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# Phenomenological Study of the Experience of Infertility in Romanian Patients: The Female Perspective

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**Abstract**: *The subjective experience of infertility, the emotions, thoughts and problems stated in the patients' narratives show that the psycho-social impact of infertility is real, and patients need permanent support, the recent qualitative studies suggest. The present paper explores the patients' experiences with a diagnosis of female or male infertility from the perspective of patients undergoing IVF to become pregnant. The sample included 17 participants, patients of a private reproductive health and fertility clinic in Iasi, Romania. Patients were interviewed based on a semi-structured interview guide to obtain information about the infertility experience, from diagnosis to IVF procedures, regardless of the therapeutic approach. The data was enriched through observation notes. The data obtained were analyzed from a qualitative perspective, with a phenomenological approach, to describe and interpret the experience of infertility from the patient's perspective to understand and deepen the diagnosis's effect on personal, social and couple life. Six theme clusters emerged from the collected data related to the perceived definition of maternity, the personal infertility story, the array of identified emotions, couple dynamics, perceived social support and coping strategies. The body of literature gives increased interest to the biomedical aspect of infertility. However, its completion with information related to the patient's life context and the meanings attributed to it provides relevant data for therapeutic success.*

**Keywords:** *infertility; IVF; phenomenology; qualitative research.*

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## 1 Introduction

Recent studies pay more attention to the qualitative approach in the study of infertility since, from a psychological perspective, being unable to get pregnant naturally is associated with multidimensional emotional distress (Luca et al., 2022). Distress is either of a functional nature, concerning one's own body, loss of control over one's own life, or problems of a psychological nature (inability to feel and experience maternal feelings, isolation, loneliness, poor social support) (Romeiro et al. 2017; Romeiro & Caldeira, 2019; Iordachescu et al. 2021; Yao, Chan, & Chan, 2018; Vioreanu, 2021; Mete et al., 2020). In addition, qualitative studies analyzing the discourses of patients with infertility problems, whether female or male, highlight common themes of emotional distress; women diagnosed with infertility present significantly more criteria for depression and anxiety than men. Furthermore, the quality of life is significantly affected by couple infertility, especially female infertility (Kiani et al. 2021), since pregnancy and childbirth are associated with two of the most important roles in a woman's life (Yao et al., 2018; Izzat et al, 2021). Moreover, an infertility diagnosis accounts, according to the literature, for an increased level of distress for women, more than for men with similar problems, which is associated with an increased degree of vulnerability to psycho-emotional stressors in the process therapeutically, consequently affecting their perceived quality of life, (Kiani et al. 2021; Palomba et al. 2018; Cheng et al. 2018). Furthermore, recent studies suggest that accepting a life problem is a complex process, influenced by factors such as personality traits, the availability and accessibility of medical services, family and social support, and economic status. For example, regarding women's ability to compensate for medical services and infertility treatments, the literature indicates a dependence on the cumulative income of the family or partners, a situation that exposes them to the additional stress of an economic nature, in addition to that of a social, relational and psychological nature (Logan et al. 2019). The study's objective is to provide a perspective on the life experience of Romanian patients living with infertility and explore possible counselling and psychological intervention directions. Our results suggest that although certain themes and subthemes in the infertility narrative are common to those displaying criteria for anxiety and depression (mood disorders, hypersensitivity, isolation), others are infertility-specific (self-blame, shame, lack of personal achievement goals, questioning the individual value, social stigma associated with infertility, social and cultural pressure) (Dube et al. 2021; Damian et al, 2022). Furthermore, the results suggest that the lived

experience of infertility, regardless of its cause, is moderated by significant emotional and relational factors (the highest density of codes applied to the patients' discourses is in the area of emotions and the relationship with their partner). The analysis confirms the hypotheses of recent studies, which consider the experience of infertility multidimensional and multifaceted, (Hasanpoor-Azghady et al. 2019; Behboodi-Moghadam et al. 2013).

## 2 Material and method

### *2.1 Study design*

The study on the perception of the psycho-emotional impact of infertility employs a qualitative methodology; the analyzed data are collected by applying a semi-structured interview and are analyzed from a thematic-categorical point of view. The interviews were audio recorded and transcribed in full. In addition, we processed narrative data after successive readings and coding.

We coded the resulting material manually, inductively, and bottom-up to identify categories, themes and sub-themes, as well as the meta-narratives that arose from the big themes identified.

For this study, 17 female patients, either carrying a diagnosis of infertility or being in a couple where the diagnosis of infertility is mixed, male or of unknown etiology, with multiple treatments before the current one, were interviewed in the clinic where the study was carried out (median age = 33.7 years). For the patients' anonymity, the interviews were identified by the assigned code, in a series of types P1, P2, up to P17. The patients verbally agreed to the anonymous use of data for this study; we recorded their agreement at the beginning of the interview.

### *2.2 Participants and setting*

17 Romanian female patients (median age = 33.7 years) (Table 1). Among the respondents, 2 (11.76%) of the patients have a secondary school education, 2 (11.76%) have a high school education, 8 (47.05%) have a university education, and 5 (29.41%) patients have a postgraduate education. Two of the patients were diagnosed with endometriosis before the fertility procedures. The diagnosed infertility is of female cause in 5 (29.4%) of the patients and male cause in 5 (29.4%) of the patients. For two couples (11.76%), infertility is both female and male, and 5 (29.4%) couples did not identify, until the time of the study, the cause (Table 1).

### *2.3 Data collection*

First, we collected data through semi-structured interviews. Interviews were performed in Romanian and translated into English with minor editing for the sole purpose of clarity. The interviews lasted between 30 to 50 minutes, giving the patients full liberty to complete the interview guide with any other information they consider relevant to their personal experience. The additional data aim to obtain a rich, detailed and vivid description of the infertility diagnosis story and their expectations after this diagnosis.

### *2.4 Data analysis*

Data was analyzed after successive in-depth readings and coding of the recorded interviews. The coded data was grouped based on discourse units (verbal and non-verbal, noted during the conversation with the subjects). Next, we grouped the initially coded discourse units into themes and sub-themes and identified the meta-meanings inductively.

