanding socio-psychological challenges women can experience (Herrmann et al., 2011) and one that for many would require psychological counseling (Schmidt, 2009). In developed countries, when birth rates are declining and parenthood is postponed, at the same time there is a growing number of people who are not able to have a child although they greatly desire it. With the study, focusing on the support needed and received by previously infertile women, we contribute to new knowledge in this field concerning the long and difficult road to

motherhood. Increasing knowledge about these women's experiences promotes societal sensitivity to the problem and enables professionals to improve services to better respond to the various needs of women in the context of growing infertility. Although we conducted the present study in Finland, the phenomenon is a universal one and concerns women worldwide.

Background

While social support is known to be important in coping with infertility-related challenges, most infertile women find it inadequate and only a few seek professional help (Peters, Jackson & Rudge, 2011; Shreffler, Greil, & McQuillan, 2017). Therefore, it is vital to explore women's experiences and identify their support needs and coping in their own words. In this study, we focus on external resources for social support (Garcia, 2010; Lazarus & Folkman, 1984). Social support can be subdivided into emotional (showing empathy, love, and caring), informational (giving information, advice, and suggestions), and instrumental (for example, practical services) types of support (Garcia, 2010; Lazarus & Folkman, 1984).

The ability to somehow adapt to infertility-related challenges depends on the coping mechanisms deployed (Li, Liu, & Li, 2014; Rockliff, Lightman, & Rhidianm, 2014). Coping methods are the specific strategies individuals apply to reduce, endure, or master difficult situations (Folkman & Lazarus, 1980, p. 223). Researchers have found that women experiencing infertility commonly use either active-avoidance (Benyamini, Gozlan, & Kokia 2009; Gourounti, Anagnostopoulos, & Vaslamatzis, 2010) or meaning-based (Aflakseir & Zarei, 2013) coping methods. "Active-avoidance coping" refers to efforts to avoid rather than deal with stressors, such as not telling others about one's infertility, keeping difficult emotions inside, and avoiding children and pregnant

women (Sormunen et al., 2017). “Meaning-focused coping,” in turn, refers to looking for the positive outcomes of stressful experiences (Thompson, 1985).

The authors of previous studies (Read et al., 2014; Sina, ter Meulen, & Carrasco de Paula, 2010) have clearly demonstrated that infertile women desire support, especially during fertility treatments. However, the fact that many women are reluctant to tell others, including relatives and friends, about their infertile status, means that the social support available to them is very limited (Peters, Jackson, & Rudge, 2011). Social support is especially needed from one’s “significant others” (see Berger & Luckmann, 1991; Haller & Woelfel, 1972). A “significant other” is a person who has great importance in one’s life and for one’s well-being and who thus has a strong influence on one’s self-image and self-esteem (Haller & Woelfel, 1972). For an infertile woman, her significant others are likely to be her spouse, family of origin, and friends. However, professionals can also be important providers of support (Frederiksen et al., 2015).

Given the social stigma associated with infertility and the secrecy that commonly surrounds its treatment, women with fertility problems are often unwilling to talk openly about their infertility, even with family members and friends (Ried & Alfred, 2013; Batool & de Visser, 2016). In such cases, the spouse often becomes the main source of support (Malik & Coulson, 2008). Sormunen and her colleagues (2017) have indicated that the majority of infertile women turn to their spouses about infertility-related issues (see also Batool & de Visser, 2016). However, amidst the stress caused by infertility and its treatment, spouses may find being each other’s sole supporters challenging (Darwiche, Milek, Antonietti, & Vial, 2015). Women may also feel that their spouses are unable to fully understand the bodily experience of infertility, and hence that spousal support is inadequate (Ried & Alfred, 2013).

