

Group Therapy as a Social Response to Infertility: Participant Perspectives (A Case Study)

By

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### **Abstract**

Given the prevalence of depressive symptoms in women who experience infertility, and the high numbers of Canadian couples likely to be diagnosed with infertility, this case study seeks to elucidate participant perspectives of couples who attended group therapy with regards to whether participation reduced suffering, especially what may have been termed “depression” or “depressive symptoms.” An adaptation of a Response-based Contextual Analysis research framework was used to explore one couple’s experience of infertility: the couple’s context, their experience of the infertility, the social responses the couple received (including that of group therapy), and their agentic responses to each of these. The couple perceived the following as beneficial factors present in counsellor-led group therapy: the normalizing and contextualizing of the experience of infertility, observing resilience in others, the opportunity to engage in perspective-taking, and the instituting of boundaries and safety measures. In addition to the above, the following were seen as beneficial factors present in the peer-led support group: the convenience of determining meeting times/places, the intimacy afforded by a smaller group, the immediacy of being able to contact group members between meetings, and advantages of peer leadership. Attending counsellor-led group therapy helped “to some degree” with the “challenge” and “depression” associated with the infertility but overall the couple preferred the convenience, intimacy, and immediacy factors offered by the peer-led support group. From a counselling perspective, remaining aware of factors cited as important by participants will assist therapists in providing meaningful support that is responsive to the needs of couples, and effective in terms of reducing distress associated with infertility. Group therapy offers an opportunity for counsellors to facilitate positive social responses reducing feelings of social isolation, marginalization, and exclusion, thereby mitigating the often-negative social responses many couples receive.

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### **Dedication**

I dedicate this work to Stella Allison, who did not have children of her own but was surrogate mother and grandmother to many. And to the men and women who permitted me to see and hear their struggles in the midst of infertility.

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## Chapter One

### Introduction

#### Background

For many couples and individuals, the ability to create a family defines the essence of life itself. However, the World Health Organization (1992) reports that approximately 8–10% of women and couples worldwide experience infertility. Statistics available in Canada indicate that between 11.5% and 15.7% of couples experience infertility (Bushnik, Cook, Yuzpe, Tough, & Collins, 2012). Cousineau & Domar (2007) state: “For many couples, their infertility becomes the focal point of daily discourse and tasks, often to the exclusion of other important aspects of life” (p. 295). There are several psychological responses (often termed “effects”) to infertility and infertility treatments, which include anxiety and depression in women and couples (Cousineau & Domar, 2007; de Liz & Strauss, 2005; Eisenberg, Smith, Millstein, Nachtigall, Adler, & Pasch et al., 2010). Assessing the significance of psychological outcomes of infertility for women, Domar, Zuttermeister & Friedman (1993) write, “When compared with women with heart disease, cancer, chronic pain, or HIV+ status, infertile women reported equivalent levels of anxiety and depression to all but the chronic pain patients” (as cited in Domar, Clapp, Slawsby, Kessel, Orav & Freizinger, 2000, p. 568). Domar, Broome, Zuttermeister, Seibel & Friedman (1992) found that women who experience infertility are twice as likely as women in a control group to have depressive symptoms.

As noted by Van den Broeck, Emery, Wischmann & Thorn (2010), infertility counselling in all its forms provides the opportunity to “explore, discover and clarify ways of living more satisfyingly and resourcefully when fertility impairments have been diagnosed” (p. 423). Counselling approaches may include individual counselling, couple counselling, and group

therapy. Counsellor-led group therapy is one of several psychosocial interventions designed to help couples cope with the often-stressful experience of infertility. Group therapy with couples who are experiencing infertility involves “an explicit choice to invite the marital dyad to the group, so both partners and the relationship simultaneously may benefit ... it has the additional advantage of reframing the infertility problem as a relational issue rather than a male or a female problem” (Lemmens, Vervaeke, Enzlin, Bakelants, Vanderschueren, Hooghe et al., 2004, p. 1918). Counsellor-led group therapy can serve a variety of purposes including reducing isolation, sharing experiences, catharsis, receiving information, improving communication skills, learning relaxation techniques, or providing other forms of psychological support. The act of engaging in group therapy involves an element of risk-taking for both the individual and the couple. This risk is offset by the opportunity for engagement with others, a sense of being less alone, and the potential positive effects of learning together as a couple. This paper also discusses the potential for group therapy to counteract the often-negative social responses received by couples, providing a forum where positive social responses can be facilitated.

### **Problem Statement and Research Question**

For the purposes of this thesis, the broad research question is: For couples who have experienced infertility for at least one year, does participation in group therapy decrease suffering, especially with regards to what may have been labeled or named “depression” or “depressive symptoms?”

### **The Research Approach**

There is a reasonable amount of literature regarding group therapy’s applications and efficacy for individuals who experience both infertility and anxiety (see literature reviews by Boivin, 2003, and de Liz & Strauss, 2005) but relatively little addressing group therapy’s

effectiveness for couples who experience infertility in conjunction with what is usually referred to as “depression” or “depressive symptoms.” In addition to examining from a participant perspective the effectiveness of group therapy as a psychosocial intervention aimed at decreasing “depression,” this paper will also explore the use of language in the literature and elsewhere with regards to terms such as “depression” and “depressive symptoms” to describe what could alternatively be formulated as an understandable response to the experience of infertility.

For the purposes of this paper I have used an adaptation of the theoretical and research framework of Response-based ideas (Bonnah, Coates, Richardson & Wade, 2014; Richardson & Wade, 2008) to conceptualize the issues, design the interview questions, engage with participants, and interpret the data. Response-based ideas acknowledge the agentive responses and acts of resistance by individuals to events and adversity rather than the “effects” upon a person of these same events (Wade 1999; Richardson & Wade). Using a Response-based lens, attention will be paid to the context of the couple’s situation: the history of their relationship, their respective families of origin, their systems of support, the story of how they found out about their infertility, social responses to their infertility, their responses to the social responses, and the nature of their experience in group counselling.

### **Significance of this Study**

The relevance of the proposed research is to examine from a client perspective whether counsellor-led group therapy for couples is an effective intervention in terms of reducing psychological suffering, specifically what may have been named (by themselves or by others) “depression” or “depressive symptoms.” It is my hope that in light of the small number of articles in the literature linking infertility, group therapy, and depression, knowing specifically

what was most and least helpful from a participant perspective will be useful information for counsellors who are leading or designing groups for clients experiencing infertility.

### **Defining the Terms**

**Infertility** is typically diagnosed when unsuccessful and focused attempts for a pregnancy have been made by a cohabiting couple for a duration of at least twelve months if a woman is thirty-four years or younger, or for at least six months if she is thirty-five years or older, or if there is a history of repeated pregnancy loss (Centre for Disease Control, 2005, p. 149).

The Diagnostic and Statistical Manual of Mental Disorders-V (American Psychiatric Association, 2013) cites the following (in particular combinations) as potential criteria for a **depressive episode** (commonly referred to as “depression”): depressed mood; lost of interest and enjoyment in usual activities; reduced energy; decreased activity; reduced self esteem and confidence; ideas of guilt and unworthiness; pessimistic thoughts; disturbed sleep; diminished appetite; and ideas of self harm. Any of the above, taken alone or in combination, may be thought of as “**depressive symptoms.**” The DSM-V uses strict criteria to define Major Depressive Disorder or an isolated depressive episode and therefore the author distinguishes between the two. For the purposes of this paper, Major Depressive Disorder is not discussed and is not included when using the terms “depression” or “depressive symptoms.”

For the purposes of this study “**group therapy**” is distinguished from a “**support group**” in that group therapy is counsellor-led and incorporates psychotherapeutic interventions aimed at specific factors essential to group therapy such as those identified by Yalom (2005). Yalom describes in detail twelve therapeutic factors present in group therapy: interpersonal input, catharsis, cohesiveness, self-understanding, interpersonal output, existential factors,

universality, instillation of hope, altruism, family reenactment, guidance and identification. In contrast, a support group is peer-led, more informal, and will be less concerned with attention to the above psychotherapeutic factors.

**Response-based** ideas are “based on talking about events, responses to events, social responses to the person and the ways in which the person responded to the social responses” (Bonnah, Coates, Richardson & Wade, 2014). A response-based perspective looks for contextual detail and “situational logic” (Wade, 1999) in a person’s actions, and uses this as a way to elucidate agentic responses to adversity rather than focusing on the “effects” or “impacts” of that same adversity. A Response-based approach uses “response-based” rather than “effects-based” language to reveal ways in which individuals maintain dignity and demonstrate resilience in the face of adversity. Therapists using Response-based practice “employ a number of techniques to clarify context and interactional details, develop accurate descriptions of violent actions (and other adversities), explore the forms and ‘situational logic’ of responses and resistance to those actions, review social responses, and discuss individuals’ responses to those social responses” (A. D. Wade, personal communication, April 29, 2015).

## Chapter Two

### Literature Review

#### Introduction

In 2003, Boivin undertook a review of the literature regarding psychosocial interventions for patients with infertility, specifically studies evaluating the positive effects of psychotherapy for infertile couples. Boivin looked at existing research in the field and highlighted a need for further evaluative studies. From the 380 studies appraised by Boivin, only 25 were classified by the author as independent studies and, due to lack of adequate control groups, only eight of those met the minimum quality research standards established by Boivin. The results of these eight studies indicated positive effects of psychotherapy for infertile patients. According to Boivin, group interventions which had emphasized education and skills training (for example, relaxation training) were found to be significantly more effective in producing positive change across a range of outcomes than were counselling interventions which encouraged emotional expression and support. Men and women were found to benefit equally from psychosocial interventions.

De Liz & Strauss (2005) conducted a meta-analysis on research examining the positive outcomes of psychotherapy on negative affect as well as its possible positive influence on conception rates. This is an extensive analysis of the data from 1979 to 2003. De Liz and Strauss concluded that the literature supports both group, and individual or couple psychotherapy, all of which lead to a measurable decrease in feelings of anxiety and/or depression. The authors found only a small between-groups effect of individual/couple therapy and group therapy, suggesting that both psychotherapy types yield positive effects for patients. De Liz & Strauss found in the existing literature only two studies that discussed offering group psychotherapy to patients with infertility (Domar, Clapp, Slawsby, Kessel, Orav, & Freizinger 2000; Galletly, Clark,

Tomlinson, & Blaney, 1996). Overall analysis of the research indicates that upon termination of psychotherapy, a reduction of depressive symptoms in patients was greater after 6 months. Since this paper examines depression in the context of infertility and group therapy, it is worth noting that de Liz & Strauss conclude “depressive symptoms” increase with length of infertility duration & that women and couples may be more receptive to support earlier in therapy rather than later in therapy. Due to the limitations of a meta-analysis, de Liz & Strauss note that conclusions must be viewed with caution due to methodological and informational bias within the studies analyzed. For example, sample selection tended to be from clinics or private practice and subjects were mostly Caucasian, upper-middle class couples and women.

A third meta-analysis was conducted by Haemmerli, K., Znoj, H., & Barth, J. (2009). The authors examined the existing literature to determine the efficacy of psychological interventions for infertile patients with regards to mental health measures and pregnancy rates. Unlike Boivin (2003) and de Liz & Strauss (2005), Haemmerli et al. limited their analysis to only those studies with controlled investigations. They found an absence of clinical effect of psychological interventions on mental health measures including depression. Interestingly, psychological interventions were found to have a positive effect on pregnancy rates. Haemmerli et al. did not select for the kind of psychological intervention being tested. The definition of a psychological intervention was broad and characterized as a face-to-face intervention designed to influence psychological functioning based on a psychological theory and incorporating psychological strategies through interaction. Since all of these elements could be present in any of individual, couple, or group counseling, the usefulness of this particular meta-analysis is somewhat limited for the purposes of this paper, which looks specifically at the efficacy of counsellor-led group therapy.

Eisenberg, Smith, Millstein, Nachtigall, Adler, & Pasch et al. (2010) examine predictors for U.S. patients with diagnoses of infertility who do not pursue infertility treatment. The study had a sample size of 434 male and female patients recruited from eight participating endocrinology and fertility clinics in California. A longitudinal study lasting 18 months found that when interviewed about why they had chosen to not pursue infertility treatment, 58% of participants described financial concerns, 38% listed personal life circumstances (i.e. moving, death in family, return to school), 26% mentioned medical futility, and 20% stated emotional stress as reasons for not pursuing infertility treatment. Eisenberg et al. note, "Not only was emotional stress commonly cited as a reason for not proceeding with treatment, but we also found that patients with higher depression scores were more likely not to pursue infertility treatment than those with lower scores" (p. 2370). A baseline depression questionnaire (Center for Epidemiologic Studies Depression Scale) was used as a screening and assessment instrument. Confounding effects were accounted for and included age, education, income, insurance coverage, religious affiliation, race, marriage status, duration of infertility, previous live births, perceived infertility diagnosis, depression, and anxiety. Recruitment was based upon subject willingness to participate and therefore there may be unmeasured biases in the study. The importance of higher depression scores on the willingness of patients to pursue fertility treatments suggests that examining ways to reduce depressive symptoms for patients or clients with infertility becomes important when considering not only the effect on fertility but also individuals' ability to cope with the distress of their situation.