The interview focuses on the experience of the patients and their partners, where the information could be identified as a couple, to explore how they perceive infertility, defined by the patients' narrative of the inability to get pregnant naturally. The present study explores how patients feel and relate to infertility and its treatment, as well as how they manage dominant emotions in the process. We also investigate how infertility did or did not change the couple's dynamics and how these changes are in nature (positive, negative, or the partners do not notice any change at all). Last is the subject's perception of social functioning (relationship with extended family, friends, and professional environment). In addition, through interview and guided conversation, the personal story of the patient, the patient or the couple, where appropriate, upon learning the diagnosis and the perceived psycho-emotional impact is also explored.

### *2.5 Ethical considerations*

The study received ethical approval from the Research Ethics Committee of the University of Medicine and Pharmacy "Grigore T.Popa" Iasi. Participants were informed about the study procedure and were asked to give informed consent to participation before the interview by the attending physician. Interviews were conducted with the participants' anonymity, and consent was audio- recorded before starting the conversation. Interviews were audio recorded and transcribed in compliance with data protection regulations. Participants were informed that they could withdraw their consent during the interview and research. We collected data in July 2022.

## 3 Results

The essential structure of the phenomenon was identified as 'Going beyond the apparent difficulties to be able to conceive and have a biological child'. Narrative data collected through the interview were verified through additional guiding and probing questions to ensure the answers' accuracy. The essence of the phenomenon is presented as six theme clusters, and 18 themes emerged from analyzing patients' experiences with infertility: (1) definition of motherhood, (2) personal journey of infertility, (3) prevalent emotions, (4) couple relations and changes in interpersonal dynamics, (5) social support system, (6) coping with stress (Table 2).

### *3.1 Definition of motherhood theme cluster*

The analysis of narrative data suggests that patients define motherhood as mainly linked to their infertility diagnosis. We prompted patients to define motherhood and childbearing in their own words, and the answers produced four themes: i) the desire of having biological children; ii) the imperative need to have a child (obsession); iii) perception of femininity; iv) life fulfilment.

#### *3.1.1 The desire of having biological children theme*

Some patients argue that the privileged and special relationship they establish with children justifies the desire for motherhood, suggesting self-perceived competence and a high degree of emotional comfort around children. Other patients express the desire to compensate for a difficult upbringing with an absent mother or lack of parental protection experience amid social or financial deficits from childhood. Patients offer various explanations for the anticipation of motherhood. In some cases, they relate to instinct; in others, it is about social identity or the bond between the two partners. However, in most cases, becoming a parent is a choice that the woman makes after going through certain life stages: finding a partner, building a career, a family life that provides emotional and material conditions for the future child, prioritizing activities couple, such as vacations and trips, strengthening the couple relationship.

> *P1: "It was always easy for me to talk to and relate to children. I may not remember the parent or adult when I work with children. However, I certainly remember the child, with all his emotions, pluses and minuses, and everything. I understand that language, and I feel comfortable there. There is my universe. I feel comfortable".*
>
> *P3: "(Motherhood) means a lot to me. Especially since I lost my mother at the age of two, I missed her, and I know what it is like to be there".*

### *3.1.2 The imperative need to have a child (the obsession) theme*

The imperative desire to have children is identified in four of the 17 interviews (23.52%) at a level of intensity that differentiates it from the basic need of becoming a parent. The imperative urge to have a child is more acutely perceived after the infertility diagnosis. One patient reported that if the desire was not strong until the medical investigations, it increased in intensity after the identification of the medical problem.

> *P7: "Now I think I am at the point where I want a baby. Although I am not against adoption, I was talking to my husband about starting the procedure because it takes a long time. However, I still want the experience of being pregnant, and I know it sounds selfish, but forgive me; I think I will cry now".*
>
> *P9: "This is a very sensitive topic; I have wanted more since I discovered I had zero chance of conceiving. I was left there crying. However, after I had an MRI after my first surgery, my biggest wish would be to become a mother".*

### *3.1.3 Perception of femininity theme*

The perception of femininity relates to the ability to give birth to a child. The experience of motherhood and carrying a pregnancy to term is part of this perception of fulfilled femininity as a personal identity and social role. However, after all attempts to give birth to a biological child have been exhausted, patients consider further options (for example, adoption or insemination with donated genetic material) to become mothers. The desire to go through the pregnancy experience is greater considering the obstacles of infertility diagnosis; one of the patients reports that this desire is all the greater as she faced failures in previous procedures.

> *P13: "It is what is missing, what we are missing. Well, it is what completes me. It is a desire, maybe a woman's desire, but I want to be a mother".*
>
> *P14: "I told my husband that it would leave me a bit sad if I could not get pregnant and we had to adopt. However, motherhood also means carrying that child, feeling it inside me, feeling the first heartbeats, feeling how it moves, later giving birth and all the way through".*

### *3.1.4 Life fulfillment theme*

Fulfilment in personal life is the most frequent theme in the subjects' narratives; it most often defines motherhood and the associated feeling from the parent's perspective. Personal contexts intertwine with narratives of motherhood and bring to the surface a wide palette of emotions, anticipated regret, and revisions of decisions made in other life contexts. For example, one of the two patients who achieved a pregnancy through IVF speaks about the feeling of fulfilment and unconditional love discovered after the first child's birth, without this feeling being present before the procedure.

*P13: "(...) fulfilment, I long for it so much, I have a twin sister, and I practically consider her child my son. I like children very much. Now she is big, she is 13 years old, but I like children very much.*

*P12: "I also want a child, but we have known each other for a long time; we are late, and that is why I do not have a child; it was also the doctorate. I focused more on my studies as the years went by. I did not even have a relationship while I was doing my doctorate. I was out of a relationship, I was young, and it was enough for me".*

### *3.2 Infertility journey theme cluster*

The story of infertility and finding out the diagnosis reveals much important information about the psycho-emotional status of the respondents, whether we have the female or male cause of infertility, mixed cause or of unknown etiology. In all instances, the personal narratives focus on the emotion felt upon learning the diagnosis. At the same time, the patients recall the medical and emotional stages they went through until the moment of the interview and outline each of them, a multidimensional psycho-emotional profile. During the interview, four themes emerged: i) the patient's immediate reaction after diagnosis; ii) the perception of life changes after the diagnosis; iii) negative emotions and thoughts; and iv) positive emotions and thoughts.

