

The Unique Challenges in Counseling Infertile Individuals and Couples

A DISSERTATION
SUBMITTED TO THE FACULTY OF
UNIVERSITY OF MINNESOTA
BY

Ju-Ping Huang

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

Dr. Kay Herting Wahl, Adviser

June 2013

Acknowledgement

This dissertation is a collective effort for which many individuals should be thanked. I would like to give my hearty thanks to those who have assisted and accompanied me during this journey:

My interview participants, who willingly and openly shared their experiences and wisdom.

Dr. Kay Herting Wahl, my advisor, whose commitment to my professional development throughout my graduate school, writing support and thoughtful comments to my dissertation, as well as ongoing encouragement have been invaluable and empowering to me personally and professionally.

Dr. Linda Hammers Burns, Dr. Thomas Skovholt, and Dr. Michael Goh, my committee members, for their stimulating questions, insightful feedback, and encouragement.

My research team, Heather Bemmels and Elsa Gaikwad, who willingly volunteered their time to assist with data analysis.

My CSPP peers and fellow interns at the University of Illinois of Chicago for their continuing support and encouragement, especially Chia-Chen Tu, Juihsien Kao, Suzanne Stambaugh, Hannah Bush, and Edel Mauritzen.

My parents and siblings, who have offered support and encouragement throughout my graduate study.

Lastly, and most importantly, my beloved husband, Chee Ming Yong, whose unconditional support, encouragement, and belief in me have given me strengths to overcome many obstacles in this long process.

Abstract

This current study explored the unique challenges encountered by counselors and the adapted strategies the counselors used when working with infertile individuals and couples. A total of 17 licensed practitioners (psychologists, clinical social workers, clinical professional counselors, and marriage and family therapists), with formal training on infertility counseling and with clinical experience in offering infertility counseling services to infertile clients participated in a semi-structured face-to-face interview. The participants responded to questions regarding their clinical experiences in working with infertile clients, overall challenges in infertility counseling, facilitation of infertile clients' emotional reactions, issues with self-disclosure, experienced ethical dilemmas in infertility counseling, a memorable case, their adapted strategies to resolved the encountered challenges, and etc. The data was analyzed by the utilization of the Consensual Qualitative Research (CQR) methodology (Hills, Thomson, & Williams, 1997; Hills & Williams, 2011). Four major themes regarding counselors' encountered challenges emerged from data analysis, including challenges related to infertility counseling education, challenging clinical issues, ethical concerns in infertility counseling, and the effect of counselors' personal experiences on the counseling process. One theme addressing counselors' strategies was identified, suggesting a need for adapting an interactive, solution-focused, flexible, and integrated approach in order to offer effective services to infertile clients. The results of this study are discussed and recommendations for training, credentialing, practice and future research are provided.

Table of Contents

Acknowledgement.....	i
Abstract.....	ii
List of Tables.....	iv
List of Appendices.....	v
Chapter 1: Introduction.....	1
Chapter 2: Literature Review.....	19
Chapter 3: Methodology.....	55
Chapter 4: Results.....	65
Chapter 5: Discussion.....	107
Tables.....	135
References.....	139
Appendices.....	160

List of Tables

Table 1: Demographic Characteristics of Participants.....	135
Table 2: Domains and Categories Extracted from Participants' Responses.....	137

List of Appendices

Appendix A: Invitation Letter.....	160
Appendix B: Demographic Questionnaire.....	162
Appendix C: Semi-Structured Interview Protocol.....	164
Appendix D: Consent Form.....	166

Chapter 1: Introduction

Statement of the Problem

This paper is designed to explore unique challenges encountered by counselors and the adaptive strategies they used in working with infertile individuals and couples. To understand these challenges and adaptations, the topic of infertility will be explained and explored. The Center for Disease Control and Prevention (CDC; 2012) and the World Health Organization (WHO; 2009) define that infertility or involuntary childlessness can be primary or secondary. Primary infertility is defined as the inability to conceive a first child or carry a pregnancy to full term for either partner after one year of regular sexual relations without contraception. Secondary infertility is defined as the inability to conceive or carry a pregnancy to full term after one live birth while desiring another pregnancy (CDC; WHO, 2009). For women after the age of 35, the period of defined infertility is shortened to six months to address age related infertility decline and to encourage earlier medical interventions (CDC; WHO).

Disrupted reproduction or involuntary childlessness affects ten percent of women between the ages of 15 to 44 in the United States and other developed countries while the incidence of infertility is higher in underdeveloped areas of the world; as a result, infertility in women is ranked the 5th highest serious global disability (WHO, 2009), and the American Society for Reproductive Medicine (ASRM) in 2006 defined infertility as a disease. Infertility has received increasing attention in the media and in research as a result of the high prevalence and the profound impact of infertility on individuals and couples. Various established and potential causes of infertility include genetic abnormalities, aging, medical conditions, behavioral factors, and exposure to

environmental and occupational hazards (CDC, 2012). The CDC also has recognized some preventable risk factors of infertility, including forbids and untreated sexual transmitted diseases, and has suggested that the proportion of preventable infertility can be substantial. Thus, the CDC announced infertility as a *public health priority* in the Unites States, plus the CDC is in the process of developing the National Health Action Plan for the Detection, Prevention and Management of Infertility (2012).

The National Survey of Growth estimates that between 2006 to 2010, 7.4 million American women (11.9%) of all marital statuses, in an age range from 15 to 44, have received infertility services, including: medical advice, medical help to prevent miscarriage, reproductive function examinations, ovulation drugs, and artificial insemination (CDC, 2010). In other words, at least one in ten women from 15 to 44 years old seeks medical assistance because of her infertility issues. Moreover, among these women, 1.5 million married women of reproductive age (15-44 years old) have experienced some form of disrupted reproduction (CDC). Thus, 6.0% of married couples encounter female infertility issues (CDC). The CDC data further identifies an increasing trend for women to encounter infertility as they age. However, the CDC recognizes that the data does not include the women who stopped trying or experienced infertility in the past (CDC, 2012), and the above data also does not reflect married infertile males. Thus, the infertility data of the CDC generated in 2010 may have underestimated the total amount of infertile individuals in the United States. In the CDC data, only infertile females who seek medical assistance are counted. The data found that 1/3 of infertility is accounted for by female issues, 1/3 by male issues, and another 1/3 by combined issues (CDC, 2010; WHO, 2009). Thus, if including individuals who have limited access to

health resources, who cannot afford infertility treatment financially, or who decide not to undergo intensive and intrusive investigations and treatments, the prevalence of infertility may be much higher.

Impacts of Infertility

Infertility is often referred to as “frozen dreams” (Mahlstedt, 1985; Rosen & Rosen, 2005), a life crisis (Atwood & Dobkin, 1992; Gibson, 2007; Rosen & Rosen) or multiple losses (Gibson, 2007 & 2008) with significant and prolonged impact on life. Infertility is a medical condition that brings multiple psychological and sociological effects (Watkin & Baldo, 2004); infertility, therefore, is defined as a biopsychosocial crisis (Van den Broeck, Emery, Wischmann, & Thron, 2010). As a result of infertility, infertile individuals and couples face psychological, physical, financial and social consequences (Gibson, 2007; Watkins & Baldo, 2004); Infertile individuals’ feelings, emotions, thinking, and beliefs are often challenged by the consequences of being infertile (Becker, 2000; Gibson & Myers, 2000; McQuillian, Greil, White, & Jacob, 2003).

Infertility strikes infertile individuals and couples profoundly. Victor Frankl (1946) in his book, *Man’s Search for Meaning*, asked “what is suffering and why am I experiencing it?” He was reflecting on his imprisonment in Auschwitz and his struggle to find reasons to live. Similarly, “suffering and why am I experiencing it” are questions that infertile individuals and couples often ponder (Burns, 2005). Although their infertility experience is not as intense as imprisonment in a death camp, infertile individuals and couples struggle with making meaning of their involuntary childlessness and its profound impacts. Furthermore, the experience of infertility not only impacts

infertile individuals and couples, but their partners, siblings, parents, and peers (Burns). For instance, infertile individuals' intensive reactions, such as anger, depression, guilt or shame, often surprise their family members. Peers and siblings feel awkward inviting infertile individuals and couples to attend baby showers and birthday parties for children, but also do not want to exclude them from social or family events. Grandparents may desire grandchildren, adding more stress for infertile individuals and couples. Infertility strikes infertile individuals and their family and friends negatively in direct and indirect ways (Burns).

Infertility can strike any individual, regardless of marital status, sexual orientation, racial/ethnic backgrounds, or disability. When individuals are first diagnosed with infertility, their response is usually shock or surprise (Burns, 2005; McQuillan et al., 2003). As time goes on, especially after multiple failed attempts at fertility treatment or miscarriages, infertile individuals' feelings often become more devastated and bitter (Burns; Shapiro, 1993). Not only losing the experience of child rearing, infertile individuals also experience losses in many aspects of their life, including life's goal, pregnancy experience, fertility, personal identity, sex identity, etc. (Harris & Daniluk, 2010). The loss of personal control and loss of confidence are often reported, reflecting on the inability to become pregnant or carry a baby to term (Gibson 2007). As a result of multiple losses, infertile individuals experience complex feelings, including sadness, anger, guilt, inferiority, loneliness, fear, moodiness, shame, betrayal, helplessness, powerlessness, and low self-esteem (Atwood & Dobkin, 1992; Daniluk, 1997; Gibson). Among infertile individuals' complicated feelings, bereavement is fundamental as a result of multiple losses associated with infertility (Burns; Gibson). Not surprisingly,

infertile individuals often have similar bereavement feelings and reactions to those facing the death of loved ones (Gibson & Myers, 2000).

Infertile individuals may experience identity crisis since parenthood is viewed as an entry into adulthood (Burns, 2005), and society expects individuals to become parents as they grow into adulthood (Atwood & Dobkin, 1992). Consequently, feelings of self-worth, sexual identity, and the meaning of marriage are usually confirmed through parenthood, and a failure at fulfilling the role of a parent may lead to a major reconstruction of identity (Gonzalez, 2000; Shepherd, 1992). In addition to the struggle to fulfill the social expectation, infertile couples also cope with the stigma of childlessness. Childlessness is a disgrace in many cultures; childless individuals and couples are often viewed as immature, selfish, unhappily married, career-orientated, and psychologically maladjusted (Gibson 2007; Lampman & Dowling-Guyer, 1995). Such distorted viewpoints on childlessness often lead to infertile individuals' alienation and inability to relate to their peers, siblings, and parents (Burns, 2005). A loss of close relationships with peers and family members is often a consequence (Harris & Daniluk, 2010).

Once infertile individuals and couples decide to pursue infertility treatments, more psychological, physical, and financial consequences follow. Though more advanced fertility treatments have been developed and have given infertile individuals more opportunities of family building, the experience of fertility treatment may create another layer of distress. The treatment experience is described as an "emotional roller coaster" (Burns, 2005; Watkins & Baldo, 2004). Infertile individuals can experience intense, out of control, wavelike emotions that occur without warning (Watkin & Baldo). As couples decide to pursue treatment, they organize their lives around their efforts to conceive. As a

result of planned intercourse, couples often report the loss of intimacy, sexual passion, and spontaneity, and some couples develop sexual dysfunction (Peterson, Gold, & Feingold, 2007).

Gender differences in emotional reactions to infertility and infertility treatment are also recorded. Females report lower self-esteem and more negative emotions than their male partners (Daniluk, 1997), and females also carry the physical marker of failure at the start of each menstrual cycle, while males do not experience failure physically. Males are often shocked by their wives' intensive reactions, and these men tend not to communicate their frustrations with their partners. Peterson, Newton, Rosen, and Skaggs (2006) claim that infertile men tend to distance themselves from the pain of infertility and at times may appear less affected by infertility. However, Moreno-Rosset, del Castillo Aparicio, Ramirez-Ucles, and Martin Diaz (2011) assert that men are equally affected by infertility but may experience difficulty with identifying and describing their emotional reactions toward infertility. Therefore, gender differences in responding to infertility create tension between couples (Edelmann & Connolly, 2000; Gibson & Myers, 2000 & 2002).

In sum, infertile individuals and couples suffer from multiple consequences as a result of involuntary childlessness. To assist with infertility issues, various researchers have suggested that counselors who work with females and couples should attain medical knowledge of infertility, fertility treatment options, and repercussions of infertility (Burns, 2005; Edelmann, 2008; Peterson et al, 2007; Savitz-Smith, 2003; Williams, Bischoff, & Ludes, 1992). However, it is noted that most counselors and psychologists do not have basic medical knowledge of infertility and treatment options (Edelmann; Kurpius &

Maresh, 1998; Watkin & Baldo, 2004; Williams et al.). Williams et al. suggest that the medical knowledge of infertility helps counselors have a better understanding of multiple stresses of infertile individuals, and counselors can better direct their infertile clients toward proper medical treatments.

Development and Scope of Infertility Counseling

Prior to 1980s, infertility was viewed as a psychosomatic condition reflecting women's unresolved feelings and ambivalence about motherhood or their relationships with their own mothers (Covington, 2006). Treatment was typically offered by psychiatrists who were psychoanalytically trained and were usually males. Menning (1980) started the consumer movement and asserted that emotional distress was a consequence instead of a cause of infertility; meanwhile, Menning also established an organization, RESOLVE, to offer emotional support and education to infertile women and men. Gradually, literature on infertility recognized the psychosocial effects of infertility and began to emphasize the importance of supportive counseling for individuals who underwent fertility treatment (Covington).

Infertility counseling was developed and included as part of reproductive treatment in the early 1980s as a result of the first in vitro fertilization (IVF) birth in the United Kingdom (UK) in 1978 (Covington, 2006). The Warnock Committee in the UK in 1984 recommended that counseling should be available to infertile couples at any stages of fertility treatment (Department of Health and Society Security, 1984). The UK Human Fertilisation and Embryology Authority (HFEA) in 1991 ordered counseling to be offered to intended parents using third party reproduction or requesting certain reproductive treatments. The HFEA also requested counseling for donors who were involved in third

party reproduction (Human Fertilisation and Embryology Act, 1990; Human Fertilisation and Embryology Authority, 1991). The HFEA clearly defined the goal of counseling to be: assist infertile couples with decision making and offer psychological support throughout all stages of fertility treatments (HFEA, 1991 & 1995). Since these early beginning in the 1980s in the UK, infertility counseling has continued to evolve globally. Professional associations of infertility were formed in major countries, e.g., USA, Australia/New Zealand, and later in Germany, Japan, Greece, Switzerland, Canada, etc. Several international professional organizations also have been established, such as Psychology and Counselling Special Interest Group of the European Society for Human Reproduction and Embryology (ESHRE) and International Infertility Counseling Organization (IICO).