The authors of earlier studies have indicated that previously infertile women feel best understood and emotionally supported by those who have gone through similar experiences (Ried & Alfred, 2013). Peer support has been deemed a valuable and functional form of support, especially in various life crises (Ried & Alfred, 2013). Peer support groups facilitate the sharing of infertility-related experiences and coping strategies, and thus demonstrate that one is not alone in the face of difficult emotions, challenges, and negative responses (Bond et al., 2014). The internet is also very actively utilized by women diagnosed with infertility, as a site for gathering information and accessing support groups for sharing infertility-related personal experiences, thoughts, and concerns (Satir & Kavlak, 2017). It appears that more than half of all fertility patients, albeit women more than men, seek support on-line (Satir & Kavlak, 2017).

It is known that fertility patients desire more professional psychosocial services than are currently available (Read et al., 2014). Various psychological interventions have been demonstrated to reduce psychiatric symptoms, particularly anxiety and stress (Chow et al., 2009; Frederiksen et al., 2015). While the interventions are effective in increasing the well-being of infertile women (Wischmann, 2008), only a few women seek professional help (Bond et al., 2014; Wischmann et al., 2009).

Researchers support the notion that women using fertility treatments experience more pregnancy-related anxiety and fears than women who conceive spontaneously (Dornelles et al., 2014; McMahon et al., 2013). Even successful fertility treatment may be followed by distress, uncertainty, and delays in early interaction with the long-awaited baby (Ladores & Aroian, 2015; Lehto et al., 2019). As we can see from the literature cited above, social support is essential in various ways and at different stages (Read et al., 2013; Sina et al., 2010), yet it is rarely sought and is frequently experienced as inadequate to meet the challenges presented by infertility (Erdem & Apay, 2014).

Given the prevalence and complexity of infertility and its treatment, more knowledge is needed to better understand women's coping experiences and their emotional and relational nuances. It is, therefore, crucial to know how women themselves experience support, its suitability, reliability, and timing. To this end, we obtained written stories from and conducted in-depth interviews with previously infertile Finnish women (n = 26), who had later conceived. Our aim was to explore the meaning previously infertile women attribute to social support in coping with infertility-related challenges. Thus, we formulated the following research questions: What kinds of coping stories can be identified in the narratives of previously infertile women? How do women position themselves and others with regard to the provision of support in these stories?

Methods

The Finnish context

In Finland, an estimated 3,000 new couples seek medical help for their infertility each year (THL, 2019). In 2017, more than 14,000 fertility treatments were initiated, enabling the births of nearly 2,600 babies, an estimated 5.6% of all children born that year (THL, 2019). In Europe, only Denmark, in proportion to the population, carries out more fertilization treatments than Finland (de Mouzon et al., 2010). The psychosocial support offered to individuals undergoing fertility treatments in Finland is restricted compared to many other countries, as there is no legislation on support in Finland (Tulppala, 2012).

Participants and data collection

Participants (see Table 1) were recruited through an open invitation posted on social media (Facebook and a few open and closed discussion forums), the webpages of various infertility and family organizations, and maternity clinic notice boards. In addition, a group of public health nurses from different parts of Finland were asked to inform their

clients about the request for participants. We asked participants to write freely about their journeys to motherhood. We sent a subsequent request for an interview to participants who had responded to the original invitation and sent in narratives. We used the episodic interview method (see Bates, 2004), which combines the narrative and themed interviewing methods.

The first author conducted the interviews and used the participants' written narratives as a basis for asking focused questions and prompting the participants to describe their journeys to motherhood in more detail. This helped to increase the depth and thematic richness of the data, clarify uncertainties, and refine earlier interpretations. A major interview theme concerned the women's expectations of support and the support they had actually received. The episodic interview method stimulated storytelling and encouraged the participants to narrate events as they saw them, in their own words and emphasizing experiences they regarded as meaningful (Bates, 2004). The women participated voluntarily and did not receive any compensation. The interviews were tape-recorded with the permission of the participants and transcribed verbatim. The final data consist of the written and spoken narratives of all 26 participants. [Table 1 near here]

Research ethics

Due to the sensitive nature of infertility and the fact that many of the participants had not told anyone about their infertility, we paid special attention to ethical issues. The necessary research permissions (including an evaluation by the ethics committee of the authors' university) were gathered before the interviews were conducted and the participants were carefully informed about the study, its aim and purpose, the use of the data, and the presentation of the results. Participants' right to withdraw at any time was emphasized. All participants gave their written informed consent before entering the study. To protect the participants' privacy, all identifying information has been removed.