For the analysis, we considered it important to inventory the set of emotions separately from the question specifically formulated for this purpose, to obtain a richer set of codes, especially when reliving and recounting some of the most difficult moments in the patients' lives. Therefore, the set of emotions accounted for refer mostly to the experience while embarking in the infertility journey. We separated for methodological considerations the emotions expressed in the present and towards the future, as explored in Emotions theme cluster, in Section 3.3.

Each narrative is unique in its way and emotionally colored differently depending on several variables, which we explore below. The codes defining negative and positive emotions are, in certain cases, also present in the definition of the "Emotions" theme cluster, such as, for example, anger or negative feelings towards people who have children, which, according to the respondents, "they do not deserve it". Sadness is also present on a personal level, shared with the partner going through difficult times after the diagnosis.

### *3.2.1 Patients' immediate reaction after diagnosis*

After finding out the diagnosis, one of the predominant reactions is silence, closure, the need for protection and confirmation of the emotional bond with the partner. A need to work on their couple's goals emerged through the narratives, pointing out the intrusions of the social environment. Leaving out excessive communication outside the couple is one coping strategy preferred by our respondents. However, the data suggests that women are more willing to talk to other people around them about the diagnosis, regardless of whether it is female or male infertility. Their partners, however, prefer not to discuss medical problems with other people, not even with relatives or friends.

> *P8: "After the diagnosis, we left hand in hand. I felt him quieter at first, as he usually talked and asked questions, but he was quieter. I asked him how he was and how he felt, and he said it was all right, but he needed to digest the situation a bit. I told him; you can talk. You can tell me, and you have my support. Yes, he said, but he feels pressure and doesn't want everyone to know the reason for our infertility right now".*

Another type of emotional reaction after the diagnosis is the stupor, the belief that the infertility is not congruent with the patient's perception of the life course, whether it is about behaviors related to health, lifestyle, food, rest, or other wrong choices that lead to at the diagnosis of infertility. Guilt is also associated with the confusion on life choices.

> *P14: "I even had moments when I wondered when I did something wrong".*
>
> *P15: "I am aware that the subconscious works, and maybe we say that we are fine, that it will happen at some point, but the thoughts remain, and we do not know how the body probably reacts".*
>
> *P13: "I cannot find an answer to this question. I really do not know why I do not have children. That is exactly why I am in a clinic; if I was looking for an answer by myself, I was at home. So I came to doctors and specialists to give me an answer. I want a medical answer".*
>
> *P9: "I blamed myself for a while, although my husband told me everything was ok and not to blame myself, but nevertheless I blamed myself. I thought I had chosen the wrong doctor and should go elsewhere and ask for another opinion, which seemed very painful".*

After communication of infertility diagnosis, the feeling of failure is present and defined as an emotion of guilt and hopelessness.

> *P2: "The strongest emotion felt - was failure. I did not blame myself. I was not like that before. I did everything I was told to do. I ate. I rested. We also have a genetic problem. We did the analysis, and we have a mutation that prevents us*

*from having a pregnancy naturally. So my body perceives the pregnancy as a foreign body".*

The infertility theme cluster analysis revealed that the personal story of infertility is told through the lens of strong emotions and comparing the experiences of loss and bereavement with that of others in the entourage; accounts of painful experiences, both physical and emotional, are especially related to pregnancy loss. Crying, as an emotional release, is present in the case of all patients, especially when recounting traumatic events and when aware of the social effects of alienation from family, friends or the social circle.

*P5: "It was very difficult for me (patient crying). First, I felt guilty for a long time, but even after identifying the problem, I know it is not our fault. Then frustration at some point, sadness, especially because I work in this environment, and it is very difficult. Somehow, without realizing it, I judged the parents of the children I work with. I put myself in their shoes".*

*P6: "When we lost our first pregnancy, my sister was pregnant with the second, and it was more difficult. We broke up like that. We got cold, kind of".*

*P4: "I cannot. I can't (patient crying). You realize that on the second insemination, I got pregnant and lost the baby after a month. There were times when I tried a third and a fourth time. I'm talking to a friend, but they don't understand you one hundred per cent either because they don't go through it and if they don't know what you're going through. All my losses are there. You can't forget. You can't help but think what it was like if it was".*

### *3.2.2 The perception of life changes*

After an infertility diagnosis, uncertainty and strong emotions depict couples' lives. Also, in this theme cluster, we explore the possible changes in the relationship with the partner, and we will return to the couple's dynamics in the dedicated section. Finally, we note that all respondents, without exception, mentioned either an improvement in the couple's relationship or did not report any change in it or the appearance of negative emotions.

*P8: "When we got the diagnosis and got home, it was sad because we tried (for a baby), and we didn't know what was going on. I mean, you know how it is in the beginning, you monitor ovulation, temperature, everything, and you try, and when you see it's not happening, honestly, I'm going to sound selfish, but it was a liberation for me because everyone was saying that women were the cause, but on the other hand, I felt his disappointment too, I think his disappointment was even greater. Probably bigger than if it was because of me".*

Patients report a positive change in their relationship with their partner after the diagnosis, in the sense that they feel closer to him, in deeper

communication than before the medical tests. At the same time, the feeling of "liberation" is also mentioned when they are not responsible for the couple's infertility, although the problem is a shared one.

> *P8: "The relationship didn't change after the diagnosis, maybe for the better. We were closer. I was more understanding, I think. But in the negative, no. It's been a change for the better, but I don't look at it differently. I have no problem with it".*

### *3.3 Emotion's theme cluster*

The expression of emotions is one of the richest themes in the infertility narrative. In the coding process, 17 codes were identified, which can be grouped into emotions with a negative and positive charge. The organization of codes presents a series of limitations, as many are multidimensional and used in different life contexts. However, the emotion map can provide a representation of their diversity. During the interviews, they were relatively difficult to identify and name, often requiring the researcher's intervention to help with additional questions to define them as close as possible to the patient's reality. Expressed or repressed feelings color the whole existence of the couple or the person who has infertility, and, often, it is defined as a rollercoaster. The concept of a rollercoaster (Janković & Todorović, 2021) is one of the most frequently used accounts related to the experience of infertility. The term best describes the emotional extremes experienced by patients or couples, with a significant impact on general well-being, social integration or even treatment adherence and, last but not least, on therapeutic success (Alamin et al. 2020). The awareness that emotions are beyond personal control leads the patient to opt, at least declaratively, for counselling services. The overwhelming feelings, which they identify as dysfunctional and affect their perceived self-efficacy for daily tasks, are superimposed on the information the patient already has and is aware of the need to manage them with the help of a specialist.