Webb & Daniluk (1999) identify some important aspects of the male experience of infertility. The study represents a qualitative phenomenological approach and uses case studies of six men. Seven phenomenological themes associated with the male experience of infertility

emerged: a sense of profound grief and loss, powerlessness and loss of control, personal inadequacy, betrayal and isolation, threat and foreboding, desire to overcome and survive, and a need to positively reconstruct their experiences. Words that these men used to express their reactions to male factor infertility included: *devastated, shocked, denial, numb, angry, disbelieving, and depressed*. Again, we see the literature reflects a need in the lives of patients with infertility for some way to mitigate the devastating effects of this condition on their lives. Webb and Daniluk suggest that the results of these six phenomenological case studies, while specific to their subjects, have “empathetic generalizability.”

McQueeney, Stanton, & Sigmon (1997) examine the experience of women with infertility who participated in group psychotherapy. Researchers conducted a controlled study with 29 participants who had struggled for an average of four years with infertility. In addition to a control group, there was an emotion-focused therapy group, and a problem-focused therapy group. Two trained therapists, an advanced graduate student, and a postdoctoral student in clinical psychology each conducted the groups at least once, and the six 90-minute sessions were recorded to ensure that the conditions were distinct. The authors found that problem-focused training was associated with improvements in general distress and infertility-specific wellbeing at treatment termination but that emotion-focused training resulted in greater improvement one month after treatment termination. Emotion-focused participants reported less depression and more infertility-specific wellbeing at 1 month than did controls. It appears that there is efficacy for both emotion-directed and problem-focused interventions in women's responses to infertility. The authors conclude that their results “lend support to the contention that emotional processing is beneficial for women, at least with regard to relatively short-term affective outcome” (McQueeney et al., 1997, p. 328).

Domar, Zuttermeister, Seibel, & Benson (1992) have been cited by both Boivin (2003) and de Liz & Strauss (2005) with regards to group therapy approaches to clients with infertility. An important and often-cited study, Domar et al. (1992) investigate psychological improvement in infertile women following a cognitive behavioural treatment plan. Domar, Seibel & Benson (1990) described results from a behavioural treatment plan used in a group therapy context, which resulted in decreases in depression, anxiety, and fatigue. The object of Domar et al.'s 1992 study was to replicate previously reported psychological improvements in infertile women attending a group behavioral treatment program. Fifty-two self-referred women participated in a ten-week behavioural treatment program. The findings indicate that psychological improvement was statistically significant and associated with significant decreases in negative psychological symptoms. A more recent study by Domar, Clapp, Slawsby, Kessel, Orav, & Freizinger (2000) points to further evidence that there is a positive impact of group psychological interventions on distress levels in infertile women. Domar et al. (2000) undertook a study to determine if group psychological interventions could prevent the anticipated increase in psychological distress of infertility patients over time. They used two group interventions: support groups, and cognitive behavioural groups (CBT; also known as mind-body groups). There was a control group comprised of patients not receiving group therapy and which instead received "routine care." One of the exclusion criteria was that participants not be clinically depressed at the start of the study. They also were selected for being English-speaking, not currently in any therapy, not practicing any relaxation technique, and not taking psychotropic medications. Ninety-nine per cent of the participants were Caucasian. To attract participants, brochures were placed in the offices of fertility clinics and specialists. The program began with 184 participants and had a high attrition rate especially in the control group, leaving only 63 participants to complete the

first phase of the study, and only 20 participants remaining at the end. Very few confounding effects were accounted for. Although there are some problems with this study as identified above, the results suggest that members of the intervention groups did not get worse over time and showed improvements on several psychological parameters. While improvements in the CBT group were somewhat greater, they were not uniformly superior to those for the support group.

Lemmens, Vervaeke, Enzlin, Bakelants, Vanderschueren, D'Hooghe et al., (2004) describe use of a "body-mind" group therapy program which is cited in several articles I've mentioned so far. The authors view this "body-mind" program as a way to approach the goal of psychosocial intervention for couples experiencing the distress of infertility. The three major characteristics of the body-mind program used by Lemmens et al. are: (a) the use of art therapy techniques, (b) the use of body-oriented techniques, and (c) the use of a marital group format. Although the effectiveness of this program has yet to be tested it is the first application of its type in the literature and its use warrants further investigation.

Hughes and da Silva (2011) conducted a pilot study to examine hopelessness, depression and anxiety before and after group art therapy sessions. The researchers had a sample size of only 21 and consider it a pilot study investigating the use of art therapy as an accessible, relatively inexpensive, and non-pharmacological intervention aimed at easing emotional distress in infertile women. Beck Hopelessness, Depression and Anxiety Inventories were administered before and after participation, as well as a qualitative exit questionnaire. Hopelessness, depression, and anxiety scores all fell following the intervention. Key themes emerging out of the exit questionnaire included: the concept of art therapy was not well understood by women prior to enrolment; key issues raised by the sessions varied greatly from person to person; the

results of art projects were sometimes unexpected and surprising; the act of painting and creating was intrinsically pleasurable; comfort was gained from seeing as well as hearing other women describe their experiences; the ability to laugh with each other about the stresses faced was common and appreciated; difficulty and pain were experienced in facing the reality and burden of infertility. Participants also identified that they felt the course was too short and that longer than 8 weeks would have been appreciated. The fact that patients were self-selected and that patients acted as their own controls in a before and after comparison, will influence study outcomes. Confounding effects such as race, socioeconomic status, education, previous live births, and marital status were not accounted for. The results of this study, while important, cannot be generalized to all infertility patients.

An unusual study out of Iran by Mosalanejad & Koolee (2013) entitled “Looking at Infertility Treatment through The Lens of The Meaning of Life: The Effect of Group Logotherapy on Psychological Distress in Infertile Women,” looks at a form of spiritual group psychotherapy which combines some of Viktor Frankl’s (1946/1955) psychotherapeutic theories around self-transcendence with Iranian culture and spirituality. Meaning-making is a focus of the logotherapy approach. Mosalanejad & Koolee found that the test group receiving group logotherapy reported decreased worry and stress perception. The authors state that the relationship between logotherapy and medicine has been the focus of considerable interest in Iran in recent years with other studies suggesting that many patients believe spirituality plays an important role in their lives and that patients would like physicians to consider these factors in their medical care. Mosalanejad & Koolee mention some “other studies” which reveal good results in the use of logotherapy with infertility patients, as well as with cancer patients, but they fail to specifically cite these studies in their article. While this study is interesting in terms of its

international perspective, it lacks academic rigor and merely points towards areas needing further research as opposed to furthering the research itself.

The findings of Galhardo, Cunha & Pinto-Gouveia (2013) represents an important and recent study done in Portugal that points to the efficacy of a Mindfulness-based Program for Infertility (MBPI). The MBPI is a group intervention for women who are experiencing infertility and is effective on several psychological and emotion standardized measures including: depressive symptoms, emotional regulation processes (decreased anxiety, self-judgment, and experiential avoidance), mindfulness skills, and the perception of infertility at an individual level. The program showed a significant reduction in depressive symptoms with maintenance of these therapeutic gains at the six-month follow-up point. Several areas are suggested for future research. Interestingly, while the partners of the women (all of whom were in current heterosexual relationships) were invited to three of the ten group sessions, no measures were reported for the male participants. Women in the control group did not demonstrate significant changes in psychological measures except for a decrease in self-judgment.

Boivin (2002) explains that as many as 37% of studies that indicate psychosocial interventions result in psychological and biological changes that enhance reproduction (pregnancy rates) did not use a control group to evaluate the interventions. He suggests that based on this information, even though many studies claim that psychosocial interventions are effective both psychologically and biologically, one cannot with confidence say that psychosocial interventions increase pregnancy rates. As a comparison, de Liz & Strauss (2005) conclude that “psychotherapy (group and individual/couple) reduces anxiety and depression in infertile patients and possibly enhances conception success” (p. 1330). De Liz & Strauss offer a meta-analysis somewhat more recent than Boivin’s, and even though many of the same studies

would be included in each of the respective analyses, de Liz and Strauss find possible evidence for a relationship between psychotherapy and conception success. De Liz & Strauss note that “extensive research still needs to be conducted before the precise relationship between psychotherapy for infertility and outcome is understood” (p. 1331). De Liz & Strauss cite several factors that may have resulted in the divergent conclusions including strong interacting bias in the analysis, the statistical methods applied to the data, and the number of treatment-only studies represented.

### **Summary of Literature Review**

There is relatively little research on how the use of group therapy specifically may lower symptoms of depression in clients or patients diagnosed with infertility. Unfortunately, the meta-analysis by Haemmerli, Znoj & Barth (2009) did not look at individual types of intervention but rather interventions as a whole and their efficacy on measures of mental health, making their results less relevant to this discussion regarding group therapy and its effectiveness pertaining to measures of depression. A substantial literature review by Boivin (2003) and a meta-analysis by de Liz & Strauss (2005) include a review of studies examining group therapy and infertility. Only four of these studies (Domar, Clapp, Slawsby, Kessel, Orav, & Freizinger, 2000; Galhardo, Cunha & Pinto-Gouveia, 2013; Galletly et al., 1996; Hughes & da Silva, 2011) specifically examine the use of group therapy for couples (or for women, in the case of Hughes & da Silva) experiencing infertility with regards to lowering symptoms of depression. The majority of studies to date have shown an overall effectiveness of psychotherapeutic interventions for individuals experiencing infertility, and the efficacy of group psychotherapy for individuals (and for couples) with infertility. In the above four studies all psychosocial interventions (CBT groups, emotion-focused groups, problem-focused groups, art therapy groups, and Mindfulness-

based practice groups) demonstrated improvements in psychological measures of wellbeing for participants (levels of distress, anxiety, and depressive symptoms all decreased in the respective studies). Notably, one study (Galhardo et al.) indicates a possible relationship between psychotherapeutic interventions and conception rates, a suggestion echoed by Schweiger, Wischmann, & Strowitzki (2012) who authored a German paper suggesting a bidirectional relationship between mental disorders and infertility, especially ovulatory infertility, hypothalamic amenorrhea, and polycystic ovary disease concluding that psychotherapy has a potentially important role to play in the treatment of infertility.

### **Relationship of This Study to the Existing Research**

Of the studies that have examined the efficacy of psychotherapeutic interventions for individuals experiencing infertility, all interventions including group therapy led to demonstrated improvements in psychological measures of wellbeing for participants. Studies examining the use of counsellor-led groups (including counsellor-led support groups, CBT groups, emotion-focused groups, problem-focused groups, art therapy groups, and Mindfulness-based practice groups) all noted demonstrated improvements in measures specific to depression (Domar, Clapp, Slawsby, Kessel, Orav, & Freizinger, 2000; Galhardo, Cunha & Pinto-Gouveia, 2013; Galletly et al., 1996; Hughes & da Silva, 2011). Depression is usually researched as a part of a constellation of psychological “measures” including anxiety, mood, and “negative affect” but is not often addressed or examined as an independent factor. This study focuses on participant perspectives of group therapy’s effectiveness with regards to the lessening of “depression” or “depressive symptoms” in the context of couples’ experience of infertility.

## **Chapter Three**

### **Methodology**

#### **Introduction**

For the purposes of this thesis, the broad research question is: For couples that have experienced infertility for at least one year, does participation in group therapy decrease suffering, especially with regards to what may have been labeled as “depressive symptoms” or “depression?”

Using Response-based ideas and an adaptation of a Response-based Contextual Analysis research framework (Bonnah, Coates, Richardson & Wade, 2014) I aimed to conduct audio recorded in-person or telephone interviews with four couples who have within the last three years participated in group therapy related to a diagnosis of infertility. Through answers to the interview questions (Appendix A) I sought to answer the following: (1) In the context of the couple’s shared history, what social responses have they received with regards to their infertility (medical, counselling, family, workplace, etc.)? (2) How do clients interpret or make sense of these social responses to their infertility? (3) What are the clients’ responses to these social responses? (4) What aspects of the group therapy experience are identified by clients as being most and least helpful? (5) Was there a reduction in suffering, especially depressive symptoms, as a result of participating in group therapy?