We considered human subject protection by also evaluating the interviews from the benefit-disadvantage point of view (Edwards & Mauthner, 2012): participation in the interviews could have raised sad memories, but participants felt that narrating their maternity path was therapeutic, and increased their self-awareness. Nevertheless, the first author, who is also a public health nurse, carefully observed the women's well-being during the encounters and reminded them after the interviews to contact professional counselors if needed. Each interview also ended with a discussion on what participation in the study felt like and on the women's current well-being.

Analysis

The study and the analysis were based on narrative ontology and on the premise that the stories people tell indicate the meaning they attribute to their experiences (Bamberg, 2016; Burr, 2003). Epistemologically, we draw from narrativity and thus followed the principles of narrative analysis (Polkinghorne, 1995). We began our analysis by focusing on the content (see Riessman, 2008) of the written and spoken narratives, in this case on the theme of social support. During this process, we utilized Atlas.ti, a qualitative data analysis program, to facilitate the identification of text relevant to our research questions from the large transcript data sets. The women narrated their need for support in coping with difficult emotions related to their infertility and evaluated the ability of their significant others to provide such support. In most cases, the support received was perceived as inadequate, hence leading to the majority of the participants using evaluative language (see Labov, 1973) and providing narrative explanations for the behavior of their significant others who failed to meet their expectations.

Two different story types, based on whether the women positioned themselves (Depperman, 2013) as *coping alone* or as *coping with support* from their spouses, peers, or professionals, emerged from the data. How the women positioned themselves was

analyzed by paying attention to the linguistic features (see Table 2) of their narration. For example, the women made use of comparisons, metaphors, repetition, and excessive terms (“I have always”; “I was totally”) in their narratives. The focalization (Bal, 1997, pp. 142–50) revealed whose points of view were heard in the women's coping stories: the women used either “I” or “we” talk (Biber & Quirk, 1999). Modalization was used to identify obligation (should/need to/have to), ability (can/could), and volition (will/would) (Chalker & Weiner, 1994) in the women’s narration.

Results

In both story types, difficult emotions were cited as the main reason for needing support. However, the types differed in terms of how the women positioned themselves and their support-related significant others (see Table 2). In the *coping alone* stories, the women saw themselves as responsible for their infertility and as strongly departing from the ideals for a woman and a mother. Others were positioned as “the baddies” or as inadequate supporters. In the *coping with support* stories, the women positioned themselves as needing and receiving support but identified and described the three groups of significant others differently, thus producing three distinct sub-stories; these were labeled *companionship*, *trustworthy peer support*, and *professionals as saviors*. Below, we describe the coping story types in more detail. [Table 2 near here]

Story type I: Coping alone

The first story type, *coping alone* (see Table 2), clearly the most frequent type and narrated by 14 women, was characterized by descriptions of feelings of shame, guilt, being an outsider, and being worthless, caused by infertility and the inability to become

a mother. When talking about themselves, these women referred to the ideals of a woman and a good mother. According to them, it is a woman's duty to become a mother:

It was this womanhood that I am not capable of what a woman is made for.

Yes, I blamed myself; I never had this sort of strong feminine confidence. What I had crumbled away, being like a useless half woman.

I just pushed onward [with treatments] without really thinking. One treatment and disappointment at a time. I felt that everything was solely up to me.

The women blamed themselves and positioned themselves as diverging from a "real, normal woman." The women used such expressions as "not capable of" and "I never had a strong feminine confidence" in their narratives to prove that they were abnormal, ashamed of themselves, and the wrong kind as women. The hyperbolic utterance "I never" and metaphors such as "half woman" highlighted the disparity between themselves and the ideal woman. Their narratives also reveal that they positioned themselves as responsible for their infertility and pointed out that, as good mothers-to-be, they had tried to do everything to achieve the long-awaited pregnancy. Although the women talked about their difficult emotions, they nevertheless emphasized their coping alone.