> *P11:" How did I still manage to get into a situation? Maybe I will still go to a psychologist, a therapist, talk a little about all these experiences because I am overwhelmed".*

#### *3.3.1 A contrasting array of emotions*

The study suggests that most of the feelings do not identify as a single emotion in the patients' discourse. Most of the time, they coexist and are listed in a single explicit statement, to a direct question, regarding the emotional state. The most common model is the coexistence of negative emotions, which, as a hypothesis, potentiate each other. For example, in one

answer from a patient, we identified anger with fear, guilt and envy, a colorful combination with other deep emotional states related to the relationship with divinity, rebellion or dissociation from one's partner:

> *P1:"...the guilt, the fear. For a long time, I was angry with my own body, why it does not work for me and it should, and why it works for others and not for me. Anger at God, outrage at the beggar on the corner who has five children and keeps them in the cold, and you struggle with a lot of money and effort and fail. This, with the wrath of God, was long and very strong. I did not make peace with this part of divinity for a long time. You end up dissociating to function. I was perfectly functional, but when I got home, I would collapse".*

Another pertinent example is the coding anger together with envy, disappointment, and loneliness, which draws attention to a situation with a high degree of distress for the patient via the density of the coding. The fact that the patient "cannot stand" herself and cannot stand the presence of those who have children translates into dysfunctional absolutist beliefs, which can be explored later through a psychotherapeutic approach.

> *P2:"Even after that, I wanted to say, after the failure, when I tried the first discussion with V., about the problem, about this, right then I suffered and told him that I looked in the mirror, and I wanted to break the mirror because I didn't, I was putting up with it (the failure). I couldn't bear to see myself. I hated myself. I couldn't bear to see myself. Only, in the end, I thought that this was it, that this is what God wanted, that there would be another chance, that there would be something else, only that I couldn't bear for someone else to smile next to me, to be happy when I'm not. I knew I had a problem, but how can someone else's happiness show me that I am unhappy".*

### *3.3.2 Negative emotions*

The emotions expressed by one of the patients are at a very high level of intensity. From her life story (she lost five pregnancies before the treatment), she justifies the feelings of sadness, despair, and, finally, envy towards women who have children, although maybe they didn't want them as much as the patient wants them. The desire is thus exposed in the context of other emotions that the patient relates.

> *P6: "I'm crying differently now than with the five losses. Now it's charging me, and I feel hate inside me after I cry. To the girls who have kids, I want them too. They have kids and act like... I can't get over the fact that someone didn't want kids, and now they do, and it's good, thank you".*

Envy towards women who become mothers is present in most patients, even if it appears in the conversation camouflaged under another, more desirable and perceived more "conventional" emotion, i.e. frustration.

One of the patients recounts when a co-worker, who had another child and was not very convinced that she wanted the second one, became pregnant near the diagnosis of infertility. The coincidence of time and the overlap of medical procedures did not prevent our patient from attending her colleague's event and being close to her, although frustrated by the absence of the child she wanted so much.

*P7: "I think when we found out we were having fertility issues, she got pregnant. I was very happy for her, I mean I was close to her with the ultrasounds and everything, but at the same time I'm also a little envious, although I don't think that's the word, more frustrated, I think that's the right word for me ".*

Resignation is present in the patient's stories, especially when faced with a hopeless situation combined with hopelessness, with a lack of hope.

*P12: "I haven't cried for some time. Yes, I used to cry before, but not anymore for about two years".*

Sadness is a complex and pervasive emotion, which appears in different forms in most responses, has a well-defined contour, and is present because the patient does not have the child she wants or it is present in every moment of daily life and has become a way of life, in which the participation of those around is refused, preferring silence and withdrawal.

*P15: "I am sad that I do not have a child".*

*P13: "I prefer to I keep inside myself. And then I wouldn't be able, like in my moment of anger, to accept other people's questions either. Let me calm down, maybe when I feel the need I say, but at that moment when you're on the ground, no you still need two or three more people to come and ask you things, when you can barely hold on".*

When the patient is also preparing for the scenario in which she will not get pregnant, the dominant feeling is still sadness because she will miss the experience that defines her femininity and worth.

Sadness is present in all the moments spent having a child. It acquires a deep character and marks everyday life at every moment. However, the feeling of deep sadness is important to monitor from the perspective of a potential clinical depression, therefore guided conversations can reveal such a situation.

*P14: "I was also talking to my husband that if I couldn't get pregnant and we would have to adopt, I would remain with my soul a bit like this, sad, because for me motherhood also means carrying that child, feeling it in me, to feel the first heartbeat, to feel how it moves, then to give birth to it and all the way through and know that I gave life to that being".*

Guilt is present in most patient responses, regardless of the source of infertility. There is a stage in the process, which the patients mentioned explicitly, that even in the case of the diagnosis of male infertility, a certain feeling of guilt and responsibility is present on her part. This feeling of guilt, coupled with the mistrust generated by negative medical experiences, is present and difficult to manage if it is not objectively substantiated. It brings an additional element of distress, the patient questioning all her life choices up to that point, whether about health behaviors or about the time chosen to become a mother.

*P9: "Guilt, that was really hard. And in a way I was thinking that why is it happening to me, even though I went for check-ups, that I was very careful about this part, and I was thinking about the first operation, which I had, that we still have I went to the doctor, I didn't stay at home, and yet it happened to me."*

A specific female feature emerged from the conversations with the patients, namely the willingness to share thoughts, emotions and ideas to a greater extent than the male partners. The patients reported that in most cases, their partners preferred not to discuss at all how they perceive the diagnosis and to admit if it causes them significant distress. Moreover, there were situations in which the partner declared that she did not even know if the husband told the close family circle what he was going through, let alone friends or work colleagues. This unavailability to communicate is attributed to the personality traits of the partners or to some implicit feelings of non-fulfilment and lack of control over one's own life.

*P8: "That's how he is, he doesn't talk to anyone".*

This lack of communication does not mean, says the patient, that the partner does not assume his path in the therapeutic process but only refuses to discuss it.