#### **Participant Selection**

The ideal group size for this project was originally identified as being four couples (eight interviewees) based upon reasonable resources and time to execute the study. The criterion for participants included: participants will have experienced infertility with their current partner for at least one year prior to participation in group therapy, and participants will not have had a

diagnosis of clinical depression prior to knowledge of the infertility. For the purposes of this study I wished to make a formal diagnosis of clinical depression an exclusion criteria since if a person had a preexisting diagnosis of depression then they may also have received treatment for the depression. If this were the case then it would be difficult to obtain an accurate sense of whether or not group therapy was effective in reducing suffering related to depression (since we can't rule out the efficacy of therapy or medications). In addition, a previous diagnosis of clinical depression would likely reflect a condition which predated the knowledge of the infertility and is therefore unlikely to be addressed by group therapy aimed at lessening suffering for couples experiencing infertility. Subjects will be English-speaking even if English is not their first language. Ideally both partners will have participated in group therapy but if it not enough responding couples attended group therapy together, and instead just one partner attended, these couples will be considered as potential participants so long as both partners were interested in participating in the interview process. The rationale for this was that speaking with partners who chose not to attend group therapy might provide useful and relevant information regarding perceived needs of both partners.

To attract participants, a notice (Appendix B) with details of the research project was displayed in counselling offices (3 offices), a naturopathic physician's office (1 office), a psychologist's office (1 office), and a fertility clinic (1 office). A fourth counsellor chose to email clients she knew to have attended group therapy during their experience of infertility. The notice was also posted online using three venues: the first was a "Facebook" page dedicated solely to alerting potential participants to the thesis project; the second was an online notice posted by the Infertility Awareness Association of Canada (IAAC); the third was an online

notice of the research project on IVF.ca, a Canadian website devoted to infertility forums and blogs. Some recruitment of participants may also have occurred as a result of word-of-mouth.

The sampling cannot be considered truly random in that respondents will have seen the notice in offices only as a result of attending an appointment (excluding couples not currently seeking medical interventions or counselling treatment for their infertility), or online (excluding couples who do not participate in online forums or websites related to infertility). The creation of the Facebook page gets around this in some ways by being accessible to anyone who has both internet and a Facebook account but still excludes couples who are experiencing infertility but do not use online resources. Finally, participants may have been somewhat more likely to come from those communities where notices were posted in offices although the notices also reached wider audiences throughout Canada (and possibly elsewhere) as a result of social media.

Originally designed as a qualitative study that would provide data from interviews with four couples, the interest in participation of only one couple necessitated a change in approach to that of a case study. This shift did not result in a change to the topic, the participant criteria, the interview questions, or to the researcher's approach to the subject matter.

### **Ethical Considerations**

Informed consent was explained and obtained from participants prior to conducting research. Clients were asked to confirm that they had read and understood the consent form, and were giving their consent to participation in the audio-recorded interview process.

Confidentiality was reviewed. An explanation of how participants' privacy would be protected was given. Participants were asked if they had questions. Participants were made aware that if at anytime they wanted to withdraw their participation or inclusion of their information from the research project they were free to do so without penalty.

Participant names are not included in the thesis document. All identifiers have been removed including information about what, if any, fertility clinic the participant went to for medical treatment, the name of the physician(s) or nurse(s) who provided treatment, the name of any counsellor(s) they saw for individual or group therapy, where they live, details about their obstetrical history that might uniquely identify them to those familiar with that information, and anything else that might potentially identify participants.

The researcher discussed with participants the possibility that participation in the interview process might cause participants to recall difficult times they went through (or are presently going through) with regards to the infertility. Participants were made aware of this risk through the process of informed consent, and on the day of the interview they were offered access to information about counsellors in their area with a special interest in supporting clients who have experienced infertility.

### **Interview Process**

Three women responded to requests for participants. Of these only one woman and her partner indicated an interest in participating in the research study. The participating couple did not live locally and so the interview was conducted by telephone and audio recorded for the purpose of transcription. The interview focused on the Interview Questions (Appendix A) and these were asked exactly as written. As the interviewer I took the position that any additional information participants wanted to introduce into the discussion would be welcomed, time permitting. I spoke with both partners in an effort to obtain answers that would reflect perspectives of male and female participants whether or not both partners attended group therapy.

## Data Collection

The interview was conducted with both partners together via telephone. The conversation was audio-recorded and later transcribed. The length of the interview was 90 minutes. Using a Response-based research framework, themes from the transcribed interviews were identified and coded. The interview was guided by the prepared interview questions (Appendix A); these were incorporated in a flexible manner with the intention of eliciting those views and opinions that were of significance to the participants. Results elucidate both common and divergent themes that are significant to both participants and, retrospectively, to the researcher.

In coding the interview transcripts, small units of data were identified and mapped within a system of concepts identified by the participants (see Appendix C). From this emerged themes elucidating how participants view the usefulness of group therapy in the context of their experience of infertility. Strauss and Corbin (1990) developed a system of open coding in which the task of selecting, focusing, and simplifying the data is described. I adapted this process for use in the context of a Response-based research framework. After identifying emergent categories and concepts contained within the interview data, the arising themes were then situated within the research framework in order to explore how the participants' concerns may be viewed in terms of the following: the context of the couple's shared history and their responses to the diagnosis of the infertility, the social responses participants received with regards to their infertility, how participants make sense of these social responses, and participant responses to the social responses. Finally, the discussion will highlight participants' views regarding what aspects of group therapy as a social response were most and least helpful, whether their suffering (especially what may have been named "depression" or "depressive symptoms") was reduced by participation in group therapy.

**Additional Considerations**

Some consideration was been given to whether or not to provide the interview questions to participants prior to the interview itself. I elected to not provide the interview questions in advance in order to facilitate a conversation that was as unrehearsed as possible. I hoped to elicit candid retrospective observations and in-the-moment responses from the participants.

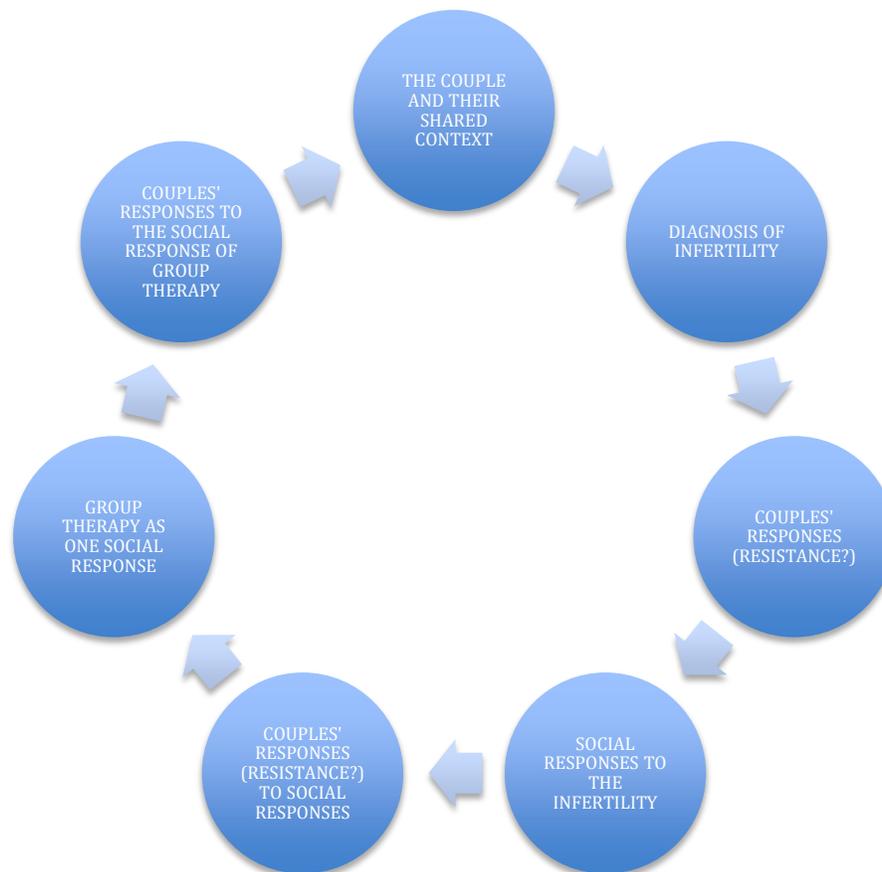
## **Chapter Four**

### **Results**

#### **Systems Used for Organizing Data**

For the purposes of organizing the data I used an adaptation of a Response-based Contextual Analysis research framework (See Figure 1), which identifies seven main concepts at which the interview questions were directed. The main concepts are as follows: (1) The Couple and Their Shared Context; (2) The Diagnosis of Infertility; (3) The Couples' Responses (Resistance?) to the Diagnosis of Infertility; (4) Social Responses to the Infertility; (5) The Couples' Responses (Resistance?) to Social Responses; (6) Group Therapy as a Social Response to Infertility; (7) The Couples' Responses to the Social Response of Group Therapy.

**Figure 1**  
**Conceptualization of Social Responses to Infertility**  
**Using a Response-based Practice Lens**



The most clear or provocative examples of each concept, as articulated by the couple, were excerpted from the transcribed interview and are included in Appendix C. Once examples of the participants' responses to concept-linked questions were lifted from the interview transcript, emergent themes were identified (see Appendix C).

### Findings

**The couple's context.** The two interview participants live in Canada and have been together as a couple for four and a half years. They have been married for two of those years. For

the purposes of this document they are identified as “IVF Warrior” (female partner), and “The Governor” (male partner). These “code names” were requested during a moment of humour in the last few minutes of the interview. Since the participants’ privacy is of prime concern I decided to go ahead and use abbreviations of these code names (“IW” and “TG”) to identify each partner.

Awareness of the couple’s context demographically, socially, and relationally is essential to understanding, from a Response-based perspective, how the two individuals respond to the infertility, to the responses of others, and to group therapy as a social response to the infertility. IW was born in England to a father who was born in India, and a mother born in Pakistan. TG was born in Canada to a father born in Holland, and a mother born in Germany. IW identifies as English while TG identifies as Canadian. IW has post-secondary education at the Masters level; TG has completed secondary education. Their self-rated socioeconomic status is middle-class. The couple began trying for a pregnancy in November 2012. IW and TG tried to achieve a pregnancy on their own for six months before seeing their family doctor. At that time IW and TG were ages 35 and 39 respectively. IW was aware that trying on their own for six months without success when a female is aged 35 or older was reason to seek medical advice. During that time IW took her basal body temperature to determine the timing of ovulation each month. Also mentioned in the context of the couple’s medical history was a therapeutic abortion at the age of 23 for IW, and the use of recreational drugs approximately fifteen years ago for TG.

During this period of “trying” IW and TG discussed their somewhat divergent views, which in turn influenced how they each processed the information that they may not be able to conceive on their own. TG said his approach was to “*try to be as positive as you can ... that’s what you can control.*” IW noted that she is “*the kind of person where you prepare for the worst*

*and hope for the best.*” In combination with other factors these personality factors, or perspective-taking factors, seem to influence the couple’s subsequent responses to their context, circumstances, events, and social responses.

In addition to how personality or perspective-taking factors influence each partner, there is the “outside the partnership” influence of family to consider. TG has what he describes as a supportive family comprised of two older sisters and mother. One of his sisters did IVF (in vitro fertilization) approximately 15 years ago. IW on the other hand has a father and stepmother living in a different province, both of whom she finds to be generally unsupportive and judgmental. She has two half-brothers through that marriage whom she characterizes as *“lovely.”* The older of IW’s two half-brothers is in medical school and she has been able to have conversations with him about the medical side of the infertility. IW’s mother died when she was just ten years old.

**Diagnosis of infertility and the couple’s responses to the infertility.** When the couple discovered the infertility they asked their family doctor for a referral. Apparently that doctor was *“skeptical”* and did not provide a referral right away. IW followed up and asked for the referral a second time. It took a year from when they began trying for a pregnancy until the couple was seen by a fertility specialist. Initially IW and TG felt they didn’t *“ever want to have IVF”* although they were willing to *“just get all the other tests done.”* They made several lifestyle changes in an effort to improve their overall health including: the use of nutritional supplements – *“We both take 20 to 25 pills a day;”* acupuncture (IW); stopping the use of alcohol (TG & IW); avoidance of hot tubs (TG); adopting a gluten-free diet (TG & IW); massage therapy (IW, e.g. Mayan abdominal massage); and naturopathic interventions (TG & IW). The couple also wondered and looked into alternatives to IVF such as adoption. On IW’s 38<sup>th</sup> birthday she came

to a decision that she wanted to go ahead with IVF: *“I think the day that I said I was going to do IVF was my 38<sup>th</sup> birthday ... and we still hadn’t had any success and I just turned 38 ... that was the decision point for me.”*

For IW and TG, one response to the infertility was to share with their social and family supports news of their decision to pursue IVF treatments. For TG, this included friends (who were supportive), some couples who were friends (who were especially supportive if they were also going through or had previously gone through IVF), and his family whom he also found to be supportive. For IW, this included two close friends whom she found to be relatively unsupportive, many of her colleagues at work (generally supportive), and her stepmother (wholly unsupportive). The responses of others to the couple’s infertility will be addressed further in the Discussion.