You can't really say how everyone is doing. And I would have got [support] if I'd had the sense to open my mouth in the right places. [...] But I didn't, though. Of course, I grit my teeth and say that I can cope. That it was down to me that I didn't get help. If I had realized to ask for it.

The main reason women felt that they had to cope alone was finding that the people they perceived as their support-related significant others were unable to support them. In this story type, the woman's own agency and need to cope alone ("it was solely up to me") were emphasized and produced an ethos of self-coping. It is notable that these participants used a great deal of I-talk, instead of mentioning a spouse, relatives, friends,

or professionals as supporters. Some had a fear of being labeled by infertility; they did not seek support because they were afraid of appearing insane or weak. Coping also acted like an armour; having control protected the women. Many underlined their lone coping, as not being able to cope might demonstrate that they were not meant to be mothers.

Well, he [the spouse] hasn't in a way really understood how it feels. I don't know if I've expressed it so much all the time. Or maybe I don't talk about it that way with him. I don't know if he can ever kind of understand it in the same way; it must be different for a man than it is for a woman.

[Deep sigh.] I feel now, but it could be that I didn't then, but now I feel that the feeling of loneliness was the hardest one, when I felt like my spouse wasn't up to it. To give support. [...] A man maybe doesn't experience it as concretely as a woman.

As the above quotations illustrate, the women produced explanations for their spouses' clearly inadequate support. When evaluating their spouses' inability to provide support, the coping-alone women cited gender as the reason why their spouses were unable to support them. Blaming the spouse also occurred in a more subtle and implicit way. For example, sometimes the women narrated the loneliness and the solitariness of their mourning ("most of my crying I have done alone"), thereby simultaneously revealing the lack of spousal support.

I went to get it [the fertilized egg] by myself. There were eight of us women in the same corridor and we all chatted, and we all talked about if we were nervous and if it doesn't work out, then what. And how labor will go. And would labor be more horrible than this? I was like quiet and then I said, well, it's not that horrible, I already have one child. Then it was like, "woah." Everyone turned to look at me and I was like, I shouldn't have said that. There was this deathly silence, you know. Then everyone started talking again, but for a moment I felt [claps her hands] ... that "she's not one of us after all."

Peers were also represented in this story type as a depleting rather than empowering source of support. The women saw themselves as caught up in a comparison of infertility-related difficult experiences from which they would be excluded if they did not meet the requirements of being “infertile enough by length and primacy of infertility.” When denied access to their peer group, the women produced narratives of blame. In this way the women positioned the peers as “the baddies.” The support of health care professionals, in turn, was narrated by women in this story type as very feeble or completely non-existent. They narrated how their need for psychological support had been ignored in clinical care situations.

I understand that doctors don't actually have time to ask questions like they do in a private clinic, like “so how are you doing now,” so that the answer would not have to be really short. I can well understand that if they have 20 minutes or half an hour or whatever they have per patient, that they can't be like psychiatrists, but what I would like to say to them is that then, when someone does say something or they have questions, that there should be somewhere they could refer them to. Because, for example, I myself tried to tell the nurses when it started bothering me that no-one ever asked me anything, something like “I just can't take this” – that was also just dismissed there. The nurses did nothing to acknowledge it either.

A repetitive mode of narration such as the above was used to position women as in need of help and professionals as incapable of noticing their critical state. They referred positively to the structures and resources of the health care system, but at the same time blamed the professionals for not noticing their needs. This was contrary to the cultural expectations they had of the health care professionals: their task was to help. The women thus positioned the professionals as “other” and as non-empathetic: “no-one ever asked me anything.” Overall, the women employing this story type positioned themselves as ruthless survivors (see Table 2).

Story type II: Coping with support

In the second story type, *coping with support* (see Table 2), the women underlined their view that they would not have survived without the support they had received. The story type was divided into three subtypes (*companionship*, *trustworthy peer support*, and *professionals as saviors*), where the supportive significant other varied and was differently positioned, as the women also positioned themselves differently in each subtype.