*P8: "...at that moment I was left with the impression that I was to blame and that it was because of me. But I felt that still the assessment wasn't ok, it wasn't done right, it was just a feeling, but still, at that moment, right after, I talked to some of my girlfriends and told them that maybe I to be to blame, I opened up, I took the blame, that doesn't mean he doesn't take it, he just doesn't talk about it". (P8)*

The feeling of guilt disappears when the couple's situation becomes clear. This clarity offers the partners obvious options and knowing what they must do makes things easier for them both emotionally and procedurally.

*P6: "...I felt guilty, I had these thoughts, but now I'm fine. Not knowing the problem yet, I felt guilty, but also after the karyotype, I had a period when... but now I'm fine, we focus on what we must do".*

Crying, as an expression of overwhelming emotions but also as a coping method, is present as a manifestation in most patients. Each displays a hypersensitivity, and even if the interview guide and free conversation are not likely to produce distress, simply recalling the infertility story and key moments triggers an emotional reaction. Crying also signals release from negative emotions, as well as genuine sharing of experiences and closeness to the interlocutor or partner to whom we show our full vulnerability (Halkola et al., 2022).

*P9: "I was very lucky (with my husband) that I cried a lot, wore myself, lost about ten kilograms in a month. I had more, and my hair fell out due to stress".*

*P6: "Now I'm actually crying more from joy than from sadness, that I'm getting closer to the moment when I'm going to do the implantation, for example the last time, when the embryologist called me and told me that she had the embryo and that she was testing it (cries) . I cry differently from now on than at the five losses".*

*P9: "I took everything on myself, and I felt like that, when someone opened the discussion, I felt embarrassed, I felt, I'd get home and start to cry".*

*P10: "But now I am very emotional. I feel like crying when I think about it".*

*P13: "It was very painful then, very painful. I was down for two or three days, crying about everything. I said that's it. Then I took out a loan to go and do the embryo transfer so that I could take care of the IVF, and I said that's it, I don't have any more money. It's over".*

In the carousel of emotions in the most difficult moments, usually around the procedures and after learning some sad news, crying is the way to release negative emotions. The refusal to cry is, in turn, correlated with social factors, with the presence of those around whom the patient no longer wants to cry, considering it a sign of vulnerability and weakness.

*P14: "I thought maybe I was pregnant, and I lost the baby, and I realized that no, there was still some traces left there, and I repeated the test. Part of me was still hoping, but when I saw that it came back negative, I cried well, for about two days, I let it all out, and since then, I haven't cried until now".*

### *3.3.3 Concealing emotions*

In opposition to the full manifestation of negative emotion, we also have attitudes and behaviors that display a deliberately limited emotionality.

*P7: "Emotions... We dig them deep; we pretend not to see them".*

One of the patients explicitly expresses the desire not to expose themselves to other people with painful experiences and explains their choice both through a personal trait, self-assessing themselves as a type of withdrawn person who does not expose themselves, but also through the

fear of being perceived as vulnerable or of being the target of harmful comments. In this case, the stated "harm" can be interpreted in the context of stigmatization, a concept frequently found in the narratives of infertile women closely related to the manifestations of their social environment.

> *P15: "It's not really my style to expose myself like that, that's how I've always been, if I was like at work and started crying because it's a bit harder for me, yes, that would be it too, because I'm weak, but it would also be evil. And in this case, that's why I try to be stronger".*

### *3.4 Couple relationship theme cluster*

Exploring the relationship with the partner in the context of an infertility diagnosis is relevant to the therapeutic approach and the success of the biomedical act. The family and partnership contexts between spouses are closely related to the emotional state of the partners, with an impact on the way of making decisions, on adherence to treatment and last but not least on the relationship with the doctor (Ebrahimzadeh Zagami et al. 2018). The supporting role played by the partner has been highlighted in the biopsychosocial model of infertility (Gerrity, 2001), where it is explained through an exercise to define the roles of "the clarifier" is the person who helps clarify thoughts and emotions in excess, brings clarity to confusion and ambivalence; the role of "the confronter" is intended for the person in the social support network who does not confront the patient, not in a negative and hostile sense, but through clarity and a positive attitude brings arguments and counterarguments for the situation in which the patient presents discrepancies and contradictions in the speech or behavior; and last, but not least, the person who plays the role of "the comforter" is identified, the person who offers comfort, encourages the release of emotions, is the shoulder to complain on, the hug and the emotional warmth that the patient needs. As the author of the counselling guide states, in the patient's social support network, there are people who play all three roles or only one (Donnis, 1984).

Regarding the relationship with the partner, from the applied interviews, the results show that the husband/partner plays a supporting role in most aspects of the patient's life: emotional, financial, and social. The themes identified after grouping the codes are: 1) partner support; 2) intimate dynamics; and 3) relationship uncertainty.

#### *3.4.1 Partner support*

The partner's support is necessary both explicitly and implicitly, states patient P1, who describes the support she received precisely through

the absence of pressure, through understanding the behaviors she displayed, through tact and by offering personal space when it was explicitly requested. Moreover, from the patient's account, the partner took over the household tasks and eased what already seemed like a burden in caring for the family. The anxiety and depression manifested by the patient did not allow her interactions with her family, nor the caring behaviors she practiced before the emotional crisis, and the discreet and patient support of her partner was the solution to get out of this crisis. The manifestation of the personal identity crisis generated by the medical problem touches all the intimate aspects of the patient's life. Although this emotional storm is not explicitly named, it can be assimilated into the roller-coaster identified in other patients' accounts. The effects of the crisis, as the patient describes them, are primarily social and personal dissociation; outside the family environment, she is perfectly functional, but in the intimate space, a tumult of emotions gathers that must be discharged safely. The accumulation of emotions is outlined almost visually and metaphorically by "the rush", "many emotions to unload", and "if I open that door, I will not be able to close it" (metaphorical expression of openness to awareness and exposure of all emotions).

*P1: "Moreover, it helped me a lot that he was patient and stayed with me to advise and help me. I would come home and sit on the phone or hide in a book, and that was it. I couldn't even speak. I didn't want to do anything-nothing. I was lucky he was there and waited for me to get out of this".*

The results of the analysis also show that in none of the accounts do we have situations of abuse or emotional abandonment, at least not explicitly. Only one situation was identified in which the patient feels isolated from her partner, detached, without counting on his emotional or factual support, following a conflict described in detail in the interview. The patient reports how, while missing the family and the partner's support, she felt his actions as abandonment and refused any communication of the needs to the child's father, repeatedly stating, "I am alone in the world" and "you are always alone ". At the declarative level, the patient is willing to give up the relationship with the partner.