Specifically, in the USA, a group of mental health professionals of the American Fertility Society [later the American Reproductive Society of Medicine (ASRM)] had the first meeting to discuss the issues of infertility counseling in 1985. The Psychological Aspects of Infertility Special Interest Group was established in 1987 and later became the Psychological Special Interest Group in 1995 to focus on the psychological, social, and emotional perspectives of infertility (Haase & Bylth, 2006). Now known as the Mental Health Professional Group (MHPG), there are 319 members from various disciplines. In 1995, the ASRM/MHPG also developed the qualification guidelines for mental health professionals in reproductive medicine in response to the growing need for infertility counseling services: 1) graduate degree in a mental health profession; 2) license to practice; 3) training in the medical and psychological aspects of infertility; 4) one year of supervised clinical experience in offering infertility counseling; 5) continuing education

in infertility counseling. Currently, the ASRM/MHPH has a committee, the Professional Development Taskforce, to identify educational and professional resources for members of ASRM.

Despite identification of complicated clinical issues in infertile individuals' (Atwood & Dobkin, 1992; Daniluk, 1997; Gibson, 2007; Watkins & Baldo, 2004); various skills needed to provide effective infertility counseling (Applegarth, 1999; Boivin, 2003; Gordon & Barrow, 1999; Shapiro, 1999); the advocacy of the ASRM/MHPG and other professional organizations; and legislation requiring infertility counseling in some countries (e.g., Australia), there are currently no requirements, certification, or standardized specialization within any mental health field or mental health professionals who counsel infertile clients in the USA (Klock, 2006). In addition, no national or state policy or regulation in the USA requires infertility clinics to provide or recommend counseling to their patients. In fact, approximate 75% of reproductive clinics in the USA fail to offer information about mental health services to infertile patients (Holley, Bleil, Shehab, Nachtigall, & Katz, 2012).

The British Infertility Counseling Association (BICA) was established in 1988 in the UK; the BICA recruited mental health professional from various disciplines which offered counseling to infertile patients. In 2009, the HFEA determined that practitioners in the field of infertility counseling needed to demonstrate their specialist competence and needed to be accredited by the BICA. As a result, with the support of HFEA, the BICA developed the first accreditation schema of infertility counseling in the UK and worldwide. In the same year, the BICA began to offer two categories of accreditation to its members, including Accredited Member and Senior Accredited Member, based on

members' level of clinical experiences in offering infertility counseling (BICA, 2012). Currently, the BICA provides six categories of membership and three levels of accreditation, and accredited counselors are required to apply for re-accreditation every three years to ensure their competence to practice infertility counseling (BICA).

Infertility counseling in Australia and New Zealand also evolved in 1980s, and the Australia and New Zealand Infertility Counseling Association (ANZICA) was founded in 1989. Unlike BICA who recruits practitioners regardless of their licensure status, membership of ANZICA only applies to licensed mental health practitioners (Haase & Blyth, 2006). Furthermore, Australia and New Zealand grant donor-conceived individuals the legal rights to identify their donors and to offer donor-linking counseling for those who request their donors' identity (Infertility Treatment Authority of Australia, 2001). Thus, the ANZICA has developed guidelines for donor linking counseling and suggested infertility counselors to protect the interest of donor-conceived individuals, recipient parents, and donors (ANZICA, 2013). As a result, infertility counselors in Australia and New Zealand not only work with infertile individuals at all stages of infertility and fertility treatment but their services extend to donor-conceived individuals and donors, years after fertility treatment.

Historically, infertility counselors were expected to offer supportive counseling to infertile couples and to assess appropriateness for fertility treatment (Applegarth, 2006); however, the practice of infertility counseling has become more complicated in efforts to respond to infertile individuals' multiple needs (Peterson et al., 2012). Strauss and Boivin (2002) as well as the European Society of Human Reproduction and Embryology (ESHRE, 2013) suggest psychological support for infertile individuals to be a step-wise

process, entailing patient-centered care, infertility counseling, and psychotherapy.

Peterson et al. define the components of each level of care. Patient-centered care includes information gathering and analysis as well as decision making counseling; patient-centered care is suggested to be integrated into fertility treatment and to be available to all infertile patients throughout fertility treatment. Infertility counseling includes decision making counseling, support counseling, and short-term crisis counseling. Psychotherapy includes long-term crisis counseling and therapeutic counseling. The researchers and clinicians also recommend physicians and medical staff to be involved in patient-centered care but suggest that only trained mental health professionals can provide support counseling, crisis counseling and therapeutic counseling. It is suggested that medical and mental health professionals should assess infertile patients' mental health needs and connect patients with appropriate levels of professional psychological support (Burns, 2007; Persons et al.; Van den Broeck et al, 2010).

The development of third party reproduction and fertility preservation further expands the role of infertility counseling services to fertile individuals who use or are involved in fertility treatments, such as gay and lesbian couples, single women, cancer patients, donors, surrogates, gestational carriers, and donor-conceived individuals (Applegarth & Kingsberg, 2006; Hanafin, 2006; Quinn, Vadaparampil, Lowrey, Caprice Knapp, & Bukulmez, 2011; Thorn, 2006). The ASRM and ESHRE have developed guidelines for third party reproduction education, assessment, and preparation that advise counselors to safeguard the best interest of all involved parties in assisted reproduction. It is also recommended that when counselors discuss the option of third party reproduction

with infertile clients, options of childlessness, adoption, and fostering should be presented and fully explored (Covington, 2006).

Another domain of infertility counseling is cross-border reproductive services. Different countries have different regulations about assisted reproduction and third party reproduction. Some countries ban certain forms of gamete donation and surrogacy (Gurtin, 2011; Thorn, 2006) and/or exclude certain groups from using assisted reproduction (Shenfield, Pennings, De Mouzon, Ferraretti, & Goossens, 2011). As a result of legal restrictions on third party reproduction or gamete donation, some infertile individuals turn to foreign countries to pursue fertility treatment (Gurtin; Thorn), and donors and surrogates cross international borders to provide services (Shenfield et al.). Such practice is called cross-border reproductive care (CBCR), reproductive tourism, fertility tourism, or procreative tourism (Blyth & Farrand, 2005; Cohen, 2006; Collins & Cook, 2010; Gurtin & Inhorn, 2011; Hunt, 2013; Inhorn & Patrizon, 2012). Although the aforementioned legal reasons explain the use of CBCR, some individuals pursue CBCR for better quality of care (i.e., dissatisfaction with fertility treatment in home countries or better success rates in foreign countries), more affordable treatment, or shorter waiting list (Culley et al., 2011; Hunt; Shenfield et al.). Gurtin and Inhorn further summarize the reasons for CBCR into four categories: legal and religious prohibition, resource consideration, quality and safety concerns, as well as personal preference. It is also speculated that participants of CBCR (i.e., intended parents, donors, or surrogates) may ensure additional psychological and physical risks (Blyth, 2010). Thus, Blyth, Thorn, and Wischmann (2011) emphasize the importance of competent psychological counseling services in CBCR, but the researchers also recognize that infertility counseling in CBCR

is often neglected. Thus, counselors should be knowledgeable about the laws and professional guidelines regarding assisted reproduction of the country of their own practice and in other countries, professional standards of practice for infertility counseling, and any law, guidelines, or cultural factors impacting intended parents, donors and surrogates from other countries.

Practice Settings for Infertility Counselors

The role of infertility counselors usually varies by work settings and affiliation (Gordon & Barrow, 1999). Infertility counselors typically fall within one of the following three categories although they may have practices that allow them to work in various settings: 1) reproductive clinic employees, 2) independent practitioners contracted with reproductive clinics to offer services (i.e., evaluations of donors or donor recipients), and 3) independent mental health professionals in private practice with no formal or informal affiliation with a clinic (Covington, 2006). The first two categories of infertility counselors with formal affiliation with reproductive clinics have more expanded roles and are often more involved in assessment for third party reproduction (Covington; Gordon & Barrow). For instance, the counselors provide psychological interventions to infertile individuals, donors, surrogates, and recipients as well as facilitate decision making and provide support regarding assisted reproduction. Operating as part of the medical team, infertility counselors may write patient counseling protocols, sit on patient care and ethics committees, design patient centered care interventions, and educate medical professionals on the team or in-training. Counselors with no formal affiliation reproductive centers provide psychological support depending on where clients are in dealing with infertility, and these counselors are usually not involved in the assessment

process for treatment options and evaluations of donors, surrogates, and recipients (Covington; Gordon & Barrow).

Suggested Challenges in Infertility Counseling

Since the 1980s, psychological issues associated with infertility have received more attention, and more studies have been conducted on the impacts of infertility (Edelmann, 2008; Rosen & Rosen, 2005). Recent trends in infertility counseling research have started to address the ethical and moral dilemmas that infertile individuals encounter when faced with controversial reproductive technologies, such as donated eggs or sperms, and donated embryos (Daniluk, 2001; McShane, 1997). However, few empirical studies about the ethical issues in infertility counseling have been conducted.

The difficulty in exploring debatable technologies of infertility is referred to as “an ethical crisis” since some infertility treatment procedures are unlike normal medical accomplishments and are often conflicted with morality (Gordon & Barrow, 1999; Kader & Greenfeld, 2006). For instance, the use of posthumous reproduction, assisted reproduction for patients over 50 years old, or intergenerational gamete donation is still controversial and are not viewed as typical medical treatments for infertility (Kader & Greenfeld). Ethical dilemmas continue to exist even after successful pregnancies from fertility treatment. After a successful pregnancy, parents further face the dilemma of sharing such information with their children (Kader & Greenfeld). Therefore, it is not surprising that infertile individuals will be confronted with moral and ethical challenges as more radical reproductive technologies are innovated in the future.

Aside from infertile individuals’ “ethical crisis” in responding to reproductive technologies, ethical aspects of infertility counseling have been increasingly identified

(Gordon & Barrow, 1999; Kader & Greenfeld, 2006). Some ethical dilemmas that infertility counselors may encounter are: 1) counselors' personal values toward controversial reproductive technologies (disposition of extra embryos, posthumous conceptions, or surrogacy), 2) counselors' gatekeeping role in determining who can and cannot receive certain infertility treatments/ in deciding who can and cannot be a parent, 3) different judgment between physicians and infertility counselors, and 4) counselors' anxiety about clients' motivation for parenthood (Applegarth, 2005; Gordon & Barrow; Horowitz, Galst, & Elster, 2010; Jaffe & Diamond, 2010; Josephs, 2005; Kader & Greenfeld; Kottick, 2005). Given the fact that more reproductive technologies will be introduced in the future, counselors may encounter more difficulties in screening clients for treatments. ASRM and ESHRE ethics committee has developed various ethical guidelines to guide infertility counselors in resolving ethical dilemmas. As of yet, there are few empirical studies examining how infertility counselors handle those ethical challenges.

There has been research focused on the effectiveness of infertility counseling (Boivin, 2003; Edelmann, 2008; Hakim, Newton, Maclean-Brine, & Feyles, 2012; Monach, 2013), but the challenges faced by counselors in working with infertile individuals receive far less attention in current research (Gordon & Barrow, 1999; Kader & Greenfeld, 2006; Rosen & Rosen, 2005). Rosen and Rosen also recognize that current infertility counseling studies fail to examine the effects of infertile individuals' psychological issues on counselors. Rosen and Rosen further suggest that counselors may experience emotional reactions to clients' infertility crisis, which potentially affects the counseling process and outcome. Covington (2006) suggests that infertility counselors

may experience compassion fatigue as a result of their repeated exposure to infertile clients' intense reactions and grief. However, no empirical research has examined the effect of clients' infertility experience on counselors, nor the compassion fatigue theory been applied to infertility counseling. Additionally, infertility counselors have often encountered infertility themselves (Applegarth, 1999; Covington & Marosek, 1999; Jaffe & Diamond, 2010). Covington and Marosek conducted a study on the personal reproductive history of counselors and nurses working in reproductive medicine. The researchers found over 50% of participants were diagnosed with infertility, and among those infertile participants, over 70% began to be involved in the field of reproductive medicine after their diagnosis. It is also not uncommon that clients often inquire verbally or ponder without asking about therapists' fertility and the therapist's capacity to relate with them, which likely changes the dynamic in counseling (Burns, 2005; Jaffe & Diamond, 2010; Rosen & Rosen). It remains unknown how infertile counselors respond to infertile clients' curiosity. Research suggests a need to investigate therapists' experience in working with infertile individuals, with a focus on their encountered challenges and adapted strategies.

Another major challenge in infertility counseling is the role of infertility counselors (Peterson et al., 2012). Although ASRM and ESHRE guidelines suggest that infertility counselors need to safeguard unborn children's wellbeing, the debates about counselors' obligation to protect unborn children and to assess fitness for parenthood for infertile individuals and couples continue (Gordon & Barrow, 1999; Horowitz et al., 2010; Jaffe & Diamond, 2010; Kader & Greenfeld, 2006). Josephs (2005) suggested infertility counselors to focus on supportive counseling and Horowitz et al. (2010) highlighted the

difficulty to determine “good enough” parenting. The study of Frith, Jacoby, and Gabbay (2011) found that counselors had mixed opinions on gate-keeping roles. As most of infertility counselors may undertake the responsibility to screen fitness for fertility treatment, counselors may encounter internal conflicts about their gate-keeping role.

Definition

For the purpose of this study, the phrase *counselor* refers to licensed mental health professionals providing individual counseling, group counseling, couples counseling, assessment/evaluation, or consultation to infertile clients. The term *counselor* is used synonymously with the terms therapists, practitioners, and clinicians for variety. In this paper, infertile individuals include single infertile individuals and married or unmarried infertile couples. When emphasizing couples with marital status, ‘*infertile couples*’ will be used.

Significance of the Problem

This paper explores counselors’ unique challenges in working with infertile individuals and couples and their adapted strategies in resolving the encountered challenges. This study is important for the following various reasons.

First, infertility prevalence is high and has been recognized as a public health priority in the United States (CDC, 2012). When infertile males as well as individuals who give up, cannot afford or decide not to pursue fertility treatments are taken into account, the prevalence of infertility rises dramatically. It is inevitable that mental health professionals will encounter clients who are impacted by infertility directly or indirectly at certain points of their practice. Thus, it is important for mental health professionals to recognize the complexity of infertility, and it is even more essential for counselors who

work with adults and couples to equip themselves with a basic knowledge of infertility and fertility treatment. This study aims to focus on counselors' struggles in working with infertile individuals and how they adapt their strategies to address those struggles. This study will raise awareness of the complexity and uniqueness of infertility counseling. It will also provide information about required training and helpful interventions for counselors to ultimately respond to infertility, a public health priority of this nation, more effectively.