Within the couple system, IW noted, *“... there’s no one daily that I can talk to about it [the infertility] except [TG].”* TG observed,

*“I probably don’t talk about it as much or respond probably in as much depth about it as [IW] might like. It’s always on her mind and I understand that ... but I try to deflect or just change sometimes because I don’t want to continually think about it all the time. I need to feel that we’re getting on with our lives. So I think my support, like vocally, isn’t as deep as I think [IW] would like it to be sometimes.”*

TG’s response in the context of the partnership differed to that of IW not only in his perceived ability to talk or “respond in depth” to IW but also in terms of his willingness to spend time thinking about it. For TG there was a need to include a focus on other aspects of their life as a couple. Conversely, IW noted,

*“I think that’s the difference. For me, there is no getting on with my life. I’m stuck. Move on with my life? I don’t know when I might need to take a year off of work and completely give up my body to this whole new being. I don’t even know when that will happen. It would be great if I could know when ... but in the meantime I am not able to get on with life. I’m not able to fully invest in my job because ... I try to invest in it. My job is the only other thing. Uh, I’m in limbo.”*

At this point in the conversation IW was emotional as the impact of her statements was felt. Despite some differences in personality factors and perspective-taking, the couple presented very much as a partnership, taking a team approach to the infertility with TG attending every one of IW’s appointments at the fertility clinic.

When the topic of whether either TG or IW had experienced what might have been named “depression” or “depressive symptoms” was raised, TG had this to say: *“Oh, without question there was depressive symptoms. That goes hand in hand with going through the cycles of IVF. You can’t have doubts about your biological self without being somewhat depressed to some degree, you know, depressed. But it’s being aware of that and managing that that’s important I think.”* To this, IW added:

*“I would say at that time I wasn’t, I’ve been depressed before so I know what that’s like. And I was challenged and, probably, maybe mildly depressed, I don’t know ... I felt like creating a new network, new perspectives felt good. ... But when we had our second cycle and we put all that time in emotionally, financially ... and we got nothing, after that I think I was very much at risk of plunging into a bit of a darker depression which I’ve had once in my life before ...”*

When asked what she did in response to this sense of going to a darker place IW replied,

*“... so I played a video game, which I got addicted to [laughter] ... I tried to take as many sick days as I could to stay home and sit on the couch and play Sirens [video game]. And I ate a lot of chocolate and drank Coca-Cola [laughter], which I don't normally do.”*

More about this response to the infertility and what might be called “depression” or “depressive symptoms” will be discussed later as it pertains to why IW did not at this point in time return to the group therapy sessions. As a final note in this section pertaining to the couple's responses to the diagnosis of infertility, both IW and TG have become active in a political sense, speaking out about the lack of funding in many of Canada's provinces for those people who cannot conceive on their own without the assistance of artificial reproductive technologies.

**Social responses to the infertility.** The couple experienced both sameness and variability in the nature of responses they received socially in light of their infertility. Medical responses ranged widely. The couple's family doctor suggested all they needed was to do was “*Just relax.*” A walk-in clinic physician told them “*You don't need to make it so scientific ... you don't want your baby being born ... in a Petri dish.*” One fertility specialist told TG, “*We are the professionals,*” and later, “*Don't let her go on the computer.*” A second specialist who was “*really good*” in that he “*didn't push it*” and was informative early on in the process of infertility investigations providing the couple with the information they were seeking. IW and TG feel overall that the highest quality of emotional support received from professionals came from their naturopath, a massage therapist, and an acupuncturist.

In TG's experience, the response of friends and family to whom he disclosed the infertility, was mostly supportive. IW, on the other hand, had family members and her two closest friends respond in unsupportive ways; she says this about her friends:

*“I told, uh, my two closest friends, and one of them is gay, and maybe a guy and it’s not, you know, he hasn’t really known how to respond or support. The other one is a girl and just had gotten pregnant and ... she wasn’t very supportive. She said, oh, you know, just relax and don’t think about it.”*

IW’s work colleagues were perceived as more supportive and one person in particular asked IW questions about her experience that helped IW provide the context of her situation, making subsequent conversations more specific and meaningful. Unlike TG, IW does not have supportive parents. She did tell her stepmother that they were trying IVF and afterwards wished she hadn’t. For IW it reignited a pattern in her life that was longstanding: *“Whenever anything difficult has happened in my life they [her father and stepmother] use it to blame me for not doing what they told me to [laughs] and acting as a good traditional girl. They’re from Pakistan.”* The older of IW’s two stepbrothers is in medical school. IW appreciates conversations she has had with him, saying he *“is supportive in more of a right brain ... kind of a way.”*

**The couple’s responses to the social responses.** What has been described so far sets the stage, so to speak, for a discussion of how TG and IW responded to the responses of those around them (medical systems, friends, family, colleagues, etc.). Understanding how the couple operates both individually and as a unit helps us to contextualize not only their responses to the infertility itself, but to the responses received on a social level.

As discussed, medical personnel offered divergent responses to the couple and their infertility. In the context of less supportive comments from some doctors and nurses the couple were left feeling *“talked down to.”* IW and GF are articulate and well-educated individuals who say they observed several errors made by staff at the fertility clinic they attended. About this IW

reflects, *“If I wasn’t on top of it ... using my critical thinking skills ... they would have missed a lot of things.”* The couple began taking an active role in managing their own reproductive health and asking questions about their IVF protocol. The couple continues to experience frustration related to the cost of IVF (it has cost them somewhere between \$35,000 - \$45,000 CAD so far for three IVF cycles) as well as the approach of clinic staff to payments and proper invoicing. As TG relates,

*“And, you know, it’s frustrating because you’re spending that much money. They’re just ... they called us the other day because we hadn’t made a payment for this round, and we never got an invoice, never got an e-mail, or were asked to make a payment. And they were basically giving [IW] shit on the phone because she hadn’t made the payment.”*

The couple’s response to this was to assure the clinic that they would pay but that they would do so the next time they were in for an appointment (this happened to be the next day). IW and TG also express some shock at the Western-only approach to fertility medicine they experience where they live. IW says, *“I guess I’m shocked at how ‘anti-’ any holistic approach the doctors have been. I’m very shocked because I didn’t expect that.”*

Frustration with approaches to the couple and to the infertility from the medical system were matched by frustration and disappointment in other social responses such as familial responses. TG noted that with his increased frustration at not being able to achieve pregnancy he began to adjust amount of information he shared with family. One of TG’s sisters underwent IVF more than fifteen years ago and has been very supportive. For TG,

*“... hearing that from somebody who’s been through that and seeing how healthy my nephews are now, it’s a positive outlook for me to know that and that we’re not going to give up and that there are options out there for us. But my family responded fairly well*

*for what we shared with them ...” whereas IW says, “she [TG’s sister] was a lot younger than I am when they started, so I always find that example particularly frustrating.”*

Regarding the responses of others on the whole, IW notes the couple feels “... *just mainly disappointed. It made me reassess everything. And then some people have been very supportive actually, so ... definitely very misunderstood, very marginalized, very ... alone.*” This is a significant statement illustrating how negative social responses leave couples who are experiencing infertility feeling isolated. IW mentioned that she sees the negative reactions “*fall into different buckets ... there’s the one like, ‘Relax’ ... there’s the other like ... ‘Have you tried the naturopath?’ ... then there’s the ‘Oh, well you should just adopt.’*” TG added to this explaining,

*“We even had someone say, basically, talking about their sibling, ‘That’s too old, why are you even bother trying? That’s silly to even try at that age’ ... I think par for the course and though, the two worst ones are ‘Just relax’ and ‘Well, it’ll happen if it’s going to happen, you know.’ And the other issue is, I think to answer your question bluntly is it’s a taboo subject for people. They don’t know how to respond. So they choose the path of least resistance, which is not saying much.”*

This concept of reactions falling into different buckets is used diagrammatically in Figure 2, below.

**Figure 2****“Reaction Buckets”**

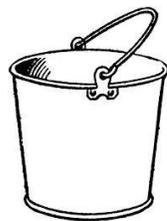
*“Just relax.”*



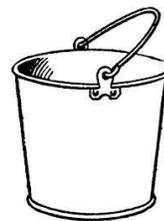
*“Have you tried a naturopath?”*



*“You should just adopt.”*



*“You're too old, why bother?”*



*“Well, if it's meant to be ...”*

The “Reaction Buckets” concept is a clear articulation by both IW and TG of the ways in which people responded to them as a couple experiencing infertility. These “reactions” or social responses are difficult to receive and contain implicit judgments; they do not represent the more supportive responses received by the couple and described in other parts of the interview. The “Reaction Buckets” are however a clear and concise demonstration of how the couple distinguishes and classifies the varied negative responses.

The couple noted that people who have *“been close to it”* or who have gone through the experience of infertility themselves often offer the most helpful responses. One person who did not have any prior knowledge of IVF but who IW did feel was supportive, was a coworker who *“just asks questions”* without offering advice. IW perceived this approach as helpful because in answering her coworker’s supportive questions, IW was able to share information that provided the context necessary for future meaningful conversations. The result for IW was that she had a sense that this person *“knows about it now because she’s asked me.”* The questions that followed were direct and specific, in contrast to more common questions such as, *“Oh, how’s it all going?”*

**The couple’s response to group therapy (a social response).** For IW, the decision to go to group therapy was made when she felt, *“I just needed the help.”* It also came at a time with TG was away for work related reasons. The night IW attended group therapy there were only female participants present. She is unsure if it was a “women only” group. The group was held once a month and was counsellor-led. For IW one of the most important outcomes from attending group therapy was that

*“... it introduced me to someone who I now have who I can text, you know, in my cryptic IVF lingo, who knows what I mean, and that’s really, really helpful. The actual session itself, it was amazing to see, you know, the strong people in the room, especially one of them, since I’ve learned how strong and bubbly they are, amazing to see them completely breakdown and be crying in this room. That was ... weirdly great because it just made me feel normal.”*

Interestingly, IW attended the counsellor-led group therapy only once. She seems to wonder aloud about going again when she talks about her one experience in this way:

*“Putting things into context, perspective, but also realizing, hey, it’s not weird that I feel so overwhelmed and it’s not weird that I feel so dark and negative sometimes. It’s all normal. It was just one session. I should probably go again. But it helps a lot to not feel like I’m crazy or I’m this horrible person for letting myself think about these things and dwell on them. It’s like any normal person would.”*

When asked why she did not attend group therapy again IW cited a number of reasons: *“timing”* [inconvenience]; *“I’ve got so much else trying to go on”* [demands on time and energy from fertility treatments, work, etc.], and that it was *“a little inconvenient to get to”* [location]. To sum up her reasons for not going again IW said, *“If it were easier I would probably go more often.”*

In part because of the obstacles associated with the inconvenience of attending formal group therapy, IW formed an informal support group with two other women she met at the group therapy session she attended. This served several areas of need, the most important of which, according to IW, was *“being able to text someone anytime.”* The immediacy of connecting by text and not having to attend a whole session to meet the need for support meant that IW found obtaining support in an informal group more manageable and more satisfying. The women met every few weeks, at a mutually convenient time, and usually over food.

When asked if he noticed differences in IW after she attended group therapy TG says, *“she was a little happier or a little less impacted by the whole thing after she had other like minded individuals to talk to”* and *“... people who are going through it get it and we can talk about it and most people don’t know what to say or do. And so it’s [group therapy] critical. It is without question critical.”*

TG noted that the smaller support group was more intimate and he sensed the women “*felt like there was somebody else helping with their exact situation.*” This was in contrast to the more formal group therapy where the process seemed “*more like ‘just getting your stuff out in the open.’*” The intimacy available in a small group of women who chose intentionally to meet with one another, and to text one another between times, offered to IW something that the larger more formal group therapy session did not.

A concern that arose for IW after a period of time was what to do if a member of their small group became pregnant. This in fact happened in the context of the small support group.