*P10: "We are rather atypical, because it was not crazy love, like in adolescence, (...) And then, we take things as they come, that is; you don't want it, why are we still in this relationship if you don't want it".*

Another atypical situation identified in the interviews is the one in which the patient admits that although she is in the process of fertilization, she has doubts about her partner's emotional and physical availability, explained by the medical problems present. The patient's experience is

narrated concisely and without many details, but the difficulties she faces in life choices are evident and contextualized. The excerpt from the interview with patient P12 can be coded with multiple codes "illness", "social withdrawal", "reluctance", "medical treatment", "death, "traumatic episode".

> *P12: "My husband has epilepsy. He is a very withdrawn man, it was very difficult for him to enter a relationship with me, until we got married, he was afraid that I would see him as a sick man, and he would not have wanted to tie me to him, that is, he would have wanted me to have a son with a perfectly healthy man. We have been trying to have a child for three or four years now. Well, probably this thing too, his thinking, if we're going to have a child, is he going to be healthy, he can't be a present father like he needs to be, because his father also died quite young, he had multiple sclerosis".*

### *3.4.2 Intimate dynamics*

The dynamics of the intimate life are described in the sense of being close to the partner, of being aware of the difficulties they encounter as a couple, but also through the metaphor of "welding" the relationship between the partners.

In most cases, the relationship between the two is stronger, deeper and with more anchors of intimacy. However, there are also crises in which the patient perceives the level of behavioral change and has the availability to work with dysfunctional emotions and cognitions in therapy. The change he feels in the couple is not in a positive sense, and through the conversation with the partner, solutions have been sought that suit both partners.

> *P14: "He told me at one point that I had changed a little and not necessarily for the better, because my focus was on the baby, and automatically neither, that we discussed this in therapy, nor intimate relationships between us they were still the same, there was a goal in my mind and everything was planned for ovulation, and I was also much more irritable, I picked on every little thing, and I didn't recognize myself anymore".*

In the vast majority, patients report an improvement in the relationship with the partner, especially in terms of communication and the fulfilment of both expressed and implicit needs. The codes used to analyze the partner-related discourse are equivalent to the ideal attribute sets "protection", "care", "attention", "help", "and presence".

> *P16: "(relationship) has changed for the better, my husband is more protective now, yes, he is more caring. He is more attentive to me, to help me, to jump before he was, but less. Now he is much more caring. (...) Emotionally, he didn't enter discussions because he knew it hurts me, and I couldn't talk much. Nevertheless, he was by my side, and I'm really glad to have a husband like that".*

### *3.4.3 Relationship uncertainty*

The relationship of the couple is put to the test. One of the patients expresses this concern, related to the information she has from the relationships of other couples that did not last.

> *P13: "My husband worked more, he put his energies, his thoughts elsewhere and I, if I left room for the bad, I stayed like this, afloat, but we don't have an evening not to talk, let us see what will happen, I really thought that it didn't affect us, that I heard many couples who parted or reproached each other".*

### *3.5 Social support theme cluster*

Social support is one of infertility patients' most important mediating stress elements. It is defined as gestures of support or comfort offered by people close to the patient to help him cope with biological, psychological and social stressors (Gerrity, 2001). Biopsychosocial theory suggests that social support and coping styles are two very important tools in mediating the psycho-emotional effect of infertility. The literature suggests that a good social support system can contribute to managing dysfunctional emotions after an infertility diagnosis, and low social support exposes patients to stigma and distress (Höbek Akarsu & Kızılkaya Beji, 2021; Taebi et al. 2021). Regarding family support, studies suggests that family members often have little information about infertility. Even if they have the information, they often cannot express themselves adequately. As a result, communication is poor (Gerrity, 2001). Regarding communication with the social support system, studies show that women give and receive more support from various sources and are much more satisfied with the support they receive from family, friends and loved ones than their partners (Iordachescu et al. 2021; Hasanpoor-Azghady et al. 2019; Gerrity, 2001). However, women are more likely to receive inappropriate advice or negative comments from those close to them.

### *3.5.1 Pressure and anxiety*

Psychotherapy or support groups are not very present in the patients' narratives in the studied sample.

However, the reference to the support group and its beneficial effects is present in the account of one of the patients.

> *P1:"Talking healed me too, we managed to create a support group in Iaşi, with volunteer psychologists, who came to our discussions, learned alongside those who came to the group. Now most of them have managed to have children, there are only two girls who still don't. Communication helps, it stayed, now there is a Facebook group with over 1000 people, with a system to find medicines when*

*needed, with a support system when needed, D. is, it's an example, also from the group, and so on, at least there's someone there to give you a message of encouragement".*

Counselling and psychotherapy recommendations include assessments of the patient's existing coping strategies and support networks, simultaneously considering the interdependence of the two dimensions. One of the patients captures this need in her answer, stating that she feels that a specialist can help her overcome emotional difficulties on the one hand. On the other hand, she says she feels best when alone and does not want anyone's company.

*P3: "I've thought many times (that I need a therapist) that sometimes I feel such pressure, only with a psychologist I think I can solve it (cries). Do I want it to be quiet? To be quiet. Safety. I do not know. I don't know how to say. I like to do everything, just to be alone. I prefer alone, to do everything, but alone, to go, to everything. I don't like the surrounding and crowding like that. I want to be alone".*

### *3.5.2 Judgment and isolation*

The data obtained from the our interviews show that the patients more often tend to address their life partners and are reluctant to talk to friends or family about the procedures. One of the communication problems identified is the need for more attention and information that they, the patients, do not feel they can supply, nor do they have the emotional availability to educate the family to understand what they are going through and react in a supportive manner.

*P2: "I would like them to pay attention to what I tell them, now I tell them what I do, how I do the treatment, I explain some steps, in two days they will forget. I only speak to my support group, they understand me, they went through the same problems".*

Studies suggest that women avoid certain social interactions because they are constantly reminded of their infertility diagnosis; these are usually social gatherings or events surrounding the birth of family or friends' children and are difficult to manage (Jordan & Revenson, 1999). Our study confirms this avoidance mechanism, but it causes distress to both partners, especially if it is about children in the family.