Infertile individuals face a wide variety of consequences as a result of infertility, including emotional distress, physical discomfort or medical complications, financial burdens, potential ethical dilemmas on deciding fertility treatments, relationship conflicts or isolation (Atwood & Dobkin, 1992; Burns, 2005; Gibson, 2007 & 2008; Rosen & Rosen, 2005; Watkins & Baldo, 2004). However, no research has examined how the aforementioned clinical issues may be presented to counselors and manifest in counseling. Literature also suggests that infertility counselors may have experienced infertility or reproductive issues in their past (Applegarth, 1999; Covington & Marosek, 1999), and the effects of those counselors' personal experiences on the counseling process remain unknown. This study allows counselors to speak to their encountered challenges in response to infertile clients' issues and share their observations on the effects of their personal experience, if any. Furthermore, the ethical challenges in infertility counseling are increasingly identified in literature, but little empirical evidence has focused on counselors' experience in handling these challenges in their clinical work. This study intends to gain understanding about challenging ethical concerns for infertility counselors in order to contribute to the welfare of infertile clients.

Chapter 2: Review of the Literature

This critical review explored challenges in infertility counseling. Although few empirical studies on infertility counselors' experiences have been conducted in the past, there are emerging studies on infertile individuals' experiences at different stages of infertility. For instance, current studies have examined the consequences of infertility, reactions toward infertility and fertility treatment, gender differences, mental health issues, infertile individuals' use of infertility counseling services (i.e., individual counseling, support groups, couples counseling, or assessment). The results of these studies have offered mental health practitioners valuable input on infertile clients' issues and the importance of professional support for infertile individuals. Greil, Slauson-Blevins, and McQuillan (2010) conducted a review of recent research on infertility experiences and concluded that there are two categories of research: 1) quantitative studies, which assessed patients' psychological needs by using standardized psychological assessment instruments, with a focus on infertile patients from reproductive clinics; 2) qualitative studies, which focused on the understanding of infertility experience and social context of infertile men and women outside of the clinic context. The following review includes current quantitative and qualitative research to grasp a more comprehensive understanding of infertile individuals' and couples' experiences and the implied challenges for infertility counselors.

Infertile Women's Experiences and Implied Challenges for Counselors

Infertile Women's Experiences

The following studies addressed infertile women's experience at different stages of infertility and fertility treatment. Gonzalez (2000) conducted a qualitative study

regarding the meaning of infertility to women. Twenty-five married women living with their partners and concurrently receiving infertility treatment were recruited for this study from a university health science department of infertility and endocrinology, a private practice of infertility specialists and a support group for infertile individuals. The recruited women's experience with infertility treatment varied from several months to less than 2 years, and the causes of infertility ranged from identified reproductive issues (ovulatory dysfunction, endometriosis, tubal factors, etc.) to unknown causes. The participants' ages ranged from 20 to 40 years old, with 22 Caucasians, 1 African American, and 2 Hispanic women. Their annual incomes varied from \$30,000 to over \$100,000. This study also included participants from reproductive clinics and outside of a clinical context.

To explore the experience of infertility, a set of interview questions was used, such as 1) When did you first become concerned with your fertility? 2) What is it like not being able to conceive? 3) How has this experience affected how you feel about yourself? and 4) What is the meaning of a biological child to you? Interview data were later transcribed and analyzed by the data analysis techniques suggested by Miles and Huberman (1994). Five finalized major themes in chronological order were: 1) failure to fulfill a prescribed social norm (characterized by perception of a violation of a social expectation, inadequate feelings as a woman, and loss of purpose of life); 2) assault on personal identity (composing powerlessness, stigma, alienation, and deprivation of ties of descent); 3) mourning (consisting of hope and denial as well as the awareness of the loss); 4) transformation (facing the reality of their inability to bear a child); 5) restitution (characterized by accepting the reality of involuntary childlessness and subsiding the pain

of the loss related to infertility). Feelings of depression were also found to be associated with the first four themes.

The above study provides insights into infertile women's experience. Findings show that infertile women's experience is a process rather than independent emotional reactions. Infertile women initially experience grief, loss, sense of failure, identity crisis, and mixed feelings of hope and sadness, but later gradually accept their infertility and loss. Limitations were also observed. First, the sample consisted of infertile women who were receiving professional psychological support and others who were not. The researchers did not enumerate the effect of the participation in professional psychological support. The researcher also did not state whether all participants reached the stage of transformation (facing the reality of their inability to bear a child) or the stage of restitution (accepting the reality of involuntary childlessness and easing the pain of the loss related to infertility). It is also unclear if the participants re-experienced emotional distress or continued to struggle with grief and loss after their fertility treatment finished. Another issue is that all participants were concurrently in fertility treatment and their duration of infertility was not reported. Although the interview questions aimed to explore infertility experience, the participants' responses might also reflect their distress caused by their involvement in fertility treatment. As a result, the effect of fertility treatment needed to be further clarified.

Harris and Daniluk (2010) chose a qualitative, phenomenological approach to study infertile women's miscarriage experience after fertility treatment. The researchers interviewed infertile women who experienced spontaneous pregnancy loss after having conceived with the assistance of medical intervention. The researchers posted research

invitations in a reproductive clinic, infertility individual self-help organizations, and online infertility bulletin boards. A total of 27 women responded to the invitations. After analyzing ten women's interviews, the researchers concluded that "data saturation" was reached and no new themes emerged in the interviews. The recruited women's experience with infertility treatment varied from two to seven years (mean of 3.8 years), and the loss of pregnancy occurred at two to sixteen weeks of gestation. Among them, four participants experienced multiple pregnancy losses, three were concurrently pregnant at the time of interview, and three had living children after miscarriage. In addition, among the ten participants, eight women were patients from the same reproductive clinic.

A set of semi-structured interview questions were used to explore the experience of infertility, including a chronological description of participants' reproductive stories (i.e., desire to become parents, diagnosis of infertility, pregnancy experience, and miscarriage), the interactions with others in their infertility and miscarriage experience (i.e., who and what was helpful?), and the meanings of infertility and pregnancy loss. The interviews were analyzed in two steps. The initial analysis only focused on what was and was not helpful across the ten interviews by the utilization of cross analysis proposed by Hill, Thompson, and Williams (1997). In the second step of analysis, all ten interviews were synthesized into a whole set of data, which was analyzed through a process of phenomenological reduction; identified themes were later validated by the participants. The researchers reported that the initial analysis suggested that others with infertility or miscarriage experiences were identified as the most helpful; friends' and family members' presence and willingness to listen were also recognized as helpful; medical staff's prompt

responses and care were also valued by participants. Nine themes were identified in the second step of analysis, including profound loss and grief; sense of having no, or very limited, control; shared loss with their partners; a sense of injustice and lack of fairness; ongoing reminders of their loss; feelings of social awkwardness; fear of investing in the treatment process or the pregnancy; the need to make sense of their experience; a sense of responsibility.

The above study by Harris and Daniluk (2010) reveals another side of infertility experience for women who conceived through fertility treatment but later experienced pregnancy loss. The finding adds knowledge of these women's intensified grief responses and losses toward infertility and miscarriage. However, there were some limitations about the methodology. First, the researchers reported that 27 women responded to the research invitations but only ten interviews were included in the analysis. It was unclear if the remaining 17 women finished the interviews. The researchers also did not articulate how the ten participants were selected from the pool, which made the sample's representativeness questionable. Furthermore, the sample characteristics might limit the results. For instance, although the researchers attempted to recruit participants from various resources, eight participants had received fertility treatment from the same clinic, and it was likely that their responses to the interview questions might reflect on their experience with the reproductive clinic. The researchers concluded that ten interviews yielded consistent results, which might be due to the high homogeneity of the sample. In addition, some participants were pregnant at the point of the interviews and some had children after or between pregnancy losses. The researcher did not conduct further analysis to articulate the effect of concurrent pregnancy or parental status on participants'

experience with prior miscarriage. In this study, there were subgroups among participants (i.e., pregnant v.s. not pregnant; childless v.s with children; single vs. multiple pregnancy losses); however, the researchers restrained themselves to a smaller sample size. In addition, the researchers used two analysis approaches to analyze the participants' responses without articulating their rationale. The researchers also did not clarify if participants' responses to what did and did not help were analyzed in both two steps of analysis.

Greil, McQuillan, Lowry, and Shreffler (2011) recognized the difficulty of sorting the effects of infertility and fertility treatment. Thus, the researchers studied the effect of infertility, fertility treatment, and live birth on infertile women's emotional distress. The researchers used the National Survey of Fertility Barriers (NSFB), which was a nationally representative telephone survey of women aged 25 to 45. A total of 266 infertile women, who responded to NSFB both at Wave 1 (W1) and Wave 2 (W2) (three years after Wave 1), were included in the analysis. The participants were divided into eight mutually exclusive groups based on their fertility treatment experience and live birth after infertility (i.e., no treatment without live birth; no treatment with live birth; treatment at W1 only without live birth; treatment at W1 only with live birth; treatment at W2 without live birth; treatment at W2 with live birth; treatment at both W1 and 2 without live birth; treatment at W1 and 2 with live birth). The dependent variable was fertility-specific distress, measured by six items developed from the Infertility Research Scale by Hjelmsted et al. (1999) and qualitative research on infertile couples. At W1 and W2, participants were asked to rate their reactions toward infertility (frequently, occasionally, seldom, or never) by answering the following items: I felt cheated by life; I felt I was

being treated; I felt angry at God; I felt inadequate; I felt seriously depressed about it (infertility); I felt like a failure as a woman. Three separate one-way ANOVAs were first performed to compare the differences at W1 among eight groups, the differences at W2 among eight groups, and the changed scores from W1 to W2 among eight groups. Then, a 2 (Time: W1 & W2) x 8 (Group: 8 subgroups of participants) mixed ANOVA was conducted to detect the interaction effect between distress changes from W1 to W2 and treatment/live birth type.

The analysis revealed the following results. First, at W1, eight groups significantly differed in fertility-specific distress ($F[7,258]=8.971, p<.001$). Post-hoc tests revealed that women, who received fertility treatment regardless of the outcomes of treatment, were significantly more distressed than women who did not seek fertility treatment. Second, at W2, eight groups also significantly differed in fertility-specific distress ($F[7,297]=7.188, p<.001$). Post-hoc tests revealed that women, who did not seek fertility treatment and did not have a live birth, were significantly less distressed than those who received fertility treatment only at W1 and did not have a live birth. Furthermore, the changed scores between W1 and 2 were found to be significant ($F[7,258]=3.466, p<.001$). Post-hoc tests suggested that the women, who had fertility treatment at both W1 and 2 or only at W2, had a significant increase on fertility-specific distress. The women who had fertility treatment at W2 and did not have a live birth were found to have the largest increase of fertility-specific distress. In addition, the mixed ANOVA results indicated that women at W2 were more distressed than W1 regardless of their fertility treatment experience and parental status. The women who received fertility

treatment regardless of their treatment outcome were more distressed than those who did not seek treatment.

The above study by Greil et al. makes important contributions to research on infertility experiences. Not only do the results speak to the effect of infertility but also to the distress associated with fertility treatment. The results suggest that longer duration of infertility leads to higher level of stress, involvement of fertility treatment adds additional suffering, and failed treatment outcomes are the most stressful. However, some shortcomings of this study were identified. The researchers did not report demographic information and medical history of participants; thus there was no report of participants' age, SES, marital status, cause of infertility, or infertility duration. In addition, the uneven sample sizes across the eight groups were observed. It was noted that the smallest group had only five participants, and the largest one had 69. The researchers did not address the effect of uneven sample sizes. Very unequal sample sizes could potentially violate the homogeneity of variance assumption of ANOVA, and analysis results could be invalidated if this assumption was not met.

The following two studies further elaborate infertile women's experience with fertility treatment. Pasch et al. (2012) examined the relationship between psychological distress and in vitro fertilization (IVF) outcomes of infertile women. A total of 202 women who underwent their first cycle of IVF were included in the study. The participants' levels of depression and anxiety were assessed before and after their IVF treatment. The results revealed that failed IVF predicted higher levels of depression and anxiety when pre-IVF depression and anxiety, duration of infertility, and other demographic variables were controlled. A study by Lee, Neimeyer, & Chan(2012)

examined the meaning of childbearing for infertile women undergoing IVF treatment. A total of 18 infertile women were interviewed (11 with successful IVF outcomes and 7 with failed treatment). Despite the outcomes of IVF treatment, the participants reported that they continuously experienced unresolved grief and ambiguous losses in their lives. The results indicate a need for counselors to explore the meaning of infertility and fertility treatment with infertile clients who go through fertility treatment.

Many infertile individuals are found to be traumatized not only by infertility and fertility treatment (Jaffe & Diamond, 2010; Shapiro, 1993) but also by multiple losses, including loss of their future, loss of pregnancy experience, miscarriage, loss of identity, or loss of friendship (Harris, 2011). As a result of the profound and traumatic impacts, infertility and pregnancy loss are considered as reproductive trauma (Berg & Wilson, 1991; Jaffe & Diamond, 2011; Lund, 2001). The following meta-analysis by Adolfsson (2011) summarizes women's experiences during and after reproductive trauma. The meta-analysis results suggested that women who experience reproductive traumas tend to recognize their depressive and anxious reactions more easily than their grief reactions since these women have no focus for their ambiguous losses. In addition, the researcher found that women tend to feel guilty and a sense of responsibility for their reproductive trauma, which may inhibit them from recognizing and expressing their grief responses. The researcher also suggested that a higher level of depression and anxiety after reproductive traumas could be an indication of grief.

Empirical studies also have found that failed fertility treatment and stress associated with fertility treatment are found to exacerbate pre-existing mental health issues, trigger un-identified mental illness, and at times lead to hospitalization (Burns,

2007). For instance, Schweiger, Wischmann , and Strowitzki (2012) found that five to ten percent of infertile women had diagnoses of depression, anxiety, and eating disorders, and the researchers speculated that female infertility might worsen, trigger, or cause the above mental health issues. Baldur-Felskov, et al. (2013) found that women who failed fertility treatment had an increased risk for all mental disorders, compared with women who had successful outcomes. Yli-Kuha, et al. (2010) also found that regardless fertility treatment outcomes, infertile women with adjustment disorders had a significantly increased risk for hospitalization; failed fertility treatment outcomes, in general, led to a higher hospitalization rate for infertile women with mental illness. Guerra, Llobera, Veiga, and Barri (1998) assessed a group of 110 infertile individuals and found 59.6% of women and 24.1% of men had co-existing mental health issues (i.e., adjustment disorder, depression, anxiety, etc.). Specifically, women with eating disorders have a higher risk for infertility. Easter, Treasure, and Micali (2011) compared women with eating disorders (n=479) with the general population in the U.K. regarding their pregnancy, infertility, and fertility treatment experience. The researchers found that women with anorexia nervosa and bulimia nervosa were more likely to have infertility issues and often needed to seek fertility treatment to achieve pregnancy.