IW puts it this way:

*“From my perspective, I was worried about how when one of us got pregnant that would impact the rest of us in that smaller group, the three of us ... and the one girl who I still meet is definitely not great around pregnant women. She has a very gut reaction to that and finds it very hard and so I don’t think she’s stayed in touch with the other one. I’ve been in touch now and then but for me the experience of seeing someone who’s been, you know, experiencing this and suffering through this and come out with a light at the end of the tunnel was really good ‘cause it was a reminder not to get too dark.”*

While acknowledging the hope that came from knowing someone in a similar situation who because pregnant, IW was also aware that the third group member experienced this differently, and found that same truth “*very hard.*”

While TG did not attend group therapy he thought it helped IW “*to some degree*” with regards to “depression” or “symptoms of depression.” IW clarified that rather than use the word “depressed” she might describe herself as “*challenged*” in the earlier stages of the infertility journey. At the time she attended group therapy she “*felt like creating a new network, new*

*perspectives felt good.*” It is important to note that when the couple was further along in the process of infertility treatments IW felt she was “*very much at risk of plunging into a bit of a darker depression.*” Despite this, IW did not return to the formal group therapy but rather relied upon the informal and smaller support group she had co-created. She reflects, “*That would have been the time when maybe I should’ve gone but that would’ve been the hardest time to go because I just get to work and get home again and I couldn’t do anything else.*”

When asked to identify any negative aspects of the counsellor-led group therapy IW attended, she noted that the parameters that were in place to try to avoid overly negative sharing actually made it more difficult for her to want to share in that setting. IW also indicated that while the counsellors identified themselves as “*becoming experts in this field,*” she herself feels that participants in these groups are also experts: “*I felt like a self-led group, where it is experts in the field because we’re all going through it, would have felt more authentic to me.*”

Normalizing the experience of infertility was identified as the most positive aspect to attending group therapy: “*Seeing that other people are going through the similar things and also that they are breaking down in the same ways that I am but becoming more resilient as well.*”

The only negative aspect of the informal peer-led support group IW identifies was her concern over how the group would handle things when a member became pregnant. IW feels that “*some parameters*” should be agreed upon so that there is a plan in place for when this eventuality occurs. The “*on demand support*” from someone “*who gets exactly where I’m at*” were identified as being the most helpful the most aspects of the informal support group.

## Chapter Five

### Discussion

#### Overview

The couple's answers to the interview questions yielded much in the way of insight, and a high level of detail regarding the couple's response to the infertility and to the social responses they received, including that of group therapy. A basic understanding of the couple's context including their partnership, their respective personalities, and the relative health of their various support systems helps to "set the stage" or contextualize their responses to their diagnosis and experience of infertility.

Overall, TG had more positive social responses when he revealed the couple's infertility to family and friends. IW on the other hand received both positive and negative responses from others. TG has an outlook on life that could perhaps be characterized as more optimistic than that of IW with regards to how he endeavors to put the couple's infertility into a perspective that is, for him, manageable. For IW, there is a powerful sense of feeling "*stuck*" and that there "*is no getting on with my life.*" Although there may be a divergence in terms of personality factors and differences in the nature of social responses received by IW and TG, the couple demonstrates an approach to the infertility that is unified and "team-driven."

The medical responses the couple received to the infertility were varied and ranged from professionals who were "*really good*" to professionals who were markedly patronizing and dismissive of the couple and their concerns. Of note, some medical professionals told the couple such things as "*just relax,*" "*don't think about it,*" "*you don't need to make it so scientific,*" "*you don't want your baby being born in a Petri dish,*" "*we are the professionals,*" and "*don't let her go on the computer.*" These examples represent the responses of three out of four

physicians the couple saw. IW and TG felt such comments minimized their “*legitimate*” concerns around their difficulty in achieving pregnancy.

In response to such messages the couple used “*critical thinking skills*” to take a more active role in their healthcare related to the infertility. From a Response-based perspective, this represents a powerful act of resistance, a way to maintain dignity in the face of adversity. The couple acknowledges concern that as a result of their proactive stance their chart may have been “*flagged,*” and they may have been identified as “*difficult patients.*” IW and TG were careful to temper reflections about their more negative experiences by noting that many of their experiences with medical personnel were positive and very supportive. They were especially appreciative of the care offered by a specialist and several nurses at their fertility clinic.

IW and TG express an overall sense of disappointment in the response of others to their infertility. IW mentions she felt “*very misunderstood, very marginalized, very ... alone.*” The couple expresses a profound sense of isolation. IW described the responses of others, including that of family and friends, as falling into “*Reaction Buckets*” (see Figure 2). Again, the couple is careful to counter their feelings of disappointment in various social responses by noting that there were those around them who were supportive. Supportive responses most often came from those who either were “*close to it*” (for example, they had been through infertility themselves), or from people who were open to receiving information and asking questions (which, in the couple’s view, contributed to a more contextualized and meaningful understanding of their situation). Characteristic of less positive interactions was a lack of contextual understanding, advice giving, unhelpful responses (“*Reaction Buckets*”), and what TG sees as a cultural tendency to view the subject of infertility as taboo.

As the couple's own frustration with the infertility and unsuccessful treatments began to increase, TG began adjusting the amount of information shared with his family members. I interpret this as a protective response, a form of resistance to negative outside influences when the couple system was troubled by factors not within its control. By withholding some kinds of information the couple would then be required to invest less energy attempting to meet the needs of others (for example, managing the responses of others to the information) during a time when their capacity to cope was already challenged.

At the same time that an interest in reaching out to known sources of support (such as family and friends) may have been declining somewhat, consideration of new outside sources of support was of interest to IW. She began widening the circle of possible social supports by attending a group therapy session when she felt most alone and in need of help. As it turns out, counsellor-led group therapy as a social response to infertility did not entirely meet IW's particular needs for support. While the counsellor-led group therapy addressed some needs related to normalizing, contextualizing, and perspective taking, the smaller peer-led support group allowed IW to facilitate a model of support that was immediate, intimate, and convenient.

In the experience of the couple interviewed for this case study, the presence of what may be named by some as "depression" or "depressive symptoms" increased with the longevity of their infertility, and the number of unsuccessful fertility treatments. Having experienced depression at another time(s) in her life, IW distinguishes between what felt like a "*challenge*" in the early stages of seeking treatment for the infertility and what felt more like "*a bit of a darker depression*" following two unsuccessful IVF cycles. This is in line with the findings of Domar, Broome, Zuttermeister, Seibel & Friedman (1992; as cited in Domar, Clapp, et al.) who

note, “When depressive symptoms do occur in infertile women, they appear to peak between the second to third year of infertility.”

### **Implications for Further Research**

Given that only four studies have examined group therapy aimed at couples with infertility and in their analysis specifically addressed measures of “depression,” there is a need for further and more vigorous research that uses control groups and larger sample sizes. Future research should examine the efficacy of peer-led support groups for couples experiencing infertility, with regards to whether participation effectively reduces “depressive symptoms” associated with infertility. This would ideally involve a phenomenological aspect to the inquiry to discover from a participant perspective what was most helpful and why. If the aspects of professional clinical support addressing safety and parameter-setting measures present in counsellor-led group therapy were translatable to support groups it may be that peer-led support groups would be an effective alternative for those individuals not wishing or unable to participate in a counsellor-led group therapy.

The couple interviewed for this case study did not attend group therapy together; rather IW attended group therapy on her own. In speaking with several counsellors who either offer, or have offered, group counselling in British Columbia, they report that group therapy is generally attended only by females even if it is advertised as being available to both partners. There is only one currently running counsellor-led group in the province I am aware of that advertises itself as being inclusive of couples. That group does attract some couples but the numbers are low, with more women attending alone than with their partners. It would be valuable to examine gender perspectives with regards to group therapy and its degree of attractiveness to both male and female partners, and what if anything would make it more attractive to male participants. Most

studies look at the female experience only. Since the male experience of group therapy is not often talked about in the literature, questions to be addressed might include the following: (a) Do male partners perceive group therapy, or a support group, to be useful in terms of reducing the distress associated with infertility? (b) If group therapy were inclusive of male partners, would men want to participate? (c) What would make the idea of group therapy more attractive to potential male participants?

Domar & Clapp (2000) recommend, and I echo, that in future research it will be important to determine if there is a best kind of psychological intervention with regards to treating distress in group therapy settings for those who experience infertility. In their meta-analysis Haemmerli, Znoj & Barth (2009) did not select for the type of psychosocial intervention used but found that when classified as a whole, psychosocial interventions did not in fact improve mental health measures for those experiencing infertility. Their meta-analysis was confined to those studies that used a control group, and so the findings of only a small number of studies are represented by this review of the literature. Responsibility lies with future researchers to utilize controls in their studies in order to make the findings more rigorous, relevant, and generalizable.

The ambiguity of results between studies to date (see Boivin, 2003; de Liz & Strauss, 2005; and Haemmerli, Znoj, & Barth, 2009), signals yet another direction for future research. Studies are needed to examine the type of intervention used both in terms of composition (individual/couple/group counselling), and in terms of the approach (for example CBT, Mindfulness-based approaches, emotion-focused approaches, psychoeducational approaches, etc.). It may be that membership in a group is at least as important as the intervention used. The

experience of the couple in this case study suggests that there are factors outside of whether the group is counsellor-led that contribute to meaningful support.

While some research has been done regarding the efficacy of the various approaches to therapeutic interventions (see literature review by Boivin, 2003; and meta-analysis by de Liz & Strauss, 2005), it is not clear that there is a substantial benefit of one therapy over another. It would be useful to see future studies use a larger sample size to gather data on measures of distress levels between the various therapeutic interventions, in addition to detailed information from a participant perspective on what was most helpful and least helpful about counsellor-led group therapy and peer-led support groups.

Of the several studies cited in this paper all of the following therapeutic modalities were employed in counsellor-led group therapy: counsellor-led support groups, Cognitive Behavioural Therapy, Body-mind (Mind-body) Therapy, emotion-focused groups, problem-focused groups, art therapy groups, logotherapy, and a Mindfulness-based Program for Infertility. Each study using modalities of intervention noted above in the context of group therapy demonstrated improvements in measures of distress, anxiety, and depressive symptoms (Domar, Clapp, Slawsby, Kessel, Orav, & Freizinger, 2000; Domar, Seibel & Benson, 1990; Domar, Zuttermeister, Seibel, & Benson, 1992; Galhardo, Cunha & Pinto-Gouveia, 2013; Galletly et al., 1996; Hughes & da Silva, 2011; and McQueeney, Stanton, & Sigmon, 1997). The particular therapeutic approach a counsellor applies to the facilitation of group therapy may matter less than whether or not the couple receives the social support that such programs offer. Where control groups were used in the above studies, and where no psychotherapeutic intervention was offered to the control group, control participants did not show improvements in measures of depression (Domar, Clapp, Slawsby, Kessel, Orav, & Freizinger, 2000; Galhardo, Cunha &

Pinto-Gouveia, 2013; McQueeney, Stanton, & Sigmon, 1997). As noted by Domar, Rooney, Wiegand, Orav, Alper, Berger, et al. (2011), “It is quite possible that some interventions are more effective than others, and it is also possible that the efficacy of different interventions may be affected by the diagnosis of the patient, the form of treatment the patient is receiving, and the baseline psychologic status of the patient” (p. 2271). In line with this thinking, it is worth noting that little research has been done to date with regards to some newer forms of intervention including that of online support groups for clients with infertility. Haemmerli, Znoj & Berger (2010) suggest, “The Internet, which offers the possibility of anonymous communication, is often considered less stigmatizing than face-to-face psychological support” (p. 136). While this may be true the results of their study show no statistically significant effect between the intervention group and control group for any mental health outcomes. There were several limitations of the study and more research is warranted since online therapy may provide a valued service that is convenient, accessible to those who have limited financial resources or time, is less stigmatizing because of its anonymity, and appeals to clients with infertility who may not meet some of the requirements for a diagnosis of “depression” (Haemmerli et al., 2010).

### **Limits of the Study**

This study was originally conceived and designed as an interview process that was to ideally include eight participants (four couples). Because only one couple responded with interest and agreed to the interview for research purposes, the study’s generalizability to the larger population is limited. The findings of this case study may also be uniquely representative of a Canadian perspective. Group therapy as an intervention for couples experiencing infertility is well established in many parts of the United States. There may have been a greater number of respondents had I included American counsellors, psychologists, fertility clinics, and online

forums as avenues by which to create awareness about this research project. As it is, the research notice was posted in the offices of several counsellors, one psychologist, one naturopathic physician, and a fertility clinic, as well as online via IVF.ca and IACC (Infertility Awareness Association of Canada). Despite over 475 views (as of April 2, 2015) of the research project on IVF.ca alone, the couple that participated in this study became aware of the research project through a notice posted for one day via IAAC. I am left wondering about the factors that determined how those who viewed the notice (see Appendix B) either in person or online made a decision about whether or not to participate.

In presenting the participant perspectives as a case study rather than a qualitative inquiry into the experience of several couples, the findings are inherently limited by sample size ( $N = 2$ ) and the results cannot be applied in a representative way to other couples or populations. Continuing with the case study despite a lack of other participants has the advantage of allowing a close examination of the participants' responses to the subject matter suggested by the interview questions, and to their more general experience of infertility. It may be that the descriptive quality of the couple's answers to the interview questions, and their generosity with the level of detail particular to them, lends what Webb & Daniluk (1999) would term "empathetic generalizability." In other words, I suspect that while the couple's experience is unique to them and their context, it also has a universal quality that would resonate with other couples experiencing infertility.