*P7:"Well, these, who bother me with my nephews, I tell them that they bother me and hurt me, and he asks me, how should I deal with that child? And your sister is going to come here with her parents and kids, and that's an issue for me, I can't understand why she is like that."*

### *3.5.3 Selecting the social setting*

Our data show that after speaking to their partner, patients tend to address to the social group of friends with whom patients do not hesitate to share what they are going through in the experience of infertility, especially in cases where there are people with similar experiences. However, there are also particular situations when the patient or the couple distance themselves from the social group ue to communication deficiencies, unfulfilled expectations or even hurt feelings by those close to them.

*P13: "I don't know, I consider that not everyone is with me. I don't trust, and then I don't think once you turn your back, it starts to get talked about, and I don't need to know or keep it in. I'd rather keep it to myself".*

Patients' sisters are usually the family members who provide the most emotional support.

*P15:"Discussing, my sister is very close, with my husband, and I with myself, I try to overcome, that I think you must work on yourself when it's like that. I try to console myself, that it will be fine, to trust".*

*P13:"I talk about it with my sister the most, with friends, no, honestly. Because I don't have very close friends to talk to about this and the only one, I talk to is my sister. I really talk to her all the time. She has no children; she is younger than me. And being a doctor, she understands me, she understands things differently, even if she is in a different field".*

### *3.6 Coping strategies theme cluster*

Coping refers to a person's efforts to manage internal and external pressures that consume their resources (Halkola et al., 2022); efforts are focused on emotional coping, planned problem-solving, seeking social support, distance from the problem, showing self-control, escapism and avoiding the problem, cognitive reframing of the problem or confrontation, with negative connotations, suggests Donnis (1984) and Halkola et al. (2022) studies.

Regarding personal coping resources, patients generally tend to prefer action to non-action, (Donnis, 1984), such as communicating with loved ones or reference persons, even if it is only the partner, achieving a certain level of understanding of the situation they face, where no matter how much medical or financial effort the couple puts in, there is always the possibility of failure. Making absolutist thinking more flexible is suggested by studies as a useful intervention direction for couples facing infertility and for whom other options (adoption, for example) may be considered. In the case of the interviewed patients, the identification sub-themes are centred around personal care (self-care), both physical and mental, manifested through

behaviours undertaken consciously, constructively and through individual efforts or with the help of reconfiguration specialists of dysfunctional cognitions.

Coping in infertility is a very important dimension in the healing path, and the qualitative approach identifies useful directions for counselling, given the diversity of approaches, regardless of whether we are talking about female, male or mixed infertility (Halkola et al., 2022; Romeiro & Caldeira, 2019; Rooney & Domar, 2018).

One of the patients finds emotional support in an activity she borrows from her grandmother, talks about tailoring in the sense that it brings her comfort, and is supported by a partner who immediately responds to the need for protection and calm. However, even positive gestures elicit deep emotional responses. The patient breaks down in tears when she recounts that she started sewing to forget the traumatic events.

> *P6:"I started tailoring. I had found someone on Facebook who sells materials, my grandmother was a seamstress and as a child I had no business with that. Then, after I lost my third pregnancy, I said I would like to buy a sewing machine. (crying) And I told I. and he immediately got me a sewing machine. It's like that, I feel when I go in there, in my room, it's my place... (crying) It costs skirts, I. laughs at me, we hope to make children's clothes too..."*

The patient identifies a dysfunctional behavior, says that she has a problem with the way she spends the family budget, and is aware that her partner, who is a major financial contributor to the couple, is very dissatisfied with this behavior: *"I don't know if it is related to putting the card (when I go shopping) I don't even eat anything I bought, I put them in the cupboard and after a month I throw them away because they are expired. But I buy them, and I leave the store and leave a few hundred lei there and I get home and I know they are waiting for me, "how much did you give"? oh..." (P7)*

Only one patient among those interviewed notes a secure attachment to the pet, which she prefers over the company of family members or her partner. Moreover, in her account, there are also dramatic moments, which negatively mark the relationship with family members who do not understand and respect her attachment to the puppy that she considers her first child *"... the puppy could die, that she had a stroke and was being treated, she really could die then, honestly, I prayed to God to give me the baby when he knows but not to leave me in despair that the puppy will die and I will be left alone in the world." (P10)*

Giving up the things that gave both partners pleasure and built a secure attachment is reported by one of the patients, who is aware that the couple's dynamics have changed in this regard. However, at the same time, he also admits that he cannot find the motivation to resume a couple's habits

and look for outlets in various activities without identifying things that give him pleasure.

> *"We were both dancing. We also met at dances; we both did Latin. And ok, the pandemic also came, but before we went to dance classes (...) we also used to dance around the house, music, I don't think there was a day when we didn't dance, and we didn't really do that anymore. I was doing yoga before, I also tried during the pandemic, I kept up for a while after which I didn't keep up, same with sports, I was going to the gym before the pandemic, the pandemic came, a period passed when I didn't played sports, by default I also gained weight because we started ordering them, and I'm still trying to get rid of the kilos I gained then. (...) Dance, sports, I don't know why I can't find the motivation to stick to sports. I had many moments when I got back together, when I said, that's it, it's ok, I'm holding on." (P14)*

## 4 Discussions

One recent global public health analysis, The Lancet Global Health (2022) suggests a divide between two realities in terms of reproductive health; on the one hand, high fertility rates, limited access to or reduced use of contraception and a pressing need for information related to reproductive health and family planning reported in many of the under- and medium-developed countries.

However, on the other hand, we have another worrying aspect – infertility, which currently affects over 48 million couples and over 186 million people globally (Duffy et al. 2020; Ombelet, 2008). The cited studies assess the impact, both social and psychological, beyond economic, of infertility on couples or people with this diagnosis, The Lancet Global Health (2022).

The Global Health report argues that people diagnosed with infertility will experience at least stigma and social rejection, shame, ostracism, anxiety, depression and low self-esteem. Particularly in cultures where continuing the family line through biological children ensures a social status, marriage, transfer of material rights or ensures a person's financial future or even social security in the third age (Ombelet, 2008).