Companionship stories

In this subtype, narrated by five women, sorrow was strongly emphasized and narrated as the most important reason for the need for support.

A kind of an unfathomable sorrow that's much bigger than what you could ever imagine experiencing, let alone endure, the kind that you can't move past from, the kind where you face a wall in all directions, and the kind where you almost think that I don't want this to be true because if this is true, I can't continue with my life.

The women employing this story type highlighted the spouse's role. They felt that they were experiencing infertility together with their spouses ("we cried our eyes out;" "first I crashed, then the man"). Many women narrated their infertility as the most important crisis in their lives thus far, both his as well as hers. This story type included more we-talk than the other story types, demonstrating the cohesiveness and mutual support that existed between the spouses. Although the woman was the main protagonist, the man was described as an active supporter and equal experiencer.

We mostly did pretty OK; of course, we hit lows sometimes. Sometimes we cried our eyes out. Usually it was me who fell apart first and when I'd got myself back together, he fell apart.

So then we did this. Sometimes the other one [of us] felt stronger and was therefore able to support the other one better. We took turns. My husband has said that whether we have kids or not, we will be together. It means that the support is, like, always there.

In reporting “we did this,” the participant emphasized the activities of both parties: the project of having a child was the couple’s mutual project. The spouse’s role was narrated as especially meaningful when the woman’s own resources were exhausted: her spouse was the first person she shared her emotions with and the person to whom she dared show her worst side and moments of breakdown. The spouse was perceived as a safe partner whose presence could be relied on. Many described how infertility eventually even strengthened their relationship. Through their difficulties, they had learned how to talk about things and their shared struggle to have a child had further cemented the couple’s relationship:

We believe that whatever happens to us in the future, we are stronger than before.

I’m sure that the long background of infertility has both strengthened my relationship with my husband but also developed us as humans. Our attitudes have also changed.

It was easy to note that these women were turning past experiences into positive ones. They wanted to see their previous infertility-related experiences as a path to personal growth and marital success. Infertility and its treatments were described as meaningful experiences and that suffering had made them stronger. The women narrating this story type positioned themselves as co-survivors (see Table 2).

Trustworthy peer support stories

In the second subtype, narrated by four women, *trustworthy peer support* (see Table 2), seeking information and hearing or reading about the experiences of others were narrated as the most meaningful source of support. Their ability to cope with infertility-related difficulties had benefited from reading literature on the topic, following public figures who were known to suffer from or to have suffered from infertility, following

conversations in different internet chat rooms, and sharing experiences face-to-face either with friends or relatives who had experienced infertility or in meetings coordinated by different organizations.

I sought very hard for the information from the literature and from libraries. When I was going through the treatments, I read those stories. I identified with the stories of others – they acted as a resource in that way. I got support through the stories somewhat like anonymously [laughing]. That stayed strongly in my mind that she had gone through exactly the same things and it felt like a similar story.

With “I sought” and “I read,” the narrator expresses strong agency and simultaneously positions herself as an active actor who influences her own coping. I-talk largely described active information seeking: visiting libraries and reading infertility-related books and articles – actively doing something by themselves to support their coping. When they talked about peer support, these participants emphasized that only a person who had gone through the same things could truly understand infertility and the emotions it gave rise to. In their narratives, the women strongly identified with other sufferers from infertility. Peer support helped them understand that they were not alone with their thoughts and difficult emotions, including feelings of shame. The stories of others were perceived as meaningful and as mirroring their own experiences.

In this story subtype, the women positioned themselves as intellectual survivors (see Table 2), with social support in the form of information playing a central and significant role. The need for support appeared as a necessity not only to gain information but also to find an approving and normalizing reflection of the women’s own feelings and experiences. Others’ stories and the infertility literature served as peer support and as an important form of social support. These coping narratives seemed to be task-oriented and knowledge-centred.

Professionals as saviors stories

The last subtype, *professionals as saviors*, narrated by three women (see Table 2), was characterized by descriptions of nagging fears, such as the fear of being left alone, the fear of losing the child, the fear of having a miscarriage, and/or the fear of being hurt or injured when giving birth. Impending motherhood also aroused fear.