### **Recommendations**

Since it has been demonstrated that depressive symptoms are prevalent for individuals who experience infertility and that this tends to occur between the second and third year of infertility (Domar, Broome, Zuttermeister, Seibel & Friedman, 1992), it is important to make

information about sources of support available early on in the process of infertility treatments. In addition, the meta-analyses by Boivin (2003), and Haemmerli, Znoj & Barth (2009), indicate the most effect psychotherapeutic interventions are brief therapy approaches (six to eight weeks) with a skills-based component. As already mentioned, employing group therapy interventions early on in a couple's infertility journey may be most effective and prevent higher drop out rates from IVF programs. Meeting as a smaller group if the group size becomes too large is also recommended. Yalom [2005] suggests maximum group size of 8-10 individuals. Keeping to a smaller group size could potentially address the desire for intimacy felt by some participants to be lacking in counsellor-led group therapy.

From a counselling perspective, psychosocial support for couples experiencing infertility may take several forms: counsellor-led group therapy, couple counselling, individual counselling, or psychoeducation. Studies examining the efficacy of counsellor-led group therapy as a way of addressing what is often named "depression" or "depressive symptoms" were examined in some detail in the literature review. While it appears clear from many of the studies that psychosocial interventions do reduce in substantive ways measures of distress in participants, it is not yet clear which approaches (by modality or individual/couple/group configuration) offer the best support especially in terms of reducing "depressive symptoms." Rather than focusing on the type of intervention offered, it may be important for therapists to focus on factors that are reported by participants as most helpful (normalizing and contextualizing the experience of infertility, perspective-taking, observing resilience in others, parameters for interpersonal safety) and to address factors that were perceived as less helpful (inconvenience of meetings, perceived lack of intimacy, lack of immediate "in the moment" support, leadership self-representation [counsellor as "expert"]). Given the high number of

negative social responses received by IW and TG, and the isolation the couple experienced as a result, attention to the role of social responses by therapists facilitating group therapy for couples may be one means by which to increase the participants' perceptions of support.

For those who prefer to participate in an informal peer-led support group there may be a desire and need for counsellor-developed recommendations and suggested guidelines for peer facilitators. Counsellors with an interest in this area could make themselves available in a consultative capacity to those actively facilitating peer-led support groups to advise on matters such as how to create and maintain safety, how to promote confidentiality, what to do when a member becomes pregnant, and suggestions for how to skillfully manage "difficult" situations common to support groups.

Van den Broeck (2010) notes that the role of the counsellor in group therapy settings will depend in part upon the "setting" of the counsellor, whether the counsellor works within the context of a medical practice (i.e. an obstetrician/gynecologist's office or fertility clinic) or in private practice. Van den Broeck observes that counselling is a "notoriously imprecise" term but that a distinction between "patient-centred care" and counselling should be made. Boivin & Kertenich (2002; as cited in Van den Broeck, 2010) advise that infertility counselling demands professional qualification for addressing the particular psychological and social challenges associated with infertility. Criteria for qualifications of counsellors leading group therapy for clients experiencing infertility has not been well established at a professional level. As noted by Boivin, Appleton, Baetens, Baron, Bitzer, Corrigan, et al. (2001), "While an agreed set of criteria for 'who should counsel' has yet to emerge, at the minimum counsellors should have received training in one of the mental health professions (e.g. psychology, social work, counselling) as well as training in the medical aspects of reproduction", (p. 1304).

## Support Groups versus Group Therapy

While group therapy with both partners is seen as ideal by authors such as Lemmens, Vervaeke, Enzlin, Bakelants, Vanderschueren, Hooghe et al. (2004), only the female partner of the couple represented in this case study participated in group therapy. IW attended once, and on her own. Rather than continue, IW chose to create an informal peer-led support group. The couple identified the following as beneficial factors present in counsellor-led group therapy: normalizing/contextualizing their experience, observing resilience in others, the opportunity to engage in perspective-taking, the instituting of boundaries and safety measures. In addition to the above, the following were seen as beneficial factors of the peer-led support group: the convenience of determining meeting times/places, the intimacy afforded by a smaller group, the immediacy of being able to contact group members and receive a response, and advantages of member-led leadership (see Table 1).

**Table 1**

### Group Therapy as Compared to Support Group

Theme	Group Therapy (counsellor-led)	Support Group (peer-led)
Convenience	Meets once a month on a set date/time at a predetermined location	Meets whenever members want to meet
Intimacy	Perceived as a forum for <i>“just getting your stuff out in the open”</i>	Smaller, more intimate; participants <i>“felt like there was somebody else helping with their exact situation;”</i> a sense of <i>“buddying up”</i>
Normalizing/Contextualizing	Saw other <i>“strong people in the room ... completely breakdown;”</i> members had contextualized information about infertility/IVF	Saw other <i>“strong people in the room ... completely breakdown;”</i> members had contextualized information about infertility/IVF
Observing Resilience	<i>“Seeing that other people are ... are breaking down in the same ways that I am but</i>	Resilience was likely present in the support group also but was not specifically

	<i>becoming more resilient as well.</i> "	identified.
Immediacy	Members may or may not connect outside of group meetings	Members text, email, or phone one another between meetings; the most important thing was <i>"being able to text someone anytime;"</i> not having to attend a whole session to obtain support
Perspective-taking	<i>"Hearing other people's stories"</i> and <i>"putting things into context"</i>	<i>"Hearing other people's stories"</i> and <i>"putting things into context"</i>
Safety	Managed interactions with parameters and boundaries set by counsellor(s); IW felt this limited her ability to share	No formally managed interactions or parameters; this led to concerns around how to handle situations such as when a member becomes pregnant
Leadership	Counsellor-led; therapists were viewed as seeing themselves as "experts"	Peer-led; members perceived themselves as <i>"experts in the field;"</i> <b>IW</b> suggested reframe of group therapy to a model more like "AA" where <i>"people suffering [are] helping other people who are suffering"</i>

IW expressed concern regarding the fact that in a difficult circumstance such as when one of their small group members became pregnant, the group did not have a plan for how to manage the situation. In this case, a counsellor-led approach to support would perhaps have helped to address the problem as well as other eventualities such as what to do when the group has a difficult member(s), what to do when the rules of engagement are not adhered to, how to maintain confidentiality, how to manage conflict, and how to encourage group cohesiveness. As Yalom (2005) notes, a skilled therapist can help to switch the group energy from the initial experience of conflict (here-and-now) towards reflection on that experience.

If the couple in this case study are an indication, then the modality used by a therapist may not be as significant as membership in a small support group, and in fact participation in the peer-led support group was preferable to the couple in this case study. It appears that for some participants peer-led support groups may be at least as effective as counsellor-led group therapy. For IW, membership in this small group was an effective way to meet her particular needs for support. This raises the following question: how important is it to offer counsellor-led group therapy as opposed to peer-led support groups, and what assumptions are we, as therapists, making when we choose or design formats for group therapy? This may be an especially important line of inquiry with direct implications for those who experience infertility and who live in communities without access to a counsellor trained in this area. Addressing how skilled practitioners can adequately support facilitators of peer-led support groups may add tremendous benefit to the experience of couples unable to access counsellor-led group therapy.

In Boivin's 2003 review of the literature it was concluded that group counselling interventions that included education and skills training were more effective in producing positive change across a range of outcomes than counselling interventions used on their own. Domar (2011) reflects that this finding may be due to some interventions being more effective than others but also could be attributed to the fact that "the efficacy of different interventions may be affected by the diagnosis of the patient, the form of treatment the patient is receiving, and the baseline psychological status of the patient" (p. 2271). The factors of diagnosis, current treatment, and baseline psychological status will be important to consider when formulating an approach to group therapy for couples experiencing infertility. Not taking these factors into consideration and not accounting for the kinds of social responses the couple may have received may contribute to less-than-ideal outcomes for group therapy participants.

### Language: “Depression” as Descriptor

It is important to acknowledge the term “depression” as one in a wide range of descriptors that express potential individual responses to the experience of infertility. “Depression” is medical term that outlines a specific set of “symptoms.” The Diagnostic and Statistical Manual of Mental Disorders-V (American Psychiatric Association, 2013) cites the following (in particular combinations) as potential criteria for a depressive episode (commonly referred to as “depression”): depressed mood; lost of interest and enjoyment in usual activities; reduced energy; decreased activity; reduced self esteem and confidence; ideas of guilt and unworthiness; pessimistic thoughts; disturbed sleep; diminished appetite; ideas of self harm. Any of the above, taken alone or in combination, may be thought of as “depressive symptoms.”

An individual describing their responses to infertility might indeed use the term “depression.” The person may or may not mean it in a medical sense. They may or may not have been told by a medical professional that they have depression. There are many other words that might be used to describe what is going on for the person, for example specific descriptions of what is happening such as wakefulness, worry, grief, and sadness. Terms used by the couple in this case study to describe the distress they experienced include “*definitely very misunderstood, very marginalized, very ... alone,*” “*challenged,*” “*feeling so dark,*” “*stuck,*” “*frustrated,*” “*wishful,*” “*dismissed,*” “*in limbo,*” “*overwhelmed,*” “*negative,*” “*there is a big, dark cloud above my head,*” “*breaking down,*” “*at risk of plunging into ... a darker depression.*” These very descriptive words and phrases reflect the couple’s response to negative social responses received; the couple feels misunderstood, marginalized, and dismissed.

The etymology of the word “depression” is from both Old French and Late Latin origins. The Old French *depresser* (early 14<sup>th</sup> century) means to “put down by force,” and the Late Latin

(15th century) *depressare* or *deprimere* means to “push down physically.” The word was later used to describe psychological “depression,” meaning a “dejection or depression of spirits.” I suggest that in the context of the experience of infertility that the term “depression” be conceptualized first as a descriptor rather than a diagnosis, and that counsellors and others working to support couples who are experiencing infertility consider finding other or additional descriptors that are less pathologizing and possess greater specificity with regards to giving voice to exactly what the client is feeling. That is not to say that clinical depression does not sometimes occur in those who experience infertility. As we can see from the literature, women who experience infertility are twice as likely as women in control groups to have depressive symptoms (Domar, Broome, Zuttonmeister, Seibel & Friedman, 1992). Clients should be assessed and offered the appropriate medical and psychosocial supports whenever clinical depression is suspected. In addition to this, and especially before a person is told they may have depression, it is important for therapists to consider the context in which the “signals” of depression occur. The negative social responses a couple has likely received are a powerful force often leading to feelings that are associated with depression such as marginalization, isolation, grief, loss, feeling overwhelmed, misunderstood, and stuck “in a dark place.” From a Response-based approach, these signals that may suggest what is often termed “depression” or “depressive symptoms” could instead (or also) be formulated as an understandable response to the infertility, and a reflection of the quality of social responses the couple faced along the way. Depression can be conceptualized as a grief response to the loss, alienation, social isolation, marginalization, exclusion, and “dismissal” couples endure because of the infertility.

Most people in western societies presume they are fertile and take measures to postpone pregnancy until a time when the individual or couple desires it. The result, as Lukse (1985) puts

it, is that when infertility is discovered it becomes "... a life crisis, arriving unexpectedly and possibly disrupting the self concept, marital relationship, and sexual relationship" (p. 67). Lukse notes "Feelings of grief are usually attributed to the death of a significant loved one. However, grief may result from a loss of an aspect of the self-concept, how we view our self-worth, or feelings of being powerless" (p. 67). Grief and loss are commonly felt in light of a couple's inability to achieve their "child wish." In coming to terms with the possibility of a life without children, individuals face the possibility of "non-parenthood," and the resulting tension between this wish and the couple's present reality challenges the relationship, their concept of "family," and ideas about identity. As Van den Broeck (2010) notes, "psychologically, the wished-for-child is present whereas physically, the wished-for-child is absent" (p. 423), a concept also known as "boundary ambiguity" (Covington & Burns, 2006; as cited in Van den Broeck). Counselling provides an opportunity to process the personal, relational, and social difficulties associated with unwished for childlessness.

Webb and Daniluk (1999) discuss aspects of loss particular to male partners experiencing infertility. Seven phenomenological themes associated with the male experience of infertility emerged: a sense of profound grief and loss, powerlessness and loss of control, personal inadequacy, betrayal and isolation, threat and foreboding, desire to overcome and survive, and a need to positively reconstruct their experiences. One can see that with this particular constellation of responses to the infertility a person might say, "I am depressed" as a way to articulate with one word how it is they feel. Interestingly, Domar, Clapp, Slawsby, Kessel, Orav & Freizinger (2000) discuss depression in infertile women and use the term (although not exclusively) "distress" rather than depression to describe the constellation of anxiety, depression, changes in mood, and changes in sexual functioning noted in women who experience infertility.

The authors at times seem to equate “distress” to “depression.” This is interesting since “distress” seems a much broader and more expansive term than “depression,” a term without clinical and medical overtones, and one that takes into account a wider range of possible responses to the infertility. “Distress” as a descriptor appears as a more recent development in the literature with regards to the use of language describing individual responses to infertility.