Population studies in industrialized countries suggest that the lifetime prevalence of infertility is 17– 26% and that only half of the infertile couples will seek medical services (Schmidt, 2006). For many infertile couples, the diagnosis and treatments represent a challenge to interpersonal relationships, creating significant distress and existential crises. The literature indicates that women, unlike men, tend to have lower self-esteem, are more

depressed, report lower satisfaction with the quality of life, are more likely to blame themselves for infertility, and most commonly consider a completely unacceptable diagnosis (Schmidt, 2006; Bolton & Gillett, 2019). Guilt, as a maladaptive emotion, resignation or frustration, is also present in our study, manifest or implicit, especially in patients who discuss their infertility diagnosis under social pressure.

The literature suggests that individuals and couples who start fertility treatments report better psychological status than the general population average (Schmidt, 2006). However, several ongitudinal studies have investigated the impact of infertility and associated treatments in couples whose ART has not been successful. For example, a Swedish longitudinal study, (Sydsjö et al. 2005), suggest that marital relationship, communication, conflict resolution, intimate relationship and other aspects of social insertion are to be taken into account when assessing the psycho-emotional status of patients. The Sydsjö study conducted research on a sample of 45 infertile couples for 1-5 years after the last IVF cycle and showed that marital satisfaction was not significantly affected by the stress associated with the medical procedures (Sydsjo et al., 2002). After the completion of treatment, couples who did not achieve a pregnancy reoriented to other solutions, such as adoption (Sydsjo, 2002; Sydsjö et al. 2005). Our results suggest that medical procedure failure is more stressful for couples. Furthermore, our data support the hypothesis of the Swedish study that the couple's relationship is not significantly affected by stress if the benefits in the marital relationship come from a clear shared goal and a desire to move forward, regardless of the outcome of the medical procedures. Furthermore, in our study, respondents indicate that cohesion and harmony in the couple are valued, regardless of the medical results.

One of the variables assessed in several infertility studies (Sydsjo, 2002; Gerrity, 2001; Imeson, 1995), is the perception of parenthood. The literature suggests that an unrealistic or overly positive image of parenthood may lead to disappointment once they become parents. However, no hard data suggests that the risk of partners being disappointed correlates strongly with the length of time they faced infertility. On the contrary, couples who maintained a functional relationship and balanced expectations throughout the treatments are better prepared for raising a child, argue the authors of the Swedish study (Sydsjö et al. 2005). From the perspective of our study, we investigated the parenting expectations with an open-ended question that encouraged the respondent to define the parenting role, particularly the perception of motherhood.

Literature suggests that although, in most cases, the relationship is not affected by treatment or the disappointment of its failure, it is most likely because couple dynamics and not individual well-being go through the assessment (Donnis, 1984; Rockliff et al. 2014). This distinction is especially important for infertility therapy and counselling, where individual and group approaches can be used simultaneously for enhanced therapeutic effects. The difference between the functional relationship of the couple and the emotions felt on a personal level by each person are also noticeable in our study's sample, where there are distinctions between men and women, especially on the free expression of feelings, thoughts and emotions.

## 5 Conclusions

The study aims to provide as complete a perspective as possible on the life experience with infertility diagnosis from the study sample and to explore possible directions of counselling and psychological intervention for infertile couples. The results confirm the findings in recent studies, namely that although certain themes and infertility narratives are common to those in anxiety and depression (mood disorders, hypersensitivity, isolation), others are specific to infertility (self-blame, shame, personal failure goals, questioning the individual value, social stigma associated with infertility, social and cultural pressure). In addition, the results suggest that the lived experience of infertility, regardless of its cause, is complex and moderated by significant emotional and relational factors, which confirms the hypotheses of recent studies to consider the experience of infertility as multidimensional and multifaceted.

The present study has strengths and limitations. One strong aspect is that qualitative approach is increasingly employed in studying infertility narratives, with implications in patients' management in clinical settings. The phenomenological methodology offers valuable insights to healthcare providers as to how the lived-in experience of infertility is impacting the patients and the biomedical outcomes of fertility procedures.

However, the size of the sample cannot suggest a generalized approach to infertility as it is a unique and individual experience, and further studies are required in the field.

## 6 Conflict of Interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

## 7 Author Contributions

All authors listed have made substantial, direct, and intellectual contributions to this research, and approved it for publication.

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**Table 1.** Demographic data

| **Demographics** | **Variables** | **Values** |
|---|---|---|
| Age | Median (SD) | 33.7 (3.2) |
| Education | Secondary | 2 (11.76%) |
| | High-School | 2 (11.76%) |
| | University | 8 (47.05%) |
| | Post-graduate | 5 (29.41%) |
| Marital Status | Married | 15 (88.23%) |
| | Single | 2 (11.76%) |
| Family income | Low[1] | 2 (11.76%) |
| | Medium[2] | 8 (47.05%) |
| | High[3] | 7 (41.17%) |
| Parenting status | Children | 2 (11.76%) |
| | No children | 15 (88.23%) |
| | Pregnant | 0 |
| Infertility length (years) | Median (SD) | 4.11 (2.8) |
| Infertility cause | Female | 5 (29.4%) |
| Male | | 5 (29.4%) |
| Mixed | | 2 (11.76%) |
| Unknown | | 5 (29.4%) |

1 < 1.000 euro; 2 - 1.000 euro; 3 > 1.000 euro
The infertility diagnosis is mixed (female, male or of unknown etiology), with multiple treatments before the current one.

**Table 2.** Theme clusters and themes.

| **Theme Clusters** | **Theme** |
|---|---|
| Definition of motherhood | The desire of having biological children<br>The imperative need to have a child (obsession)<br>Perception of femininity<br>Life fulfilment. |
| Infertility journey | The patient's immediate reaction after diagnosis<br>The perception of life changes after the diagnosis |
| Emotions | A contrasting array of emotions switching between highs and lows<br>Negative emotions Concealing emotions |
| Couple relationship | Partner support<br>Changes in intimate and relationship dynamic<br>Insecurities and anxiety regarding the relationship |
| Social support | Pressure and anxiety from family members' misunderstanding of the diagnosis<br>Judgement and isolation Selectiveness in social settings |
| Coping strategies | Behavioral coping strategies Managing negative thoughts Self-care approach |