The above studies address infertile women's experience at various stages of infertility, and the results reveal the effects of infertility, fertility treatment, successful or unsuccessful treatment outcomes, and miscarriage after conceiving with fertility treatment. Infertile women endure high levels of emotional distress, depression, anxiety, grief, multiple losses, identity issues, relationship difficulty, or mental health issues as a result of the above experiences. Specifically, Gonzale (2000) found that infertile women

in fertility treatment have complicated feelings and reactions toward their infertility, such as a sense of failure, assaulted identity, mixed feelings of grief and hope, and acceptance of their inability to bear a child. The Harris and Daniluk (2010) research speaks to the effect of miscarriage after conceiving with fertility treatment on infertile women. The researchers find that pregnancy loss intensifies infertile women's grief and loss associated with infertility, such as a sense of being out of control or a sense of injustice; multiple pregnancy losses become ongoing reminders of infertile women's inability to have children, and infertile women become fearful of fertility treatment or investigation and future pregnancy. Greil et al. (2011) find that duration of infertility, fertility treatment, and outcomes of fertility treatment are associated with infertile women's emotional distress. Longer infertility suggests higher distress for infertile women, and involvement of fertility treatment adds additional suffering and failed treatment outcome is the most stressful. The studies of Pasch et al. (2012) and Lee et al. (2012) on infertile women's distress associated with fertility treatment also validate the findings of Greil et al. and Harris and Daniluk. Adolfsson (2011) further finds that infertile women tend to recognize their feelings of depression and anxiety more easily than their grief and loss. Finally, infertile women's pre-existing or un-identified mental health issues can be worsened or triggered by stress associated with fertility treatment (Baldur-Felskov, et al., 2013; Burns, 2007; Schweiger, et al., 2012; Yli-Kuha, et al., 2010).

The above review on infertile women's experience also suggests the importance of professional psychological support. Wischman (2008) suggests that attendance on group counseling and psychotherapy can improve emotional coping and reduce negative affect. For instance, Domar, et al. (2000) examined the impact of group therapy on the

emotional distress of infertile women. A sample of 184 infertile women, who had tried to conceive for one to two years, were not clinically depressed, and did not receive any form of professional psychological support, were recruited from reproductive clinics and local communities. The participants were randomly assigned to three different groups: 63 to cognitive-behavior groups, 65 to support groups, and 56 to control groups. The support and CB groups met weekly for 10 weeks in 2 hour sessions, and the control groups did not receive any interventions. The cognitive behavior group significantly had better stress management skills, interpersonal support, emotional adjustment and healthier life styles than the control and support group participants. Lykeridou, et al. (2010) also examined the factors contributing to infertile women's perceived importance of professional psychosocial services (i.e., individual counseling, support group, couples counseling, or group therapy). The researchers surveyed 404 infertile women and found that participants with higher fertility-related stress and less social support tended to rate professional support more important.

Implied Challenges in Counseling Infertile Women

It is inevitable that counselors will encounter challenges in addressing infertile women's complicated reactions. One challenge for counselors is to recognize the various effects of infertility, fertility treatment, failed treatment, and miscarriage after fertility treatment on infertile women since different experiences bring different levels of emotional distress. Every infertile woman may have distinct reactions based on where they are in resolving infertility. Thus, it is important for counselors to have a thorough understanding of infertile women's reproductive stories and involvement in fertility treatment in order to understand their subjective experience and to facilitate healing.

Counselors need to be knowledgeable about medical and psychosocial aspects of infertility and fertility treatment.

As fertility treatment brings hope and offers opportunities for family building, involvement of individuals in fertility treatment is highly stressful and overwhelming, often leading to feelings of depression, anxiety and tensions in intimate relationships. Infertility counselors need to recognize the stressful nature of fertility treatment, prepare infertile clients for intense emotional reactions, and facilitate effective coping for all possible treatment outcomes. Thus, fertility treatment can be viewed as a crisis period, and infertility counselors need to offer psychological support accordingly, promptly, and individually to infertile women and their partners during and after fertility treatment. As infertile women have mixed feelings of hope and loss in facing fertility treatment, a potential parallel challenge for infertility counselors is finding balance between processing grief and holding hope for infertile clients (Jaffe & Diamond, 2010). Especially, since after multiple failed treatments, infertile clients may feel defeated and worn out, infertility counselors may experience similar challenge in holding hope for clients.

One of challenges that counselors may encounter in infertility counseling is how to process multiple losses and grief with infertile clients. Infertility counselors need to recognize the ambiguous nature of infertile clients' multiple losses and create a space for clients to process their grief and loss. Unlike other traumas that are one-time occurrences, infertility is a chronic condition that brings multiple traumas to infertile individuals; this phenomenon usually brings loss of control and sense of helplessness for infertile individuals in addition to multiple losses (Berg & Wilson, 1991). Mourning during and

after multiple losses caused by traumatic events is often difficult, and many individuals usually need time to recover before they can fully recognize and grieve what has happened to them (Ornstein, 2010). It is also found that infertile individuals often delay processing or cannot express their grief (Hunt & Meerabeau, 1993). Infertility is not an acknowledged death (Harris, 2011), and the society does not have grief rituals to recognize infertility or pregnancy loss (Jaffe & Diamond, 2010). Thus, the multiple losses caused by infertility often are ambiguous (Lee et al., 2010). Geller (2004) and Lund (2001) express concerns about mental health professionals' lack of awareness of the impacts of reproductive trauma, and they also observe that grief caused by infertility or pregnancy loss is often neglected by counselors. Though mental health practitioners may have basic knowledge of grief counseling, current models of grief are not designed to address multiple losses and infertility (Knapp & Myer, 2000; Price & McLeod, 2012). It is possible that most mental health professionals may not have adequate training that prepares them to address the unique grief issues of infertile individuals.

Another challenge that counselors can potentially encounter is dealing with transference, countertransference, vicarious grief, compassion fatigue, and self-disclosure (Covington; 2006; Jaffe & Diamond, 2010). It is suggested that most counselors may become involved in infertility counseling as a result of their own fertility experience (Covington & Marosek, 1999; Applegarth, 1999 & 2006). However, not every counselor who works with infertile clients has experienced reproductive trauma (Jaffe & Diamond). It is not unusual for infertile clients to inquire counselors' motivation to enter the field of infertility counseling and counselors' fertility experiences (i.e., "Do you have children?" or "Did you have infertility?"). As a result, counselors might encounter transference or

countertransference and need to decide the content and amount of self-disclosure regardless of their fertility experience.

Appropriate self-disclosure can promote a sense of normality, but it can also stir up feelings of competition and isolation for clients (Stricker, 2003). Knox and Hills (2003) also point out the risks of self-disclosure when counselors have not fully resolved their own issues. It is suggested that self-disclosure be done cautiously as a part of a therapeutic intervention (Jaffe & Diamond, 2010; Stricker). However, in some situations, counselors will be forced to self-disclose. Counselors may become pregnant while working with infertile clients. Counselors physical pregnancy is a statement of disclosure despite counselors' decisions to disclose or not and can be emotionally provoking to clients (Lyon-Pages, 2004). A recent study by Tonon, Romani, and Grossi (2012) examined the effect of therapists' pregnancy on general counseling clients. Tonon et al. found that clients usually experienced envy and fear of abandonment and viewed therapists as a mother figure. It is possible that infertile clients may potentially have stronger reactions as a counselors' pregnancy may become a reminder of their own loss and grief. Finding a therapeutic way to process their pregnancy with infertile clients can be challenging. Thus, counselors may be dealing with issues of transference, countertransference, and self-disclosure simultaneously.

In facing infertile clients' reproductive traumas, repeated losses, and grief, counselors may also have their own internal reactions. Recent research suggests that mental health professionals who work with trauma survivors may experience vicarious trauma or compassion fatigue (Cohen & Collens, 2012; Michalopoulos & Aparicio, 2012). Listening to repeated failed treatment outcomes and multiple losses of infertile

clients may trigger vicarious trauma for counselors. If counselors have experienced reproductive trauma concurrently or in the past, they may potentially experience vicarious grief or countertransference (Jaffe & Diamonds, 2010) as they re-experience their own loss and grief. Currently no empirical research addresses infertility counselors' self-disclosure and countertransference, suggesting a lack of understanding in the counseling process of infertility counseling.

Infertile individuals' pre-existing or un-identified mental health issues may create additional challenges or tasks for counselors. Burns (2007) suggests infertility counselors to address the interactions between psychiatric conditions and emotional distress caused by infertility and fertility treatment; make decisions about the use of psychotropic medications during fertility treatment and pregnancy; assess the effect of fertility medications on current mental illness; assess appropriateness for involvement in third party reproduction. At times, it may be difficult to differentiate mental health illness, grief responses, and emotional distress from fertility treatment. Counselors also take on the role to educate infertile individuals and couples about the impacts of infertility and fertility treatment on mental health, assist them with managing their symptoms, and facilitate with decision making on fertility treatment. Thus, it is important for infertility counselors to know the interactions between infertility, fertility treatment, and mental health issues in order to safeguard infertile individuals' and couples' best interest.

Infertile Men's Experience and Implied Challenges for Counselors

Although most of current research on infertility has focused on infertile women and couples, researchers has begun to pay more attention to men's experience of infertility and fertility treatment (Fisher & Hammarberg, 2012). Fisher and Hammerer

(2012) also observed that few empirical studies have directly investigated men's experiences of infertility and fertility treatment. Through reviewing studies on infertile couples and gender differences, the researchers concluded that men, regardless of the cause of infertility, have equal desires for parenthood in comparison with their female partners; involvement in fertility treatment and unsuccessful outcomes also create emotional distress for men. Thus, one of potential challenges for counselors is to recognize the psychological needs of men and create space and time for men to process their experience.

The following two empirical studies specifically explored men's psychological reactions and encountered consequences as a result of infertility and fertility treatment. Mikkelsen, Madsen, and Humaidan (2012) conducted a survey on 210 infertile men undergoing fertility treatment. The researchers found that 46% of men wanted to be as equally involved in fertility treatment as their partners, but 63% of participants reported that medical staff primarily communicated with their female partners. A total of 62% participants identified their need to talk about male infertility with medical staff, and 72% reported not receiving enough information about the psychological consequences of male infertility from physicians. Chi-square tests revealed that men's feelings of involvement in treatment were associated with medical staff's behaviors (i.e., taking initiative to talk with men about their concerns, giving information about psychosocial consequences of infertile men, and giving opportunities for men to talk about their desire for fatherhood).

Peronace, Boivin, and Schmidt (2007) studied men's mental and physical health, support, and psychological and social stress before and after unsuccessful fertility treatment. The researchers attained data from the Copenhagen Multi-Centre

Psychological Infertility (COMPI) research program, which investigated infertile men's experience with fertility treatment from five reproductive clinics in Denmark.

Participants finished the COMPI questionnaires, which measured health, support, stress, and coping with infertility, on the onset of fertility treatment (Time 1 [T1]) and after 12 months of treatment (Time 2 [T2]). A total of 256 men, whose partners did not become pregnant after 12 months of fertility treatment, were included in the study and were divided into four groups according to their diagnosis (unexplained, female factor, male factor, or mixed). Most participants were employed (93.4%) with an average 4.3 years of infertility (<1 to 16 years).

Multiple ANOVAs were performed to assess the differences between four diagnostic groups in socio-demographic (age, years married, and focus on being a parent) and clinical (duration of infertility, previous treatment experience, and numbers of treatment cycles in the 12 months of study period) variables. Chi-square tests were conducted to analyze the categorical or ordinal variables (parental status, social position, and disclosure of infertility to others). A 4 (Diagnosis) x 2 (Time) mixed ANOVA was performed to assess changes over time on the following variables, including mental and physical health, coping, stress, and negative comments from others. The researchers reported the following results. The participants in the analysis were found to have longer infertility duration and attempted more fertility treatment cycles than the rest of COMPI infertile sample, but the methodology for this analysis was not reported. The results of multiple ANOVAs revealed no differences between diagnostic groups on any socio-demographic and clinical variables. Chi-square tests revealed no differences between groups on their disclosure of infertility to others. The mixed ANOVA suggested the main

effect of time on the following variables. Over time regardless diagnosis, participants' social and marital stress, physical health stress, coping efforts, and negative comments from others significantly increased; meanwhile, participants' perceived mental health became worse. The main effect of diagnosis and the interaction between (Diagnosis x Time) were also significant on negative comments from others. Post-hoc tests revealed that the unexplained group received more negative comments than other diagnostic groups. The researchers also reported the results of regression analyses and indicated poor mental health at T1 predicted more negative comments.

The study by Peronace et al. enhances understanding of men's experience with infertility and fertility experience. The results reveal that men are affected by unsuccessful outcomes of fertility treatment regardless of their diagnosis; increased suffering of men over time is observed. However, limitations on statistical analysis were also observed. The researchers divided the participants into four groups based on infertility diagnosis, which created uneven sample sizes. The smallest group was 21 while the rest of groups had 75 to 81. The researchers did not address the effect of uneven sample sizes. Very unequal sample sizes could potentially violate the homogeneity of variance assumption of ANOVA, and analysis results could be invalidated if this assumption was not met. In addition, the researchers compared the participants in the analysis with the rest of COMPI sample without articulating statistical procedures.

The next two empirical studies investigated infertile men's use of professional psychological support. The study by Pook, Rohrle, Tuschen-Caffier, and Krause (2001) examined infertile men's reactions toward infertility and contributing factors to their decision in seeking couples counseling. A total of 94 male patients (mean age=33.4,

mean duration of infertility=39.6 months) with reduced sperm quality, who were in couples counseling, were recruited from an andrological clinic in Germany. Another group of 143 male infertile patients (mean age=33.2, mean duration of infertility=33.5 months) with reduced sperm quality at the same clinic, who did not receive any psychological services due to limited personal resources, was used as the control group. The participants in both groups finished the Symptom-Checkliste von Derogatis-Deutsche Version (SCL-90-R; Franke, 1995) to measure levels of anxiety and depression.

A multivariate analysis of variance (MANOVA) was performed to compare differences of depression, anxiety, and sperm impairment between two groups, and a significant difference was found ($F_{[3, 211]}=11.31, p<0.001$). The counseling group had significant higher levels of depression ($F_{[1, 213]}=27.91, p<0.0001$), anxiety ($F_{[1, 213]}=9.34, p<0.0025$), and sperm impairment ($F_{[1, 213]}=4.49, p<0.0352$) than the control group. A configural frequency was further used to analyze the differences of the three levels of depression (little, normal, serious) and the number of impaired sperm parameters (1, 2, 3) between two groups. The results showed that most participants of the counseling group significantly had higher levels of depression (normal to serious) and had higher sperm parameters, while most control group participants had little depression and lower sperm parameters. The researchers concluded: 1) the counseling group displayed higher levels of depression, anxiety, and impaired sperm quality than the control group; 2) the number of impaired sperm parameters suggested infertile male patients' probability to use couples counseling.

There were some limitations in the Pook et al. (2001) study, which weaken the validity of the results. First, two groups took the SCL-90-R at different times. The

counseling group took the instrument in a meeting to discuss their treatment plan after learning the result of sperm analysis, while the control group took the survey before the sperm analysis was performed. The significant differences of depression and anxiety between two groups might be due to the knowledge of the results of sperm analysis. It is possible that the control group' level of psychological distress may increase after learning the results. Furthermore, the researchers stated that the control group did not seek counseling due to the lack of personal resources, but later contributed their not receiving counseling to the low levels of psychological distress and less sperm impairment. The conclusion seems contradictory and was made without supportive evidence.