Miles, Keitel, Jackson, Harris & Licciardi (2009) note that “distress” as a psychological term was originally defined by Lazarus & Folkman (1984) as “a particular relationship between the person and environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being” (p.19). Distress can encompass experiences that are characterized as reported mood, anxiety, depression, psychopathology, and general psychological functioning with considerable variability present in the distress responses of individuals experiencing infertility (Miles et al., 2009). Miles et al. found that 42% of women in their study demonstrated significant levels of distress and 62% of women were considered clinically symptomatic with regards to distress. In addition to this the participants in Miles et al. reported clinically significant levels of alienation, depression, and hostility. The term “distress” is less pathologizing than “depression” since it describes both an emotional state and psychological response to real world events rather than labeling or diagnosing it as a disorder or symptom.

With this information about how the term “distress” is sometimes being used in the literature, and it’s correlation with IW’s report of feeling “*definitely very misunderstood, very marginalized, very ... alone,*” we can begin to formulate an understanding of the powerful emotional responses to both infertility and to the negative social responses people receive. What may have been labeled as depression or depressive symptoms can also be understood as distress

and an understandable response to the infertility. From a Response-based perspective it could be argued that infertility combined with negative social responses may lead to an increase in “distress” which might be characterized as mirroring the negative social responses with feelings of being misunderstood, marginalized, and isolated.

Using Response-based ideas (Bonnah, Coates, Richardson & Wade, 2014) as a lens through which to examine the idea of a diagnosing depression or depressive symptoms in the context of a couple’s experience of infertility, as a therapist one would want to exercise caution to avoid the common tendency of concluding that signals such as those listed in the DSM-V including, for example, low mood, pessimistic thoughts, loss of interest and enjoyment in usual activities, and low self-esteem necessarily indicate the presence of depression. Instead, a therapist might proceed by intentionally slowing down the human tendency towards conclusion-drawing based upon observable or reported “symptoms,” and shift the focus from these “signals” to the context in which they occur. Using this approach, special attention would be paid to the following: the couple system, the couple’s responses to the diagnosis of infertility, the social responses to the infertility, and the couple’s response to these social responses.

In light of this approach, group therapy then becomes conceptualized as a “social response” to infertility; as such it warrants careful evaluation with regards to how couples perceive the experience of group therapy aimed at addressing their experience of infertility and suffering. For example, in this case study IW found her needs were better met through the creation of a small peer-led support group rather than formal counsellor-led group therapy. While her conclusion that group therapy did not meet her needs was based upon attending only once, her feelings on the matter were strong enough to motivate her to organize and facilitate a support group that afforded immediacy, intimacy, and convenience.

## Reflections of the Researcher

Using a particular research framework like a Response-based practice lens will have influenced the nature of how the data was collected and interpreted in this case study. I formulated questions in advance of the interview so that there would be a structure to the interview. Anticipating interviewing more than one couple, I hoped this would be a way to organize and connect common and divergent aspects of answers to the questions so that the information gathered would “get at” certain aspects of the couples’ experience that had to do with their perceptions of group therapy as a social response to infertility especially with regards to “depression.” By asking the questions I did, other information elicited either by open questioning or a different set of prepared questions will not be represented. I agree with Bainbridge (2013) who indicates, “As researchers, our ways of knowing and being are inseparable from our ways of doing, and all ways of doing make epistemological claims. We should, therefore, seek answers to our research questions in a strategic process of knowledge construction” (p. 275).

In transcribing the interview and coding the data, and then drawing conclusions from the coding by finding themes and then linking the themes, I will have noticed some things and included them as significant while ignoring or being unaware of other things which someone else may find to be significant. And so while I did my best to work with the intention of being open to the themes raised by the participants themselves, and by the data, my analysis will reflect the fact that I am a person with ideas and experiences related to the subject matter. In fact, my participation in the interview itself could be viewed by some as problematic in terms of “inserting” myself into the data set.

Another way of seeing this “insertion” of the researcher is to view it as a process of co-creation between the researcher and participant: together we create a conversation and an understanding of both individual and shared meaning. As Brené Brown puts it, “I’m a qualitative researcher, I collect stories . . . and maybe stories are just data with a soul” (Brené Brown, 2010). This story’s soul comes from the research participants themselves but the soul of the researcher also becomes apparent in the work, in the perceived meaning of the collected data, and its relevance to others.

Perhaps an especially clear example of how my person and the research framework with which I was approaching this study will have potentially affected the data collection is Interview Question #11 which is: *If you were told or suspected that you had “depression” or “symptoms of depression,” do you think group therapy lessened your suffering?* Firstly, within the language of the question itself there is a suggestion that “depression” or “symptoms of depression” are terms used in ways that are being questioned. Very often “depression” is something we are told we have, or that we tell others we have. Implied in this is the idea that professionals, medical or otherwise, advise patients when they believe that depression or its symptoms may be present. In fact, they have an ethical responsibility to do so. Depression is usually considered quite treatable, and family doctors and specialists may prescribe medication, talk therapy, or a combination of the two. However just because a professional, friend or family member has suggested the presence of depression does not always mean, in my opinion, that the responses that characterize depressive symptoms are representative of mental illness or are pathological in nature. As discussed elsewhere in this paper, what we recognize as depressive symptoms can also be understood as responses to the infertility, and to negative social responses received. These responses may even be functional for people in that the discomfort the feelings create may

motivate the individual to get his or her needs met in new and innovative ways. IW's creative response of initiating a support group tailored to the members' needs is a powerful example of this.

Finally, on a more personal level, I experienced a profound sense of compassion and empathy for what IW and TG have endured along their journey towards achieving a much-wanted pregnancy. I worked for several years in a fertility clinic and watched firsthand the suffering of men and women as they worked to fulfill what is known in the literature as the "child wish." Part of my response to this has been in the form of poems; I include one poem here as a way to honour couples like IW and TG (next page).

In/Fertility

Ten days that feel a year; her feet, still in the stirrups  
the doctor forms words she does not hear  
says the needles, the drugs, delivered one egg: a singleton, deformed  
her ovaries are the size of mangoes.

The doctor forms words she does not hear  
*"blighted ovum"* ... *"azoospermia"* ... and *"next time"*  
her ovaries the size of mangoes  
smiles become like upside down ice creams, their sweetness spoiled.

*"Blighted ovum"* ... *"azoospermia"* ... and *"next time"*  
someone pets her like a puppy  
smiles become like upside down ice creams, their sweetness spoiled  
a one chance bet, a reproductive gamble.

Someone pets her like a puppy  
tears threaten, her husband digs in his pocket for keys, finds change  
their one chance bet, a reproductive gamble  
her feet, still in stirrups.

Tears threaten, her husband digs in his pocket for keys, finds only change  
says the needles, the drugs, delivered one egg: a singleton, deformed  
her feet in stirrups  
ten days that feel a year; her feet in the stirrups.

Karen Loucks

### **Conclusion and Summary**

Statistics available in Canada indicate that between 11.5% and 15.7% of couples experience infertility (Bushnik, Cook, Yuzpe, Tough, & Collins, 2012). Given this, and the fact that for many couples the ability to conceive a family defines the essence of life itself, the way in which society in general, and therapists in particular, respond to the infertility plays an important role in supporting couples in ways that help them to cope with the experience.

The nature of the emotional distress due to infertility is marked. Regarding their assessment of the significance of psychological outcomes of infertility for women, Domar, Zuttermeister & Friedman (1993) note, “When compared with women with heart disease, cancer, chronic pain, or HIV+ status, infertile women reported equivalent levels of anxiety and depression to all but the chronic pain patients” (Domar, Zuttermeister & Friedman, 1993; as cited in Domar, Clapp, Slawsby, Kessel, Orav & Freizinger, 2000, p. 568). Domar, Broome, Zuttermeister, Seibel & Friedman (1992) found that women who experience infertility are twice as likely as women in a control group to have depressive symptoms. Couples often seek fertility treatments to address the infertility. Psychosocial interventions such as counselling are designed to lessen suffering during the treatments, and also as a way to support those couples who may not go the route of medical intervention.

There is relatively little research examining the efficacy of group therapy for couples with regards to reducing what is often termed “depression” or “depressive symptoms” (see literature reviews by both Boivin, 2003, and de Liz & Strauss, 2005). This case study examines from a participant perspective whether participation in group therapy decreased in meaningful ways participants’ suffering, especially with regards to “depression” or “depressive symptoms.” An adaptation of the theoretical and research framework of Response-based Contextual Analysis

(Bonnah, Coates, Richardson & Wade, 2014) is used as a way to conceptualize the relevant issues, design the interview questions, engage with participants, and interpret the data. Particular attention is paid to the context of the couple (the history of their relationship, their respective families of origin, their support systems, and the story of how they discovered the infertility), social responses to the infertility, their responses to the social responses, and the nature of their experience in group counselling.

The participants in this case study (IW, a 38 year old female; and TG, a 42 year old male) live in Canada, have been together as a couple for four and a half years, and have been attempting to achieve a pregnancy since the fall of 2012. They were assessed by a fertility specialist in the fall of 2013 and since then have been engaged in fertility treatments both through their fertility clinic, and other alternative health practitioners. A telephone interview with the couple was illuminating and provocative. Emergent themes were clear and identifiable. The couple's specific context (the couple system, and their familial and social systems) and their respective ways of viewing adversity influences how each partner responds to the infertility. While their individual responses are unique, as a couple IW and TG approach the infertility as a unified team. The couple has received widely variable social responses to their infertility from many sources including, family, friends, "couple friends," colleagues, doctors, nurses, counsellors, and alternative practitioners. Negative responses were common and disappointing. The couple describes at least five discrete categories of social response, which IW called "Reaction Buckets" (see Figure 2). This straightforward classification system represents a novel way of conceptualizing these disappointing social responses.

In the face of negative social responses, the couple articulates a sense of being misunderstood, marginalized, and alone. The couple responds to this in several ways including

the use of “*critical thinking skills*” to take a more active role in managing their healthcare related to the infertility. The agentic act of informing themselves about the infertility, and moving forward with the information gathered, afforded IW and TG a sense of personal agency in a process where couples often feel as if they have little or no control. The couple has also begun advocating for provincial funding for couples experiencing infertility.

While only IW (the female partner) attended both counsellor-led group therapy and a peer-led support group, both partners had insightful observations about how these experiences were received by the couple. IW and TG viewed both the counsellor-led group therapy and peer-led support group as helpful in terms of the following: normalizing their experience and responses to infertility; providing access to a community of people with a common and contextualized experience (for example, a shared sense of loss in the face of the infertility and a communal understanding of the often-technical language used by couples undergoing infertility treatments); observing resilience in others; and an opportunity for perspective-taking through exposure to the thoughts, ideas, and responses of others to their own experience of infertility. The “least helpful” aspects of the counsellor-led group therapy were perceived to be: the role of counsellor-as-expert, and the somewhat restrictive parameters that were placed upon participant sharing.

The couple viewed the peer-led support group as a more helpful intervention than counsellor-led group therapy. In addition to the above-listed benefits of counsellor-led group therapy, the peer-led support group provided the following: greater intimacy (a smaller-sized group), immediacy in terms of the connections that were possible (for example, by texting one another between meetings), convenience (for example, of choosing the time and location), and a style of leadership or facilitation that included a view of each of the members as “*experts in the*

*field.*” The “least helpful” or most concerning aspect of the peer-led support group was that there was no organized plan around what to do when a member became pregnant. This did occur in the group, and was difficult for at least one member. Pre-existing parameters or guidelines for navigating this difficult situation were lacking in the support group.

With regards to participants’ views regarding whether “depression” or “depressive symptoms” were reduced by participation in group therapy, the couple noted that in their experience depression goes “*hand in hand*” with infertility. It is important to point out that the word “depression” did not entirely fit with IW’s experience of the signals that indicated to her she “*just needed some help.*” She articulated the idea of depression’s presence in the early stages of infertility as a “*challenge*” rather than “depression,” distinguishing this experience of distress from what might be more clinically defined as depression. Attending group therapy helped IW “*to some degree*” with regards to her description of the depression. In terms of managing the challenge, distress, and “depression” associated with the experience of infertility, the couple perceives participation in the smaller peer-led support group was more helpful than attending the counsellor-led group therapy.

Given that only four studies have examined group therapy aimed at couples with infertility and in their analysis specifically addressed measures of “depression,” there is a need for further and more vigorous research that uses control groups and larger sample sizes. Future research should examine the efficacy of both counsellor-led group therapy and peer-led support groups for couples experiencing infertility with regards to whether participation effectively reduces “depressive symptoms” associated with infertility. This would ideally involve a phenomenological aspect to the inquiry to discover from a participant perspective what was most helpful and why. If the aspects of professional clinical support addressing safety and parameter-

setting measures present in counsellor-led group therapy were translatable to support groups it may be that peer-led support groups would be an effective alternative for those individuals not wishing, or who are unable, to participate in a counsellor-led group therapy.