The spiral was somehow so massive, I was so sure I was going to miscarry, and if I don't, the baby will be severely ill, and if it's not, then either I or the baby or both of us will die in labor. It was like things can't go well with me.

At the same time, these women also profusely described self-destructive and aggressive feelings resulting from a long period of sorrow, hopelessness, and lack of prospects. Many characterized the period of infertility as a black, dark, and anxious time, during which their emotional pain was so strong that they had hoped physical pain would bring a momentary respite. Descriptions of strong hate and aggression were also abundant: hate towards one's dysfunctional body and towards those who managed to get and stay pregnant and give birth to a child.

It [sorrow] was so big that it would have been great to be able to put it somewhere. Our bedpost had these sharp corners and I wanted to bang my head against them, like for a little while just let me be. Give me peace from this, because it's like it fills everything, I mean everything, and then there's nothing else.

... when your mind is so deranged that your soul hurts so badly you cannot be, then it would have been very easy if something sort of external would have been aching. I really began to understand people who cut themselves; I don't anymore, even for a moment, wonder why someone would do that.

These women emphasized the value of the help received from professionals in their narration, but they formed a clear minority (n = 3) of the participants. One of them had met a psychiatric nurse regularly, the other mentioned the public health nurse at the

child welfare clinic and the third a fertility doctor whose empathy and care had got her through the worst moments. The unpleasantness of their experiences freed them from the cultural need to cope and be in control and motivated them to seek help. Utterances such as “I was totally collapsed” and “I wouldn’t have survived otherwise” indicated how these women had surrendered to the idea of external support. Those who positioned themselves as needing assistance described how they had yielded themselves up to help from others. They emphasized that it had been necessary for their survival. The women relieved themselves of the responsibility to cope alone and put themselves in the hands of professionals.

My salvation was this public health nurse.

We had an empathic and fully compassionate infertility doctor who did his job wholeheartedly. That meant everything and I am ever so grateful.

I felt so lost and so angry that I went to talk to a psychiatric nurse regularly. I honestly don’t know how I would have survived otherwise.

The support provided by professionals was narrated as very meaningful, even a lifesaving experience. We were able to recognize this in the women’s narratives, where they underlined that they had not known how they would have ended up without external support. Thus, they positioned themselves as grateful survivors (see Table 2).

Discussion

Our key contribution was to gain further understanding of the paradox between the need for, and seeking, support by women suffering from infertility. Lonely struggling emerged as the main theme when describing infertile women’s coping and their support experiences. All women in this study, however, desired social support, especially in handling and managing difficult infertility-related emotions, including complicated sorrow, fear, and feelings of aggression and anger. For many participants such emotions

were the result of their inability to live up to the ideal of a woman and maternity. Despite the obvious need for support, only few actively sought it. These findings are consistent with those of previous studies (Read et al., 2014; Wischmann et al., 2009) that indicate that the psychosocial support is rarely sought.

Many participants were reluctant to seek support owing to fear of stigmatization, being diagnosed as “insane,” or wanting to avoid the problem. Many also felt that because of the acute crisis caused by their infertility, feelings of powerlessness due to infertility, or the determination to emphasize self-coping, it was difficult for them to seek the support they needed. This type of action refers to active-avoidance behavior, noted also in the earlier study of Benyamini and colleagues (2009). The main reason the women in this study gave for coping alone was that the people they perceived as potentially supportive significant others were unable to support them. Either the male spouse was not able to fully understand the woman’s experiences or did not know how to support her in an appropriate way. This differs from the findings of Batool and de Vesser (2016), who clearly described in their study that social support from husbands was crucial for infertile women’s well-being. In our study, surprisingly, only a few women felt supported by their husbands. The same narrative was repeated in the case of professionals: in the women’s narratives, the clinics focused on medical or nursing interventions, and psychological support was either forgotten or completely ignored. Participants blamed professionals for lack of sensitivity to their needs and expressed the wish that professionals would have had the courage to ask about the women’s well-being.