The following study by Furman, Parra, Fuentes, and Devoto (2010) assessed the use of group counseling for men undergoing IVF in Chile. The participants were identified through in a government-sponsored IVF program for low-income couples. The patients on their first IVF treatment with either male or female factor infertility were recruited, while couples with combined factors were excluded from this study. A total of 284 infertile couples met the research criterion and were included in the analysis. Free psychological services in three modalities (individual, couples counseling, and group counseling for couples) were offered at flexible timings to the infertile couples during their IVF cycle, but the participants were not required to attend any psychological services in order to receive fertility treatments. Among 284 infertile couples, 143 couples (mean age=34.9; duration of infertility=6.9 years) received psychological services and 141 couples (mean age=34.1; duration of infertility=7.1 years) did not. In sum, 135 men and their partners attended group counseling and eight men chose to seek individual or couples counseling. Only the male participants' data was used in this study.

Multiple paired t-tests were conducted to compare clinical and demographic information between male participants who sought group counseling (N=135) and those who did not receive any form of counseling (N=141), and no differences were found. Among the 135 men who sought group counseling, 35 men experienced male factor infertility and 79 experienced female factor infertility. Chi-square tests were further performed to test the differences among six groups [2 (etiology of infertility: male or female factor) x 3 (frequency of attendance of group counseling: 1, 2-3, or more than 4 sessions)]. The finding revealed that male participants with male factor infertility were more likely to attain more than four sessions of group counseling than those with female factor infertility. A subset of 98 men who used psychological services were randomly selected and were asked to evaluate the usefulness of the psychological services (1=not at all useful; 2=moderately useful; 3=highly useful). The results revealed that 92% of the participants rated group counseling as “highly useful” and 8% considered it as “moderately useful.” The researchers concluded infertile male participants preferred group counseling over other modalities of mental health services.

The study by Furman et al. is one of few studies that include low-income individuals. The finding suggests that low-income infertile men perceive group counseling highly helpful and prefer group counseling than individual or couples counseling. However, there were some limitations observed. It is noted that in this study group counseling was offered to couples. That is, infertile men attended group counseling with their partners. As a result, various variables (i.e., partners’ motivation or distress level; marital conflicts; satisfaction with partnership; etc.) could affect infertile men’s decisions to attend group counseling. It is also noted that among the 135 infertile men

who attended group counseling, only 35 (30%) experienced male factor infertility and the rest of 70% had female factor infertility. Given couples with combined factors were excluded from this study, the percentage of male factor infertility seemed low, which might decrease the sample's representativeness and limit its generalization.

Even though current research has suggested men and women respond to infertility and fertility treatment differently and females are more emotionally distressed than men (Edelmann and Connolly, 1998; Klemetti et al., 2010; Galhardo et al., 2011), the review on men's experiences suggests that men are affected by infertility and outcomes of fertility treatment. Mikkelsen et al. (2012) found that men want to have equal involvement in fertility treatment but most of them feel excluded. The researchers also conclude that infertile men want more understanding of consequences of male infertility and fertility treatment, and failed outcomes are stressful to them. Peronace et al. (2007) further found the effect of fertility treatment and failed outcome on men. It is suggested that despite the diagnosis of infertility (male, female, combined, or unknown), failed fertility treatment creates various stress (i.e., social, marital, and physical health) and requires more coping efforts for men; men also experience high levels of emotional distress. Poo et al. (2001) suggested that infertile men's use of couples counseling is related to their levels of depression and anxiety and sperm quality. Furman et al (2010) asserted that men preferred group counseling than individual or couples counseling; men with male factor infertility were more likely to attend more sessions of group counseling than those with female issues. Thus, infertility counselors need to be aware of the impacts of infertility, fertility treatment, and outcomes of fertility on men. It is crucial for

counselors to create space and time for men to recognize and process their reactions in order to promote healing for men and women affected by infertility.

Infertile Couples' Experiences and Implied Challenges for Counselors

Infertile Couples' Experiences

This section of literature review explored gender differences and couples' experiences, with a focus on the effect of infertility and fertility treatment on their mental health and the quality of relationships (i.e, sexual aspects or emotional aspects of the relationship). Edelman and Connolly (1998) investigated infertile couples' psychopathology as well as their distress related to fertility treatment. One hundred and sixteen couples with primary infertility who decided to seek infertility investigation and treatment were recruited. In their first appointment at the fertility clinic prior to any infertility investigation and treatment, the participants were asked to finish four instruments to measure their mental health and general health, including Eysenck Personality Questionnaire (EPQ; Eysenck & Eysenck, 1975), General Health Questionnaire (GHQ; Goldberg, 1978), Beck Depression Inventory (BDI; Beck, 1972), and the State-Trait Anxiety Inventory (STAI; Spielberger, Gorsuch, & Lushene, 1970). Seven months after the first appointment, participants were asked to complete the GHQ and BDI again. The comparison between the two assessments suggested no present psychopathology and little variation in the BDI scores.

In the first 22 weeks after the initial assessment, the participants were also asked to finish a weekly distress diary summarizing their feelings over the previous week. The weekly diary was a 5-point scale/checklist of 12 emotions (1=not at all, to 5=extremely), including feelings of guilt, success, anger, contentment, frustration, happiness, isolation,

confidence, anxiety, satisfaction, depression, and confidence. The range of weekly scores was from 12 to 60, with a higher score indicating higher distress. The ratings were mailed to the researchers every week. If the participants failed to do so, a reminder phone call would follow. Eventually, 57 males and 55 females finished the 22-week diaries. A two-way ANOVA (gender x time) was used to analyze the 22-week distress checklists. A significant main effect of gender ($F [1, 112]=4.82; p<0.05$) was found. The main effect of time and the interaction between time and gender were both insignificant. Both female and male participants' scores on weekly distress checklist were near the low end (males: 26.2-29.3; females: 27.6-29.5) with a consistent pattern that females scored higher than males. Further ANOVA analyses found that the participants with high distress scores had significantly higher scores on EPQ, GHQ, BDI, and STAI. The researchers conclude that males and females reacted differently to infertility investigation and treatment and most infertile individuals were better adjusted than expected.

There were several limitations observed in this study. First, less than 50% of participants finished weekly distress diaries. It is unknown why the other 50% did not finish the distress diaries. One speculation is that the high emotional strains related to infertility may prevent the participants from reporting their painful emotions weekly. Keeping track of painful emotions may add another layer of distress. Also the weekly distress diaries were collected in the first 22 weeks of investigations and treatments. Since infertility investigations take three to four months to finish, and treatment plans are not formulated until diagnoses are finalized, the data might only capture the participants' initial emotional reactions to the diagnoses of infertility causes. Especially, after receiving the diagnosis, most couples take time considering the options of fertility

treatment and making financial arrangements. Furthermore, two assessments of psychological functions in a 7-month period may not grasp the impact of fertility treatment. It is possible that most of the couples in this study were in the initial stage of fertility treatment when the second assessment was conducted. Based on the above arguments, the researchers' conclusion on distress associated with infertility and fertility treatment may be simplified and misleading. Finally, the participants' racial and ethnic backgrounds are not specified in the paper; therefore the generalization of the results is unclear.

Similar to the study by Edelman and Connolly (1998), Klemetti, Raitanen, Sihvo, Saarni, and Koponen (2010) investigated mental disorders, depression, emotional distress, perceived health and quality of life among infertile women and men. The researchers attained data from the Health 2000 Survey in Finland, which examined health and well-being of individuals aged 30 and over ($n=8208$). The Health 2000 Survey included a home interview, several self-administered questionnaires, and a thorough health examination with a diagnostic mental health interview. A subset of the participants of the Health 2000 Survey, who aged between 30 to 44, were selected and divided into six exclusive groups based on infertility experience and parental status (childless infertile men and women, infertile men and women with at least one child, and fertile men and women). Among infertile men and women, over 50% had sought fertility treatment. The following variables were included in the analysis: mental disorders diagnosed with the Composite International Diagnostic interview, Munich version (M-CIDI; Wittchen, Lachner, Wunderlich, & Pfister, 1998), depression measured by Beck Depression Inventory (BDI; Beck, Ward, Mendelsohn, Mock, & Erbaugh, 1961), psychological

distress measured by the General Health Questionnaire (GHQ-12; Goldberg et al., 1997), well-being measured two items, which asked participants to rate their perceived health and subjective quality of life.

The logistic regression was performed to calculate the odds ratios (OR) of having a psychiatric disorder. In the model, psychiatric disorders were the dependent variable and infertility was the independent variable while other demographic and clinical variables were later added into the analysis. Linear regressions were reported to analyze the following variables: psychological distress, depression, perceived health, and subjective quality of life while demographic and clinical variables being controlled. The researchers reported the following results: 1) infertile childless women had increased but non-significant risks for dysthymia and anxiety disorder, and infertile women with at least one child had increased but non-significant risks for panic disorder; 2) infertile childless men had increased but non-significant risks for all examined psychiatric disorders; 3) infertile childless men was found significantly less satisfied with their health and quality of life. The researchers further concluded that infertility was associated with mental health and suggested men and women responded to infertility differently.

The study by Klemetti et al (2010) brings important information about infertile individuals' mental health issues. The results suggest that infertile childless women may be more likely to develop symptoms of depression and anxiety and infertile childless men are less satisfied with quality of life than infertile women. However, some limitations about the research design and statistical analysis were observed. First, the researchers divided the participants into six groups and the sizes ranged from 24 to 994 participants. Smaller sample size could lead to non-significant results. In addition, variables of

psychological distress and depression in the linear regression might not be independent. For instance, dysthymia could be overlapping with symptoms of depression. Thus, the assumption of independence between variables might not be met and multicollinearity could be a potential issue, which might potentially invalidate the results of regression analysis. In addition, the researchers reported over 50% of infertile participants sought fertility treatment; however infertile participants' experience with fertility treatment was not controlled in this study. Also the researchers concluded gender differences in response to infertility and infertility's effect on mental health without any statistical evidence. The analyses did not yield significant results to support the researchers' arguments.

Galhardo, Pinto-Gouveia, Cunha, and Matos (2011) investigated infertile couples' psychological reactions toward fertility treatment and gender differences on their reactions in comparison with fertile couples and infertile couples who pursued adoption. The participants were 100 infertile couples recruited from reproductive clinics at various stages of fertility treatment, 40 infertile couples who were pursuing adoption at the point of research, and 100 fertile couples with at least one child. Data on the following variables was collected by self-reported instruments, including depression measured by the BDI (Beck et al., 1961), anxiety measured by State Anxiety Inventory Form Y (STAT-Y; Spielberger, 1983), external shame by the Others as Shamer (OAS; Goss, Gilbert, & Allan, 1994), internal shame by the Experience of Shame Scale (ESS; Andrews, Qian, & Valentine, 2002), and self-judgment by the Self-Compassion Scale (SELFCS; Neff, 2003).

ANOVAs were performed to explore the differences between three groups regarding demographic variables and psychopathology variables (depression and anxiety). Linear regression models were used to test the effect of external shame, internal shame, and self-judgment on depression and anxiety in three groups. Finally, t-tests were conducted to explore gender differences on the study variables in three groups. The analysis results revealed: 1) the infertile couples in fertility treatment reported more depressive symptoms, higher level of anxiety, external shame, internal shame, and self-judgment than other two groups; 2) external shame, internal shame, and self-judgment significantly accounted for 41% of variance of depression and 31% of variance of anxiety for infertile couples in fertility treatment; 3) infertile women in fertility treatment significantly reported more depressive symptoms, internal shame, and self-judgment than their partners.

The above study enhances knowledge about infertile couples' distress in response to fertility treatment and gender differences. Fertility treatment is proved to cause emotional distress, and infertile women display higher levels of depression, shame, and self-judgment than their partners. Issues concerning the research design were observed. The researchers used multiple t-tests among three groups to test the gender differences on the study variables, but the use of the multiple paired t-tests might increase the error rate and the chance of type I error. False significant results could be caused by multiple comparisons. As a result, the generalization of the results should be cautious. In addition, participants' experience with infertility and fertility treatment was not controlled. Within the infertile couple groups, couples might have various experiences with fertility treatment and different duration of infertility. Although the adoption infertile group did

not pursue fertility treatment at the point of data collection, participants might have pursued fertility treatment in the past. The effect of infertility duration and fertility treatment was not uncontrolled.

The above studies by Edelman and Connolly (1998), Klemetti et al. (2010), and Galhardo et al. (2011) find gender differences in responding to infertility and fertility treatment. Edelman and Connolly find that infertile women experience higher levels of emotional distress than their male partners. Klemetti et al. suggest that infertile childless women are more subjective to develop symptoms of depression and anxiety, while infertile childless men are less satisfied with quality of life in general. Galhardo et al. find that infertile women have more symptoms of depression and report more internal shame and self-judgment than their partners. Thus, it is essential for counselors to address gender differences and associated impacts on relationships with infertile couples.

The following two studies further reveal the gender differences on infertile couples' reactions toward the use of third party reproduction, and the results also speak to the importance of pre-treatment counseling. For instance, Indekeu et al. (2012) investigated infertile men's experience in Intrauterine Insemination (IUI) treatment, with a focus on infertile men's well-being and their disclosure of the method of conception. The researchers included 46 men, who used donor sperm, and 151 men, who used their own sperm. The results revealed that men using donor sperm reported more feelings of fulfillment about the parenthood but reported a lower self-image and more guilt; men using donor sperm were less likely to disclose the method of conception. The researchers suggested infertility counselors should address infertile men's self-esteem and guilt issues in pre-treatment counseling. Another study by Stuart-Smith, Smith, and Scott (2011)

examined donor egg recipients' anticipatory concerns and feelings. The researchers studied two groups of women on the waiting list of an egg donation program, including women with a biologically related child and childless women. The results of interviews indicated that childless women reported fewer reservations about the use of donor egg and reported more excitement and hope than their counterparts; women with a biological related child, in contrast, reported more reservations and mixed feelings of anxiety and hope. The researchers suggested infertility counselors to be aware of the different reactions between these two groups of women and use pre-treatment counseling to address their concerns. The above two studies also reveal that infertile men have more reservation about the use of donor sperm while infertile childless women have fewer concerns about the use of donor eggs.

Gender differences in infertile individuals' use of psychological support are also found. For instance, Wischmann, Scherg, Strowitzki, and Verres (2009) studied contributing factors of infertile individuals' use of counseling services. A total of 974 women and 906 men, who indicated openness to infertility counseling, were divided into two groups based on their actual participation in infertility counseling. Of those, who attended counseling, women were found to be more depressed and anxious, and men reported less marital and sexual dissatisfaction.