Counsellor-led group therapy and peer-led support groups are an accessible, affordable, and non-pharmacological response to a couple's experience of infertility. From a Response-based perspective, counsellor-led group therapy can be conceived of as a "social response" to the infertility. In order to best serve clients, therapists who facilitate group therapy will want to make themselves aware of what couples perceive to be the most and least helpful factors present in groups such as normalizing/contextualizing, perspective-taking, observing resilience, intimacy, immediacy, leadership roles, and convenience. Given the prevalence of negative social responses for those who experience infertility, counsellor-led group therapy becomes an opportunity for therapists to offer and facilitate positive social responses thereby reducing feelings of social isolation and marginalization, and mitigating negative social responses.

Finally, the careful use of language by counsellors can be seen as a therapeutic intervention in and of itself. Preference should be given to language that is specific in the way it describes the couple's experience of the infertility. From a Response-based perspective a therapist's use of language can serve to illuminate agentive responses and acts of resistance, to explore the context in which responses occur, to recognize the nature and role of both positive and negative social responses, and to avoid further pathologizing the client. In the absence of clinical depression, "depression" or "depressive symptoms" may be alternatively formulated as an understandable response to the experience of infertility, and a reflection of the quality of social responses a couple has received along the way.

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## Appendix A

### Interview Questions

1. How did you discover the infertility?
2. How did each of you feel when you discovered you would likely be unable to conceive on your own?
3. If you sought medical treatment, how did you come to a decision to do this?
4. How did doctors and other medical professionals respond to the infertility?
5. Who else knew about your infertility?
6. When you decided to tell others (siblings, parents, family, friends, coworkers), how did they respond?
7. How did the two of you feel about the responses you got from others?
8. Tell me how about how you came to the decision to go to group therapy?
9. What role has participating in group therapy played in your ability to cope with the infertility?
10. What differences are you aware of in terms of how you each experienced group therapy?
11. If you were told or suspected that you had “depression” or “symptoms of depression,” do you think group therapy lessened your suffering?
12. What aspect of group therapy was least helpful?
13. What was it about group therapy was most helpful?

## Appendix B

### Notice of Research



# Infertility & Group Therapy: a thesis project

**Have you participated in group therapy regarding infertility sometime in the past three years?**

A Masters level thesis research project is being conducted by Karen Chester, a Master of Counselling student at City University, which explores how couples who have participated in group therapy (either one or both partners) perceive the usefulness of that process to themselves as individuals, and as a couple.

#### **Criteria:**

- You and/or your current partner have participated in group therapy for clients with infertility sometime within the past three years
- Prior to participating in group therapy, you and your current partner experienced infertility for at least one year
- Neither you or your partner had a diagnosis of clinical depression prior to knowing about your infertility
- You speak and understand English well, even if English is not your first language
- You would be willing to be interviewed for between 60 and 90 minutes, and to have this interview audio recorded.

**Contact:** To contact me indicating your interest in being interviewed please email Karen Chester at: [kchester@cityuniversity.edu](mailto:kchester@cityuniversity.edu)

## Appendix C

### Interview Concepts, Contexts, and Emergent Themes

Concept	Context	Emergent Theme
<b>1. Couples' context</b>	Married for 2 years, together as a couple for 4.5 years	The partnership
TG = male partner IW = Female partner	Tried on their own for 6 months before seeing doctor	"Trying"
	<b>IW</b> began taking BBT (basal body temperature) to try to determine ovulation	"Trying"
	It took 1 year to get a referral to fertility specialist	"Trying"
	Personality factors: ( <b>TG</b> ) <i>"try to be as positive as you can ... that's what you can control;"</i> ( <b>IW</b> ) <i>"I'm the kind of person where you prepare for the worst and hope for the best"</i>	Personality factors
	<b>TG's</b> family: includes his mother and two older sisters, one of whom did IVF many years ago; he characterizes his family as supportive	Family of origin
	<b>IW's</b> family: includes her father, stepmother, and two half brothers all of whom live far away ( <b>IW's</b> mother died when she was ten years old); she characterizes her father and stepmother as unsupportive, the oldest of her stepbrothers as supportive (she has not discussed the infertility with her youngest stepbrother as he is only 14)	Family of origin
<b>2. Diagnosis of Infertility</b>	Referral after a year of trying	Medical System
	Age factors: <b>TG</b> (male partner) is 42 years old, <b>IW</b> (female partner) is 38 years old	Medical history
	<b>TG</b> : Hx of substance use 15 years ago, initial worry about this being a factor in the infertility	Lifestyle
	<b>IW</b> : Hx of termination at age 23	Medical history
<b>3. Couples' Responses to Dx of Infertility</b>	Sought referral	Harnessing medical interventions
	Did not want IVF	Resistance to medical interventions
	Wanted fertility testing	Harnessing medical interventions

	Lifestyle changes [supplements, acupuncture, no drinking, gluten-free, no hot tubs, massage, naturopathy]; <b>TG:</b> <i>"We both take 20 to 25 pills a day."</i>	Lifestyle adaptations
	Considered other options (adoption)	Considering options
	Decision to try IVF on <b>IW's</b> 38 <sup>th</sup> birthday	Decision-making
	<b>TG:</b> told a friends (supportive), couples who are friends (especially supportive if also going through IVF), family (supportive)	Social supports/Familial supports
	<b>IW:</b> told two close friends (unsupportive), half the people she knows (at work; supportive), her stepmother (unsupportive)	Social supports/Familial supports
	<b>TG:</b> <i>"I don't want to continually think about it [the infertility] all the time. I need to feel like we're getting on with our lives."</i>	The partnership/Personality factors
	<b>IW:</b> <i>"I think that's the difference. For me, there is no getting on with my life. I'm stuck."</i>	The partnership/Personality factors
	<b>TG</b> attends every one of <b>IW's</b> appointments at the fertility clinic	The partnership
	Regarding "depression" or "depressive symptoms" <b>TG:</b> <i>"... without question there was depressive symptoms. That goes hand in hand with going through the cycles of IVF. You can't have doubts about your biological self without being somewhat depressed to some degree, you know, depressed."</i>	Depression as a response
	Adopted two cats which turned out to be a very helpful intervention for the couple with respect to their interpersonal communication during a period of immense stress	Adaptation
<b>4. Social Responses</b>	Walk-in clinic physician: <i>"just relax," "don't think about it"</i>	Medical response
	Own family doctor: <i>"Relax!", "You don't need to make it so scientific," "You don't want your baby being born ... in a Petri dish"</i>	Medical response
	First Fertility Specialist: <i>"he was great," "he didn't push it"</i>	Medical response
	Second Fertility Specialist: <i>"We are the</i>	Medical response

	<i>professionals,” “Don’t let her go on the computer”</i>	
	Observation: some nurses and doctors “ <i>who’ve been really good</i> ”	Medical response
	Observation: Western medical approach used to exclusion of other holistic approaches	Medical response
	Most emotional support felt from naturopath, massage therapist, and acupuncturist	Alternative approaches
	<b>TG:</b> social responses (friends, couple friends, and family) mostly supportive	Social supports/Familial supports
	<b>IW:</b> social responses varied (2 close friends: unsupportive; work colleagues: supportive; father and stepmother: unsupportive; brother: supportive)	Social supports/Familial supports
<b>5. Couple’s Responses to Social Responses</b>	Feeling “ <i>We’ve been talked down to.</i> ”	Response to medical response
	Noticed medical errors, “ <i>If I wasn’t on top of it ... using my critical thinking skills ... they would have missed a lot of things</i> ” ( <b>IW</b> )	Response to medical response/Active participants in health care
	Began managing their own reproductive health	Response to medical response/ Active participants in health care
	Frustration: financial cost of IVF, approach of clinic staff to this issue	Response to medical response/Frustration/ Financial
	Resistance to staff approach to money	Response to medical response/Resistance
	Shock at Western-only approach to treating infertility	Response to medical response/Resistance
	<b>TG:</b> With increase in frustration, adjusted amount of information shared with family	Response to familial supports/Frustration
	<b>IW:</b> sometimes frustrated by TG’s sister’s story of a surprise pregnancy after they stopped IVF (fifteen years ago)	Response to familial supports/Possessing context/Frustration
	<b>IW</b> is able to speak about medical issues with her half-brother who is in medical school	Response to familial supports/Possessing context
	Regarding the responses of others, <b>IW:</b> “ <i>... just mainly disappointed. It made me reassess everything. And then some people have been very supportive actually, so ... definitely very misunderstood, very marginalized, very</i>	Response to social supports/Disappointment/ Marginalization/Isolation

	<i>... alone.”</i>	
	<b>IW:</b> “... the reactions, fall into different buckets ... There’s the one like, ‘Relax’ ... there’s the other like ... ‘Have you tried the naturopath?’ ... then there’s the ‘Oh, well you should just adopt.”	Response to social supports/“Reaction Buckets”
	Observation, <b>TG:</b> “It’s a taboo subject for people. They don’t know how to respond.”	Stigma/Possessing context
	People who have been “close to it” or who have gone through it themselves often offer the most helpful responses	Response to social supports/Possessing context
	Even if a person hasn’t experienced infertility, those people who just ask questions and who didn’t offer advice were felt to be very supportive	Inquisitiveness
	When someone already has context for understanding the technical information, this was perceived as helpful and something that “normalized” the experience	Possessing Context/Normalizing
<b>6. Group Therapy as a Social Response</b>	The decision to go to group therapy came when <b>W</b> felt, “I just needed the help”	Decision-making
	There were only women at the group (unsure if it was “women only”)	Social response
	<b>IW</b> attended this group once when <b>G</b> was out of town on work	The partnership
	Once a month, counsellor-led group therapy	Social response/Guidance
	Parameters set by counsellors regarding how to share	Social response/Guidance
<b>7. Couples’ Response to Group Therapy</b>	Introduced <b>IW</b> to “someone I can text,” who understands “my cryptic IVF lingo,” “who knows what I mean”	Possessing context/Immediacy
	Witnessed “strong people in the room ... completely breakdown” which was “weirdly great because it just made me feel normal”	Normalizing/Resilience
	“Hearing other people’s stories” and “putting things into context”	Possessing context/Perspective-taking
	Recognizing feelings of being overwhelmed, “feeling so dark,” and negativity are all normal	Normalizing/Perspective-taking
	“I should probably go again.”	Social response/Resistance
	Reasons for not going again: “timing”	Inconvenience

	[inconvenience], it's just one more thing, <i>"If it were easier I'd probably go more often."</i>	
	<b>IW</b> created an informal support group with other women from the more formal group therapy, they met every few weeks over food, the most important thing to <b>IW</b> was <i>"being able to text someone anytime"</i>	Immediacy/Intimacy
	Not having to attend a whole session to obtain support	Immediacy/Convenience
	<b>TG</b> noted differences in <b>IW</b> when she attended group therapy: she was <i>"a little happier or a little less impacted by the whole thing after she had other like minded individuals to talk to"</i> ; <i>"... people who are going through it get it and we can talk about it and most people don't know what to say or do. And so it's critical. It is without question critical."</i>	Possessing context/Normalizing
	The smaller support group was more intimate; the women <i>"felt like there was somebody else helping with their exact situation"</i>	Intimacy
	View that the group therapy was <i>"more like 'just getting your stuff out in the open'"</i>	Intimacy
	With the informal support group there was a sense of <i>"buddying up"</i>	Intimacy/Immediacy
	Concern re: how to manage the impact of a member's pregnancy on a small group	Guidance
	<b>TG</b> reflected that group therapy helped <b>IW</b> <i>"to some degree"</i> with depression, or symptoms of depression	Depression as a response
	<b>IW</b> : during initial parts of their journey felt more <i>"challenged"</i> than <i>"depressed,"</i> creating a <i>"new network"</i> and <i>"new perspectives"</i> felt good	Depression as a response/Language
	<b>IW</b> : after their second IVF cycle, <i>"I think I was very much at risk of plunging into a bit of a darker depression which I've had once in my life before;"</i> at this time she did not feel like she could make it to group therapy	Depression as a response/Inconvenience
	Instead of forcing herself to go to group therapy, <b>IW</b> 's response was to take some	Depression as a response/Inconvenience/

	sick days, play video games, drink Coca Cola and eat chocolate; things <i>“I don’t normally do”</i>	Resistance
	<b>IW</b> took a natural supplement targeting depression	Depression as a response/Alternative approaches
	During this time, communicated regularly with friend from support group	Depression as a response/Possessing context/Immediacy
	Felt parameters of support group limited the sharing	Social response/Guidance
	Therapists as <i>“experts”</i> felt less authentic	Possessing context/Guidance/Intimacy
	<b>IW</b> suggested reframe of group therapy model to one more like “AA” where <i>“people suffering [are] helping other people who are suffering”</i>	Possessing context/Guidance/Intimacy