Accessing social support was problematic, not only due to the inability of significant others to help but also due to women’s reluctance to tell their close ones about their infertility. Peters, Jackson, and Rudge (2011) have reported similar findings. Despite the burdensome consequences of infertility, most women in this study did not share their

infertility-related experiences with their family and friends, thus increasing the women's psychological vulnerability. Differing from the results of other studies (e.g., Batool & de Visser, 2016; Read et al., 2013), the participants of this study, with a few exceptions, did not view family members as support-related significant others, but instead spoke of their desire to protect them from suffering grief over their infertility. Telling friends about one's infertility was also restricted, as the participants felt the friends would not be able to understand the experience of infertility. Many also reported distancing themselves from their fertile friends.

The participants of this study attributed different meanings to social support in coping with their infertility-related challenges. The women narrating the *coping alone* stories reported not receiving social support that met their needs. According to the women's stories, they would have valued the emotional type of social support (Lazarus & Folkman, 1984). They desired empathy, personal encounters, presence, and a willingness to listen, especially on the part of spouses, peers, and professionals. These women underlined their stand-alone coping. A possible explanation for this might be that coping alone is a common, valued, and prized trait in the Finnish culture, where people are expected to be courageous and manage by themselves. The roots of self-coping lie in Finland's rural history and small size (Frigren, Hemminki, & Nummela, 2017), and in the relatively strong gender equality characteristic of the Nordic countries.

We also see a connection between the compulsion to cope and cultural ideals about femininity and motherhood (see Sevón, 2009), such as the notion that a good woman and mother is capable and can manage (Hays, 1996; Sevón, 2009). The downside to this strong ethos is that women may struggle to the last without seeking help. The ethos of self-coping is informative about attitudes to infertility, the privacy surrounding it, and the stigma it carries. The medical treatments, in turn, exacerbated the infertile women's

feelings of being the wrong kind of woman and somehow flawed. Admitting (even to themselves) that they could not manage would have increased the women's feelings that they were never meant to be mothers. This conclusion was something that the women sought to avoid even at the cost of their own well-being.

In the *coping with support* stories, the need for support and the support-related significant others varied. In the *companionship* stories, the spousal concrete and emotional type of support (Lazarus & Folkman, 1984) was emphasized and the narrators experienced infertility as a shared trial for the couple. In the *trustworthy peer support* stories, the women valued informational social support (Lazarus & Folkman, 1984). For these women, other infertile women's stories both reflected and met their needs for emotional and informational support. The knowledge that others had had similar experiences, emotions, and thoughts increased their well-being.

A minority of the participants who had received help from professionals, valued practical social support (Lazarus & Folkman, 1984) in the form of support services, counseling, and interventions. They found this to be the only effective type of support in a situation where their psychological resources were exhausted. The women narrating the *professionals as saviors* stories had experienced severe challenges: miscarriages and other health issues of such depth and complexity that this was the only form of support that had enabled them to survive their infertility crisis. It is also important to note the limitations of this study. First, the invitation to participate may have appealed mainly to those who wanted to tell their stories and who had experienced problems in receiving social support. We can therefore ask whether other stories remain unheard. Second, the interval between the women's experiences and the data collection was not considered in the analysis. However, reliability was improved by the fact that the women's stories were different, exhibiting a broad range of support needs and gaps in receiving it. In

conclusion, we suggest that future researchers could investigate the support needs and coping of those who end fertility treatments unsuccessfully.

Practical implications

We recognise many possibilities for utilizing the findings of the study: in planning, providing, and improving nursing practices and education, as these findings draw attention to the need for health care professionals to be sensitive to the difficult emotions experienced by infertile and previously infertile women (see Greil, Slauson-Blevins, & McQuillan, 2010) and to help these women cope with their emotions. An invaluable contribution of the study is a better understanding of the individual nature of women's coping and support needs. We identified huge differences between these women's needs for support and hence argue for individually tailored support models.