In sum, the above review revealed gender differences on several aspects, such as emotional distress, mental health, reactions toward third party reproduction, and contributing factors of their use of counseling. It is crucial for counselors engage both genders effectively in counseling to address gender differences and the associated impacts on intimate relationships.

Implied Challenges in Counseling Infertile Couples

This section explores other important issues and potential challenges in working with infertile couples in addition to the issues of gender differences. One important issue in counseling infertile couples is addressing the sexual aspects of intimate relationships with infertile couples. Tao, Coates, and Maycock (2011) conducted a literature review specifically addressing the impact of infertility on sexual aspects of intimate relationships. The researchers examined literature from 1990 to 2011 concerning sexuality in infertile individuals or couples. A total of 25 studies, which examined some aspects of sexuality and reported descriptive data, were included in the review. Although various studies suggested infertility and fertility treatment led to decreased self-esteem, the researchers found that no study had addressed sexual self-esteem in infertile individuals or couples. The researchers also concluded that infertile men experienced less sexual satisfaction than their female partners; stress tended to decrease frequency of intercourse. The review also suggested sexual dysfunction was a common issue of infertile men while current research revealed mixed findings on sexual dysfunction of infertile females. In addition, one identified leading challenge in couples counseling is exploring the sexual aspects of the relationship. This issue may be difficult or avoided since most counselors are not trained to address sexuality in counseling (Shepard & Harway, 2012). Thus, one important task for infertility counselors is discussing sexuality in a therapeutic manner. It is essential that infertility counselors are competent to address sexual aspects of infertility with couples and offer psychoeducation when needed.

Infertility counseling is to facilitate infertile individuals and couples with decision making regarding fertility treatment options (i.e., numbers of cycles; use of third party

reproduction) as well as termination of treatment and associated issues (i.e., disposition of frozen embryos; exploration of alternative family building options). Not only do infertility counselors assist infertile couples with finishing stressful treatment, but counselors also offer support at the time of termination. Emotional distress is proven to be associated with infertile couples' termination (Daniluk & Tench, 2007; Domar, Smith, Conboy, Iannone, Alper, 2010); stress is identified as a barrier for continuing fertility treatment and dropping out is one of the main reasons for not achieving pregnancy (McDowell & Murray, 2011). Counseling is suggested to decrease the anxiety associated with fertility treatment, and so, infertile couples can continue the stressful medical interventions (Hashemi, Simbar, Ramezani-Tehrani, Shams, & Majd, 2012). As fertility treatment offers hope, it is often difficult for infertile couples to terminate treatment after repeated unsuccessful outcomes. Boden (2013) suggests infertility counselors to address the potential impact of failed treatment on mental health, quality of life, finance, intimate relationships or other aspects of life. Counselors need to explore alternative options of family building (adoption and fostering) or childlessness with the couples whose fertility treatment outcomes are persistently unsuccessful. Boden also points out the importance for infertility counselors to address legal issues regarding domestic and international adoption and the psychological adjustment from fertility treatment to adoption or fostering. One potential challenge for infertility counselors is assessing contributing factors to infertile couples' use or termination of fertility treatment in order to provide appropriate interventions. For instance, infertile couples may exhaust their emotional and financial resources after repeatedly failed treatment but still not be prepared to give up fertility treatment. Vice versa, some infertile couples may consider giving up fertility

treatment as a result of emotional distress or relationship issues, or have different opinions on whether to continue treatment.

Research has found that infertile couples often experience difficulty with deciding the disposition of frozen embryos after the termination of fertility treatment (de Lacey, 2013). For instance, Lyerly, Nakagawa, and Kuppermann (2011) investigated factors contributing to infertile couples' decisions about the disposition of embryos after fertility treatment. The researchers found that over 39% of those with frozen embryos experienced high levels of decisional conflicts; factors contributing to the decisional conflicts were uncertainty about whether to have a baby in the future and moral status to human embryos. Thus, it is recommended that infertility counselors offer emotional support at the point of decision making and also offer space for infertile couples to process their concerns (de Lacey).

Furthermore, third party reproduction offers additional chance for family building and creates a shift from biological to social parenthood. As a result of the drastic shift, Thorn (2013) suggests that infertility counselors provide pre-treatment counseling for infertile couples, who consider or decide to pursue third party reproduction (i.e., the use of donor gamete, gestational carriers, or surrogates). In the pre-treatment counseling, counselors educate infertile couples the medical and legal issues in third party reproduction and associated emotional distress (Thorn , 2013); facilitate grieving as a result of their inability to have biologically related offspring or their loss of pregnancy experience (Indekeu, et al., 2012); assist with managing stigmas about the use of third party reproduction (Marziliano & Moyer, 2013); discuss disclosure issues to the future child (i.e., ways of disclosure; impacts of family secrets; donor-linking) and consider the

long-term wellbeing of future child (Johnson, Bourne, & Hammarberg, 2012; Goedeke & Payne, 2010).

Another important issue related to third party reproduction is to ensure that all involved parties, including intended parents, donors, gestational carriers, or surrogates) are fully informed and counseled and are capable of giving informed consent (Ethics Committee of the ASRM, 2012). Black (2010) suggests infertility counselors to assess possible conflicts of interest between donors and recipients; confirm donors' awareness of the potential risks and benefits of their involvement; offer follow-up support for donors when needed. Hence, it is essential for infertility counselors to safeguard all involved parties' well-being.

Summary

The above reviews reveal experiences of infertile women, men and couples and associated challenges for counselors. It is evident that infertile women, men and couples endure multiple consequences as a result of infertility and their involvement in fertility treatment (Adolfsson, 2011; Edelman & Connolly, 1998; Fisher & Hammarberg, 2012; Galhardo et al., 2011; Gonzalez, 2000; Greil et al., 2011; Harris & Daniluk, 2010; Indekeu et al., 2012; Klemetti et al., 2010; Lee et al., 2012; Mikkelsen et al., 2012; Pasch et al., 2012; ; Peronace et al., 2007; Schweiger et al., 2012; Stuart et al., 2011; Tao et al., 2011; Yli-Kuha et al., 2010) . In addressing infertile clients' multiple issues (i.e., emotional distress, mental health issues, gender differences, relationship or marital difficulty, sexual dissatisfaction, etc.), counselors may potentially face the following challenges: addressing infertile individuals' complicated reactions and emotional distress (Jaffe & Diamond, 2010), dealing with special grief issues of infertile individuals (Geller,

2004; Knapp & Myer, 2000; Lund, 2001; Price & McLeod, 2012), assessing and managing co-existing mental health issues (Burns, 2007), assisting couples with termination of fertility treatment (Boden, 2013), exploring sexual aspects of infertility with couples (Shepard & Harway, 2012; Tao, et al), or engaging both genders in couples counseling (Shepard & Harway; Wischmann et al., 2009). Counselors may also encounter issues of self-disclosure and countertransference as a result of their own personal experience of fertility/infertility or pregnancy (Jaffe & Diamond; Tonon, et al, 2012). It is also speculated that counselors may develop vicarious trauma or compassion fatigue responses due to their repeated exposure to clients' recurrent reproductive traumas (Jaffe & Diamond; Covington, 2006). In sum, the literature review suggests that counselors may experience numerous challenges in offering infertility counseling; this suggests a need to further investigate counselors' experience in working with infertile clients. These potential challenges also speak to the importance of infertility counseling training and education that can prepare counselors to address these challenges.

Chapter 3: Methodology

Introduction

The purpose of this study is to investigate the challenges encountered by mental health practitioners when providing infertility counseling services to infertile individuals and couples. Current literature suggests that infertile clients experience numerous psychological, physical, social, and financial consequences as a result of their loss of fertility and their experiences with fertility treatment (Gibson, 2007; Watkins & Baldo, 2004); however, in literature little attention is paid to mental health professionals' encountered challenges in working with infertile clients. Given the high prevalence rate of infertility, mental health professionals inevitably will encounter clients who are directly or indirectly impacted by infertility. For counselors who work with adults or couples, the chance of encountering infertile clients in their practice increases; it is counselors' obligation to safeguard the welfare of these individuals. However, given that formal training and education on reproductive health or infertility is often not available, most counselors may not be equipped to counsel infertile clients and handle the clinical issues specific to infertile clients. The study sheds light on how counselors who mainly work with infertile clients deal with challenges in their practice and will bring knowledge about effective infertility counseling practices.

Participants

Recruitment and Sample

Criterion-based sampling is often used in qualitative studies to ensure sample homogeneity and in-depth analysis (Patton, 1990). To attain information-rich cases, a criterion-based sampling method was used in this study. The predetermined criteria were

a) trained and educated in their perspective fields (i.e., counseling psychology, clinical psychology, social work, or marriage and family); 2) a minimum of three years' clinical experience as a licensed mental health practitioner; 3) a minimum of one-third of their clientele in current or past clinical work with infertile clients or a minimum of one-third of current or past practice focusing on infertility related issues (e.g., pregnancy loss/miscarriage, adoption, fertility treatment, loss/grief, or consequences of infertility). Participants were required to finish an in-person interview with the investigator. The targeted population of this study was mental health professionals with experience providing infertility counseling services in their practice (i.e. individual counseling, group counseling, couples counseling, assessment, consultation, etc.). Hills and Williams (2011) recommended using 12-15 participants to yield consistency of results but also advised a larger sample of 15-19 if there may be subgroups within the sample. Given that potential participants in this study were recruited from different work settings (medical and community), a larger sample size was desired. This study planned to recruit a total of 15 to 19 helping professionals experienced in working with infertile individuals and couples.

Participants were recruited from Chicago and Twin Cities Metro areas. Potential participants were identified through several networks, including: the American Psychological Association, the American Association of Marriage and Family Therapy, the American Society Reproductive Medicine (ASRM), the Minnesota Psychological Association, the Illinois Psychological Association, the National Infertility Association (RESOLVE), the Minnesota Women in Psychology, and the Pregnancy & Postpartum Support Minnesota. A total of 68 licensed mental health professionals (i.e., Licensed

Psychologists, Licensed Marriage and Family Therapists, and Licensed Independent Clinical Social Workers) from the aforementioned networks identified infertility counseling as their specialty or listed infertility counseling as a part of their practices. An email invitation in the form of a cover letter (Appendix A) was emailed to these potential participants to encourage participation in the current study. The potential participants were also asked to forward the research invitation to their co-workers or other practitioners who might meet the criteria. A follow-up email or phone call was made if no response was received. In total, 34 potential participants replied to the invitation, which yielded a response rate of .50. Among the respondents, 21 indicated willingness to participate in this study and met the predetermined criteria; the remaining 13 did not meet the full criteria. Among the 21 who were interested in joining the study, only 18 finished the face-to-face to interviews; two withdrew due to schedule conflicts and one was excluded from this study because her articles were referenced in this study. One participant who finished the full research interview was also excluded from this study due to the fact that her infertile clients were not dealing with infertility as presenting concerns in counseling. Among the 13 practitioners who did not meet the criteria, 12 reported little experience in offering infertility counseling (i.e. accumulation of 2-3 infertile clients in their practice), and one reported no experience in infertility counseling but indicated that she was in the process of building up her infertility counseling practice. The participants' demographic characteristics are reported in Table 1 and summarized in Chapter 4.

Instrument

Demographic Questionnaire

Prior to the interview, a copy of a brief demographic questionnaire (Appendix B) was emailed or mailed to the participants. The questionnaire gathered information about participants' gender, age, ethnicity, years of clinical experience, years of experience in infertility counseling, accumulated numbers of infertile clients, and theoretical orientation. The participants were asked to finish the questionnaire before the interview.

Interview Protocol

To attain consistency across participants in qualitative research, medium-length semi-structured interviews are suggested (Ponterotto, 2005), which allows sufficient time and space for participants to explore and elaborate on their experience (Hills et al., 2005). A detailed, semi-structured interview protocol (Appendix C) with ten open-ended questions was developed. The interview questions were developed by the investigator based on the findings of the literature review, including topics such as training in infertility counseling, infertile individuals' reactions toward infertility, numerous consequences of infertility, and implied ethical concerns in fertility treatment. Probes for participants were developed with the open-ended questions, which allowed the interviewer to further explore the participants' experience and to elicit clarification when appropriate. The interview questions and probes then were reviewed by a qualitative research consultant.

Burkard, Knox, and Hills (2011) suggest that an appropriate interview protocol should consist of rapport building with participants while gathering consistent and sufficient information from participants about the research interest. The authors suggest the interview protocol should include three sections: the opening section which allows participants to open up by asking less evocative but relevant questions; the second section

which focuses on the main topic of interest; the final section which asks participants to focus on broader issues of the research topic. Thus, the early questions of this current interview protocol explored participants' overall experience in counseling infertile individuals or couples, their entry into the field of infertility counseling, and their training concerning infertility counseling. The second set of questions addressed the following topics: theoretical orientation in infertility counseling and non-infertility counseling, observed differences between infertility counseling and non-infertility counseling (if any), encountered challenges in infertility counseling, issues with facilitation of infertile clients' reactions, issues with self-disclosure, and experienced ethical dilemmas in infertility counseling. The last section of the questionnaire asked the participants to reflect on their most memorable case and one critical incident in working with infertile clients.

The investigator conducted one pilot study with a licensed psychologist who had extensive experience in counseling infertile individuals and couples. Also, another licensed psychologist reviewed the interview protocol. Based on the feedback, the investigator made minor revisions (i.e., wording and suggested probes) in the protocol.

Procedure

The study was launched upon approval from the University of Minnesota Institute Review Board. The face-to-face interviews with participants in the Twin Cities Metro area were conducted between May to July 2011, and those in the Chicago Metro area were finished between May to July 2012. As mentioned above, an invitation to participate in the study was e-mailed to potential participants; a follow-up email or phone call was sent if they failed to respond. Participants who expressed interest in participation were reached by phone or e-mail to confirm their eligibility to participate and their

schedule for the interviews. During the contact, participants were also encouraged to ask questions about the study.

Prior to the interviews, a copy of informed consent (Appendix D), a demographic questionnaire, and the interview protocol were e-mailed or mailed to participants. They were asked to review the informed consent, especially the benefits and risks of participation, and to complete the questionnaire. The investigator reviewed the informed consent form with participants again before the interviews began and offered an opportunity for participants to ask questions. Participants and the investigator met at their offices or places of their choosing. Participants were encouraged to choose locations where they felt comfortable discussing and reflecting on their clinical experiences. All interviews were conducted by the investigator, a female doctoral candidate in counseling psychology with 6 years of experience in counseling interviewing. Interviews were audio-taped with a digital recorder, and the files were preserved until the completion of data analysis. Four master's students in counseling transcribed the audio files verbatim, and the investigator examined the transcripts for accuracy. Each audio file and transcript were assigned code numbers to protect participants' confidentiality; transcribers had no access to participants' identifying information.

Data Analysis

Descriptive data (i.e., frequency, mean, and medium) were enumerated from participants' demographic information. The data included gender, age, work settings, years of clinical experience, years of infertility counseling experience, and accumulation of infertile clients.

The data was analyzed by the utilization of the Consensual Qualitative Research (CQR) methodology, developed by Hills et al. (1997). CQR is an approach which incorporates essences of phenomenological, ground theory, and comprehensive process analysis Hill et al., 2005). CQR emphasizes the use of words (narratives and stories) to reveal meaning in data, and the descriptive nature allows for in-depth exploration of qualitative data. This analysis method also increases validity and reduces biases by utilizing consensus from three to five researchers (Ponterotto, 2005). As a result, CQR was chosen to analyze the qualitative data in this study for its aforementioned advantages. Below are listed key components of CQR (Hills, 2011): inductive approach; use of open-ended questions in interviews to elicit responses; reliance on words (narratives and stories) to capture participants' experience; importance of participants' context (personal and clinical experience); use of small samples; multiple viewpoints of research team members (3-5 research members and 1-2 external auditors); consensus among team members; strong emphasis on ethics, trustworthiness, and attention to culture.

The primary research team for this study included the leading investigator, a female doctoral candidate in counseling psychology, a first-year female doctoral student, and a second-year female master's level counseling student. The lead investigator and one of the team members had prior clinical experience in counseling infertile clients in college or medical settings. The other research member had not worked with any infertile clients or infertility-related issues. A doctoral level, licensed professional psychologist served as an auditor for the analysis. All research team members had prior experience analyzing qualitative data and one research member had utilized CQR in one qualitative study. In addition, all research members studied Hills et al. (2005) and Hills (2011) to

ensure the familiarity with the CQR protocol. The investigator also sought consultation with an experienced CQR researcher.

To ensure the team members' understanding of participants' culture and context, the team members reviewed participants' work settings (medical, community, or private practice), years of clinical experience, and focus of clinical works (individual counseling, group counseling, couples counseling, and assessment) before embarking on data analysis. It is also recommended that research team members discuss and explore their personal biases and expectations that might affect their responses to the data before data analysis (Sim, Huang, & Hills, 2011). Biases refer to researchers' personal issues that might affect their ability to objectively approach data, while expectations are defined as researchers' anticipation about participants' responses to interview questions (Sim et al.). Sim et al. therefore suggested addressing and recoding biases and expectations in each step of CQR. As a result, prior to data analysis, the team members discussed and recorded potential biases and expectations.

Two research members disclosed having witnessed infertile clients' struggles (i.e., grief, multiple losses, decision making, etc.) in their clinical work; as a result, they acknowledged the potential to expect participants to report more challenges in counseling infertile clients' grief and loss. One research member disclosed personal experience with infertility and another member reported one close family member's recent struggle with infertility, and both research members acknowledged their biases that participants might experience issues with infertile clients' emotional reactions. The team members were encouraged to record their biases and beliefs throughout the research process, which were later processed and discussed in the meetings.

In analyzing the data, the research team followed the steps listed below. First, research team members reviewed transcripts independently to segment the data into *domains*. The second step involved developing *core ideas* within each domain that accurately but briefly captured participants' responses. In the last step, *cross-analysis*, the research team members aggregated core ideas into categories and subcategories (if any) across cases. After each step, the research team members met to compare and contrast their findings and reach consensus on domains, core ideas, and categories. The auditor reviewed the development of domains, core ideas and cross-analysis, and offered feedback. Based on the auditor's feedback, the research team made revisions as needed.

The research team initially focused on three cases, developing domains independently; then the team met to reach consensus and jointly recoded the cases. Rotating teams of two, researchers then coded the remaining cases into domains while another team member reviewed the results to ensure all team members' familiarity with all cases. A similar process was adopted in developing core ideas. However, when cross-analysis began, the master's level team member withdrew from data analysis due to schedule conflicts; as a result, only two research team members were involved in this step. In cross-analysis, each research member independently developed categories and subcategories by reviewing core ideas across cases for each domain. Once consensus was reached, core ideas in each domain were placed into categories or subcategories. The cross-analysis procedure was repeated for each domain. In order to determine the representativeness of categories, frequency information was calculated by counting the numbers of participants who reported core ideas within each category or subcategory (Ladany, Thompson, & Hills, 2011). According to Ladany et al., categories which

consisted of data from all participants or all but one participant were considered as *general*. Categories mentioned by more than half of the participants to the cutoff for general were labeled as *typical*. Categories mentioned by four to the cutoff for typical were considered as *variant* and a category which only included two to three participants was labeled as *rare* (Ladany et al.)

Chapter 4: Results

Demographic Characteristics of Interview Sample

This study aims to explore the challenges encountered by mental health professionals working with infertile individuals and couples. As aforementioned, 18 participants finished the interviews. However data from one participant was excluded since this counselor did not practice infertility counseling but advertise to do so; although this counselor offered counseling to infertile clients but infertility was not a presenting concern of these clients. Table 1 shows the demographic characteristics and background information of the 17 participants whose data was analyzed in this study. There were 16 females and one male. Among the participants, 16 self-identified as Caucasian/White, and one was Hispanic/Latino. Eight participants reported age above 51, seven were between the age of 41 to 50, and two were between 31 to 40 years old. All participants had post bachelor training; among them, 13 participants had training at the doctoral level and four at the master's level. Regarding their academic disciplines, eight participants were trained in the field of clinical psychology, four were trained in counseling psychology, four were trained in marriage and family therapy, and one had an educational background in social work. The participants reported an average of 20.7 years of clinical experience ($SD=8.48$; Range: 9-39) and an average of 12.8 years of experience providing infertility counseling services ($SD=8.05$; Range: 3-26). With respect to percentage of caseloads dealing with infertility-related issues, two participants were in the range of 25-50%, seven were in the range of 51-75%, and eight were in the range of 76-100%.

Participants reported being licensed in a variety of mental health disciplines: 11 licensed psychologists, four licensed marriage and family therapists, one licensed independent clinical social worker, and one licensed clinical professional counselor. Regarding work settings: 11 participants had private practices. Among those practices, eight contracted and collaborated with reproductive medical centers. Five participants worked in reproductive medical centers or general hospitals, and one practiced in a community mental health center. Fifteen participants offered a wide variety of infertility counseling services (i.e. therapy, assessment for third party reproduction, and consultation) while two provided therapy only to infertile clients. Specifically, 14 participants offered assessment for third party reproduction.

Most participants ($n=14$) were affiliated with the American Society for Reproductive Medicine (ASRM). All participants reported receiving some level of formal infertility counseling training (i.e., practicum, internship, mentorship through work, ongoing education/workshops, or consultation) and informal training (i.e. reading and peer consultation). The three most endorsed theoretical orientations by participants were cognitive-behavior ($n=12$), psychodynamic ($n=10$), and interpersonal therapy ($n=9$).

Clinical Impression and Participants' Interview Behavior

The investigator conducted all interviews. The length of interviews ranged from approximately 30 to 60 minutes. Prior to the interview participants approximately spent 10 minutes asking questions about the study and completing the demographic questionnaire.

Participants' nonverbal behaviors were observed during the interviews. Most participants appeared open and reflective throughout the interview process and appeared

thoughtful in their responses. Participants clearly expressed their excitement and passion about infertility counseling. Most participants described their observation of their clients' struggles and suffering as a result of infertility, but they also described being impressed with and touched by clients' resiliency and persistence. Several participants stated their excitement about their participation in this study and requested a copy of the results or manuscript after the study was completed.

In the interview process, most participants appeared comfortable reflecting on the challenges they encountered in their clinical work with infertile clients. Two participants initially seemed slightly hesitant to report their experienced issues but relaxed and became more expressive as the interview progressed. When asked to report a critical incident in working with infertile clients (Appendix C), five participants asked for clarification about the definition of *Critical Incident*. One participant asked whether *Critical Incident* referred to a client's mental health emergency. The participants were offered a brief definition of *Critical Incident*: a meaningful event that had an impact on or was important to counselors (Fukuyama, 1994; Coleman, 2006). The participants were then able to offer responses to this question. More than half of participants ($n=9$) inquired about the investigator's motivation for developing this study. One participant expressed interest in knowing other participants' personal motivation to enter the field of infertility counseling, and this participant stated,

“Just out of curiosity, I guess my question would be, what have you found with the people you're interviewing. Is it typical that they've gone through a similar experience (infertility) themselves? Because that's just been my impression, but I've never seen any statistics about...”

Broadly speaking, participants' responses to the interview questions appeared thoughtful and thorough.

Qualitative Data Analysis

A total of five broad themes (domains) and 19 categories within these domains were identified in this study using a Consensual Qualitative Research (CQR) method. The results were summarized below and reported in Table 2. Categories and subcategories (if any) within each domain were described, with examples and participants' verbatim quotes. Category representativeness (frequency) was also reported based on CQR methods (Ladany et al., 2011). Instances of categories which applied to all or sixteen participants were considered as *general*. Those categories that applied from eight to fifteen cases were deemed *typical*, and those categories that applied from four to seven cases were described as *variant*. Instances of categories that applied from two to three participants were considered as *rare*. Hills et al. (2005) suggested that rare data was reportable when the sample size was bigger than 15.

Domain 1: Challenges Related to Infertility Counseling Education

The first domain consisted of participants' challenges regarding infertility counseling education and the impact of untrained/unknowledgeable counselors on infertile clients. A total of 12 cases reported instances in this domain, which were aggregated into three categories: the importance of medical knowledge; the need of infertility counseling training; observed reactions of clients toward unknowledgeable providers.

Category A: The importance of medical knowledge. Eight participants reported the importance of medical knowledge in infertility counseling. Counselors typically related that their understanding of medical aspects of infertility had enhanced clients' trust in counseling as well as enabled the counselors to understand clients' experiences.

Participants also spoke to the connection between medical knowledge and the counseling relationship:

“I think (medical knowledge) is another important part of this, because it’s not the client’s job to educate me. And they’re not going to trust and be open if the therapist doesn’t know the medical aspects of it.”

“Therapists can kind of understand the person’s experience, but I think to kind of actually understand what these procedures look like, sort of what the medicines look like, how much, you know, how much of an impact that has on daily life, I think, you know, if you don’t have that sort of knowledge base it’s a little bit, in my opinion, sort of harder to empathize with what your patient is going through and, you know, how major these life decisions are.”

Participants stated the necessity of medical knowledge in infertility counseling and explained why infertility counseling needed to be a specialty:

“So, I think it’s crucial that the therapist be completely comfortable with medical terminology, with interacting with medical providers, and with talking about sex and sexual function and reproduction, or it’s not the right place for you.”

“It’s specialized and if you don’t have knowledge of the different types of treatment, the different options, what kinds of experiences people are facing, what choices they might need to make or have to make; I think it’s hard to have the context to do that kind of work and yeah, I think a person could fill a doctor in, but it takes a lot of time. So I think, I really think it’s one of those places where it should be a specialty, and that knowledge does really help a lot.”

Counselors reported on the relationship between medical knowledge with ethical issues and counselors’ responsibility to explore these issues with infertile clients:

“Because you have to be very knowledgeable about the choices that people have to make, and that there are ethical issues around the corner all of the time for the couples, and the individuals if they are becoming single moms; Um, so I think that you yourself need to be aware of kind of what the ethical ramifications are so that they are aware of them and they don’t find themselves in a situation where they are having to make decisions about what to do with left-over embryos or being pregnant with triplets or something like that without having known that before they walked in.

Category B: The need of infertility counseling training. Eight participants spoke to the importance of infertility counseling education/training and typically pointed out the lack of formal training in graduate school.

“In my experience, there’s inadequate training in graduate school or therapists in working with reproductive health altogether.....”

“There is no so called ‘infertility counseling’ class or training.”

“I think that having some sort of a regulated, formal training in infertility counseling would be really, really helpful.”

“I think everyone probably coming into this field actually probably needs a mentor because you don’t hear about the issues specific to infertility outside of an OB-GYN clinic and even more specialized endocrinology clinics.”

A few of the eight participants observed that the unavailability of formal infertility counseling education might have discouraged or excluded some therapists from gaining a specialty in infertility counseling. They also spoke to their disappointment about this situation.

“I think it really takes a lot of individual motivation to find resources and find people. It’s not just something you can sign up for.”

“It’s difficult to find a clinic where there’s somebody already there or difficult to find somebody who will provide you with supervision without having to pay to do..... I think it’s disappointing. I know that working in this field is highly competitive. And anything that’s competitive is tough to get in. But I think it can feel exclusionary and I don’t like that. I wish there was another way to do it. I wish actually that graduate programs would provide some of this type of work or that there would be internships or fellowship.....I think would be nice as a field if we could provide a better way and more frequent way of training psychologists toward this field.”

Participants described their observation of therapists’ lack of understanding of infertility, and asserted infertile clients’ rights to be served by well-trained infertility counselors.

“I thought it was important to be available to other people because so many therapists don’t know anything about it. It was important to give people who were

struggling with infertility an opportunity to talk to a therapist that they didn't have to educate."

"I felt as if there was a lack of people (therapists) who had knowledge of the sort of issues related to infertility."

Category C: Observed reactions of clients toward unknowledgeable providers.

The frequency of this category was variant. Five participants reported having observed inappropriate interventions by therapists, who were not specialized in infertility counseling, including:

"They (infertile clients) may have seen other therapists who really don't get it, you know? And who are just saying, oh relax, you know, go on vacation and you know, why don't you adopt? You know all these things that the other people in their life are saying that aren't helpful."

"The worst version of that is, 'oh relax and you'll get pregnant'. I don't know how many times people have been told that by friends or even by physicians or unknowledgeable therapists."

Participants stated their infertile clients were damaged by their previous unknowledgeable therapists:

"I've seen some people who have gone to previous therapists that didn't have, maybe not necessarily a personal experience, but they didn't have the additional training in infertility either. And just had a bad experience."

"We get clients who have gone to other therapists, who did not specialize in counseling infertile people, who specialize in grief and loss, who understood grief and loss and still because they did not understand infertility, either because they did not understand the medical aspects and they just couldn't navigate the technology and the medical aspects of it, or because they really did not understand the emotional experience and did damage. And people came to me after having had damage done, after having had therapists say to them, 'why don't you just adopt?'"

One participant specifically spoke to her concerns about her infertile clients' care from their previous therapists and had debated whether those cases were unethical and reportable.

“I had a client, who said they had a bad experience with a previous therapist. But because it's such a small world, and because I've heard these things repeatedly, that has been challenging. But there are times when something happens that, again, I don't know if you would really consider it reportable. And I consulted on this actually, once, and it really wasn't reportable. But in my mind it crossed an ethical boundary.”

Domain 2: Challenging Counseling Issues

All participants reported their observations on infertile individuals' multiple and complicated issues as a result of infertility, including emotional distress, marital or relational conflicts, financial concerns, decision making on fertility treatments, ethical concerns, spiritual crisis, etc., which were consistent with the current literature. Some issues were more salient and challenging to participants while some were more manageable. Below are the issues generally identified by participants: clients' reactions toward infertility and fertility treatment, co-existing mental health issues, relationship difficulty, and unrealistic expectations on infertility and fertility treatment. All participants reported instances within this domain.