We also found that remaining silent about infertility was a general coping method in these women's narratives. That is why it is vital that professionals aim to enter into an open and understanding dialogue with individuals suffering from infertility and thus reduce the taboo and silence surrounding infertility. We suggest that professional support should be integrated into routine check-ups for infertile women (see Chow, Cheun, & Cheun, 2016). If, as we indicated in this study, many woman are struggling alone, neither seeking nor receiving any kind of support, there is a strong case for intervention by health care services. On the one hand, women should be provided with comprehensive, sufficiently extensive, and long-lasting support throughout their journeys to motherhood. On the other hand, professionals may also recommend potentially effective methods for managing difficult emotions. By teaching women how to cope with difficult emotions and encouraging them to seek support, the various consequences of infertility may be decreased. For professionals to provide such support, they must first be able to identify the need for support (Gustafsson & Ahlström, 2006). This raises the question of how to

identify women who are “gritting their teeth” and trying to give the impression of coping in care situations. Greater awareness by health care professionals of the experiences and coping abilities women would help them identify those who are in need of support but are hiding it.

According to Frank (2013), stories usually have two sides, one personal and the other social. We clearly demonstrated this in the study. With the narrative approach, we produced a picture of both the personal experiences of previously infertile women and the cultural reality in which they became mothers. Above all, with this approach we managed to illustrate the contradictory nature of social support: it is not always and in every situation experienced as helpful, and it can even undermine and impede the coping and well-being of infertile women.

One aspect of the research that enhanced participants’ coping was the act of narration. Women felt that narrating their stories was therapeutic, in that it increased their self-understanding and well-being, findings also reported by Frederiksen and colleagues (2017). Such stories render women’s experiences visible and shared. The diversity of stories will gradually, it is to be hoped, expand our conceptions of femininity, motherhood, social support, and coping. To conclude, much can be done to ease the coping of infertile women. Heightened sensitivity by professionals, along with common awareness about infertility and related challenges, would enhance the possibilities for infertile and previously infertile women to construct a positive image of themselves as a woman and a mother.

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Table 1. Participants of the study (N=26)

Respondent Characteristics	Mean or Frequency
Age, years (range)	35 (30–42)
Spouse's age in years (range)	38 (30–45)
Marital status (at the time of interview)	
Married	13
Cohabiting	8
Divorced	4
Single mother	1
Duration of infertility in years (range)	5.3 (2–12)
Length of time in treatment	
Less than 1 year	2
1–5years	20
Over 5 years	4
Education	
University/post graduate	13
College/vocational school	11
Primary school/high school	2

Table 2. The main components of the story types

Form of coping	STORY TYPE I Coping alone	STORY TYPE II Coping with support		
Name of story	<i>The ethos of self-coping (n=14)</i>	<i>Companionship (n=5)</i>	<i>Trustworthy peer support (n=4)</i>	<i>Professionals as saviors (n=3)</i>
How women positioned themselves in their narratives	As departing from ideal of woman and mother As deviant, responsible for not receiving support, lonely As ruthless survivor	Together with spouse, taking turns supporting each other As co-survivor	As an intellectual actor, capable agent and active information seeker As intellectual survivor	As yielding themselves up to the help of others As surrender and as needing assistance As grateful survivor
Difficult emotions narrated by women	Shame, guilt Feeling of being wrong kind of woman	Deep, prolonged, and complicated sorrow	Distress, and anxiety	Nagging fear Self-destructive anger and aggressive feelings
Support-related significant others mentioned by narrators	Ideal woman/mother Spouse Peers Health care professionals	Spouse	Peers	Health care professionals
How women positioned others in their narratives	Others blamed, excused and justifications given Others narrated as “others”, baddies , not capable of giving support	Spouse narrated as supportive, trusted companion , both partners described as having equal agency and responsibility	Peers narrated as important co-experiencers resembling oneself, as offering information and sharing experiences As fulfilling information needs	Health care professionals narrated as supportive and sensitive As saviors
Linguistic features of narratives	I-talk Use of metaphors Comparing Comparing and contrasting Me vs. others-talk	We-talk Evaluative adjectives and verbs	I-talk Active agency in narration (I sought, I read)	Use of hyperbolic, excessive expressions