Category A: Clients' reactions toward infertility and fertility treatment. This category captured clients' reactions toward infertility and fertility treatment that were typically considered by participants ($n=14$) as challenging in counseling. This category was divided into the following subcategories: 1) intense emotional reactions, 2) repeated losses and grief, 3) loss of control, and 4) identity crisis.

Subcategory 1): Intense emotional reactions. Eleven participants observed infertile clients' intense emotional reactions (i.e. overwhelming sadness, anger, anxiety, fear, desperation, distress, etc.) toward infertility or fertility treatment, and participants typically found it challenging to address and respond to these strong emotions in sessions:

“Sometimes the discouragement is so deep that they believe that this is never going to work. And it's really hard for them and that's hard for me”

“People are in a lot of emotional pain often. So, the degree of distress can be very hard to work with and they often need a lot of empathy. . . . People who are relatively inconsolable, that can be a bit more of a challenge.”

“There's a great deal of anxiety and I don't quite know what to do with this.”

“At times, conversations with the fertility preservation patients tend to be even more emotional because we talk about death.”

Various participants described infertile clients' “up and down” emotions when they underwent fertility treatment. These participants also pointed out counselors' difficulties to witness clients' emotional roller-coaster.

“I think the hardest part, maybe the biggest challenge for me as a therapist is just how up and down it is. You know, and even though logically I know that and I understand that, it's still hard sometimes emotionally to like.”

“So it was a very emotionally draining case for me because for many, many, for years, once a month she (an infertile client) would come in and she would be completely wiped out. And even though I knew she was wiped out, and even though I knew that, you know that, in 3 or 4 or 5 days she'll be ok, in those moments she was suicidal. You know and in those moments, it was very hard to be with her, and hold onto the fact that, the notion that: ok, I know her, we've been through this, I know she'll be ok, she's not going to kill herself, but she really went way, way, way, to a very dark place.”

“All of a sudden, they (infertile couples) are going through a very tense cycle and they will need to see you as much as possible.”

Participants stated their observations that infertile clients were more distressed than clients with other issues, and participants described infertile clients as “the hardest patients to work with”:

“These fertility patients are the hardest patients of all to work with. I’ve worked with cancer patients, I mean across the board I think they’re just the hardest to work with. I’ve done all these rotations but I’ve never seen people as upset and distressed as they (infertile clients) were in this reproductive setting.”

“Probably my most intense sessions have been with people who go through infertility.”

Subcategory 2): Repeated losses and grief. Eight participants identified infertile clients’ repeated losses and grief as a challenging issue in counseling. Counselors typically reported processing raw and painful emotions with clients immediately after their miscarriage, failed treatment, or chemical pregnancy:

“A lot of times I’m sort of the first person or the second person (to know about the miscarriage) after the spouse, where it’s always very new and very fresh and very unprocessed and it can be very, very intense. So all the grief, all the pain, kind of pours, and that’s hard, that’s hard to be with and it’s hard to sit with.”

“I don’t know if fragile is the right word, but maybe at times fragile, particularly after a treatment that has not been successful. Those are really delicate moments in some ways.”

“I’ve had people who have gotten pregnant initially and lost, you know, and had a blood [chemical] pregnancy. And you know where the expectation and the happiness and the sorrow that follows through. You know, in the days after that when you realize that actually it was not a pregnancy, that, a viable pregnancy, and so dealing with that sorrow.”

Participants identified the difficulty of “holding hope” for clients with repeatedly failed treatment, and at times counselors became tearful in sessions when facing clients’ multiple losses:

“I felt like these people have been through so much and nothing works their way. And again, and again, and again they fall on their face and it gets challenging for

me to hold on to their hope for them, you know. And it's a challenge to sit with their helplessness, because there's a lot of helplessness and powerlessness and sit with it and be there with them in it, but not succumb to it in the way that they do."

"A really, really hard challenge is people go through lots and lots of treatment and it still doesn't work. So there's this very intense, palpable grief that goes on. I'll be in tears sometimes."

Subcategory 3): Loss of control. Five participants identified infertile clients' sense of loss of control in facing infertility as a challenging issue in counseling. These counselors also discussed their difficulty in assisting clients with accepting the lack of control in response to infertility.

"I think that (loss of control) is a very central and difficult issue in therapy to try and work that through."

"I think the first one stands out the most for me just this idea of their assumption that they can solve their problem. And often times the problem is outside of their control that loss of control. I think that is often times the most pervasive and can be the most challenging."

"And trying to peel somebody off that anxiety (desire to control) is hard. It just doesn't seem to get any easier."

Subcategory 4): Identity crisis. Six participants reported that it was challenging to facilitate changes when infertility damaged infertile clients' identity and created narcissistic injury:

"I think because it has been difficult for me to adapt to working with this group (infertile individuals) because there it (infertility) seems to get at the core of people's identity..... So it really just seems to hit to the core in a way that other things don't."

"For some women, this experience of not being able to reproduce is such a deep narcissistic injury that it's really damaging their core. It's very hard to help people who are stuck there."

Participants also observed that infertility, a medical condition, evolved into a spiritual crisis for some infertile clients:

“They said (infertile clients) this (infertility) should have not happened to me; this isn’t fair. They say God shouldn’t have done this to me. So it gets wrapped up with their religious beliefs.”

“Where it (infertility) really becomes kind of a spiritual crisis.”

Category B: Co-existing mental health issues. Eleven participants observed that beyond the numerous consequences of infertility, infertile individuals were likely to suffer from mental health issues just as fertile clients did. These counselors typically reported that, at times, infertile clients’ intense reactions toward infertility blurred into depression or anxiety, and sometimes infertility triggered previously unidentified mental health issues. It was also noted that infertile individuals had pre-existing mental health issues before the infertility problem. This category was divided into two subcategories: 1) mental health issues; 2) personality disorders.

Subcategory 1): Mental health issues. Nine participants reported having observed a wide variety of mental health issues (depression, anxiety, eating disorder, substance abuse, bipolar, past or current domestic or sex abuse, etc.) among infertile clients. Participants typically spoke about infertile clients’ reluctance or defensiveness when counselors tried to address these pre-existing or previously unidentified mental health issues:

“When people have severe psychopathology or substance dependence and that comes up in the visit, talking about that is...can get very difficult because people can get very defensive about those types of things.”

“The other thing I may discover is long standing depression or anxiety that hasn’t been recognized. And if it weren’t for this (infertility), they wouldn’t have addressed it and they don’t see it that way.”

“Probably sometimes it’s difficult when /if I feel as if some mental illness that has gone unidentified, you know, is also getting triggered through the experience of infertility.”

Participants reported the challenge to differentiate between clients’ intense sadness/grief and clinical depression:

“Working with sort of the infertility-related issues that, sometimes, it’s really hard to get a clear picture.”

“For some (infertile) people, it’s blurred over into maybe a diagnosable kind of depression.”

Participants also pointed out that infertile individuals were more at risk for parenting difficulty or postpartum depression than fertile individuals:

“And you know for many people, yeah infertility is tough but then after having the baby...then it really starts getting challenging cause you’re exhausted on top of it. But I think that’s difficult when people are so kind of hell bent on getting pregnant that they’re ignoring...it’s like they won’t see how their depression or other issues are setting them up to be unhappy or ineffective as a parent.”

“The infertility process or her previous issues are setting her up for perhaps a postpartum depression.”

Subcategory 2): Personality Disorders. Among all mental health issues, seven participants singled out personality disorders as the most challenging co-existing condition in infertility counseling:

“Very often it’s more complex if a (infertile) person has a personality disorder.”

“So sometimes you get someone who is infertile plus, let’s say, has a personality disorder, then that can be a really challenging therapy.”

Various counselors stated having some of their personality disorder infertile clients became suicidal in the process of fertility treatment. Some counselors also indicated concerns about these clients’ future parenting.

“I feel worried for her (an infertile client with personality disorders) as a parent.”

“You know if somebody is treating other people like garbage now, how might they treat a child and so you have to think about it.”

“I worry for the family when...when a person is going through this (infertility and fertility treatments) with some obvious personality traits that are going to be problematic, you know to the family or raising children.”

Participants further stated their difficulty in supporting infertile clients with personality disorders:

“When I see more personality disorder or if I see somebody who is really depressed, refusing...you know and therapy isn’t really doing much other than supporting her...”

“People with personality disorders are difficult, generally. I can have lots of compassion but still there has to be that’s enough of that.”

Category C: Relationship difficulty. Participants typically recognized relationship difficulty as a challenging issue in infertility counseling, and 13 counselors offer instances. This category was divided into two subcategories: 1) marital and relational conflicts; 2) isolation and lack of support.

Subcategory 1): Marital and relational conflicts. Participants (N=11) typically found it challenging to assist infertile couples navigating through marital and relational conflicts, especially when couples had different goals and agendas on family building and fertility treatment:

“I think another challenge is when I’m meeting a couple who are in very deep disagreement about treatment. And that’s the most challenging, among the most challenging, situations that I encounter.

“One person did not want to have children or didn’t want to do IVF and the other one really wanted to. But that is not a negotiable thing. It is not something you can compromise on. So that part I think is hard.”

“No matter what, if he’s forced into this, he is going to be resentful, even if they have a child maybe. And if she agrees to stopping, she is going to resent him because he put the brakes on this. It’s almost a problem without a solution. I find it very challenging to work with them.”

Participants reported that at times couples would end their relationships or marriage because of their strong desire to have children, marital discordance, or stress from fertility treatments.

“With marital therapy, when the marital problems come up, I think I have found that about half of the time it works, and about half of the time it doesn’t. And patients will do so very ah unconscious things to end marriages. I think because of the desire to have children is so strong that sometimes it trumps the desire to be with the partner.”

“They (infertile couples) are afraid because they feel like they are in such different places from their spouse and they’ll never be on the same page again.”

“All of the time, and we know there are couples who don’t continue fertility treatment because it is destroying their marriage, we know there are couples that end up getting divorced due to fertility treatment.”

Participants reported that, when couples responded differently to infertility or fertility treatment, the differences were difficult to address in couples counseling. Some participants contributed the issue to gender differences for heterosexual couples while some argued “individual differences” for gay and lesbian couples.

“Another big challenge that I see actually is from couples, is how this gets in the way of couples communication, how this really almost makes stand out gender differences and how men and women deal with stress. And it is fascinating for me to observe, but it just keeps coming up. “

“The gay or lesbian couple responds differently to it (infertility) and one person wants to talk and the other person doesn’t want to talk. One person is not interested in sex unless they’re going to have a baby and the other person is missing that part of their relationship. And it’s not necessarily gender, because they are two different people who cope differently.

Subcategory 2): Isolation and lack of support. Participants (N=8) typically spoke to infertile couples' and individuals' isolation and lack of support:

“They (infertile couples) end up completely not talking to each other, and they end up alone.”

“A lot of people that are going through fertility treatment don't have a place to really talk about their feelings.”

Participants further described how this issue of isolation manifested in counseling:

“Like lots of infertile couples at some point in the process, they literally stop answering the phone because they're so sure it's either somebody else calling to say they're pregnant or somebody to ask how they are. And they don't want it all stirred up by talking about it. So the phone rings and it's already a traumatic experience. And then they start judging themselves, what's wrong with me, how screwed up am I that I can't even answer the phone? Then they start projecting that onto a therapist, especially if the therapist isn't so actively involved.”

Participants also stated that the lack of understanding of infertility in the society not only caused infertile individuals' isolation but also discouraged them from seeking professional support:

“I think that a lot of our culture isn't really understanding or is kind of ignorant about these issues. And so when people say things, like oh if you just keep trying you'll get pregnant, or just be patient and you're young; you've got lots of time. And when (infertile) people hear those things they internalize that as oh, maybe I'm making too big a deal of this, and I think that prevents them from coming into therapy.”

Category D: Unrealistic expectations about infertility and fertility treatment.

Participants (N=9) typically found infertile clients' unrealistic expectations challenging to address in counseling.

“It's when people have very tight expectations of what life is to be and how to live it, you know. It's very hard to talk them out of that...so that's umm...challenging.”

“I don’t want to say entitlement, but there is an expectation that this is going to be fixed quickly in the (infertile) patients’ time table, because that’s what they want. And sometimes this is the first life experience of things not going their way.”

Participants typically observed that at times infertile couples might view successful pregnancy or family building as the solution to their struggles in their daily life instead of working on the roots of their issues:

“One of the issues that’s hard is that when people (infertile clients) think that they’re going to have a baby and that will solve all of life’s problems. So if there are problems in the relationship, or if they’re not happy with themselves, or what they’ve achieved in their life, and they think well, if I can solve this fertility problem and have a baby then that will take care of everything else.”

When infertile clients denied their inability to have biologically related children or failed to recognize their inability to cooperate in fertility treatment, some participants found it difficult to facilitate acceptance in counseling:

“I once saw a woman. She was maybe 42. Her FSH was maybe 125. So she went to a physician, and he said ‘you know, I’m very sorry but you’re in menopause and you need to use donor eggs’. She wasn’t going to use donor eggs....We’re talking about all kinds of crazy treatments and she wanted to have, to conceive naturally on her own. Um, and just the denial there; she could not get, she would not acknowledge, the fact that she lost something, you know that something sad happened to her and she had lost it (fertility). So that was a challenge in that therapy to try to get her to sort of look at that instead of putting all this effort in over something which might or might not have been harmful to her physical health.”

“She (an infertile client) wasn’t able to admit that she was struggling enough to get some help for herself, to give herself some time. She was in that, ‘I’m going to adjust, you know keep charging forward, and I’m going to be ok when I finally have a baby’. But I was pretty sure at that point, given what had already happened and now she’s in more pain, that her ability to cooperate effectively with a surrogate during a pregnancy was going to be very jeopardized. So you know, delivering bad news to somebody who’s already distraught was really hard.”

Domain 3: Ethical Concerns in Infertility Counseling

This domain covered the ethical dilemmas that participants encountered in working with infertile clients. A total of 16 participants identified instances within this domain, which was sorted into three categories: A) ethical challenges in assessment, 2) ethical concerns about clients' decisions on or controversial requests for fertility treatment, 3) ethical concerns about clients' care from other providers, and 4) dual relationships.

Category A: Ethical challenges in assessment. A total of 14 participants typically recognized ethical concerns in assessment in their current or past clinical work. This category consisted of the following subcategories: 1) challenges in assessing appropriateness and readiness for fertility treatments, 2) concerns for unborn children, and 3) a personal ethical dilemma about gate-keeping roles.

Subcategory 1): Challenges in assessing appropriateness and readiness for fertility treatment. Participants ($n=12$) reported ethical challenges in assessment and described fertility treatment assessment as *an ethical minefield*. Instances included counselors assessing the readiness for fertility treatments of infertile individuals with mental health issues:

“I’m not really sure how great of a parent this person (an infertile client with Borderline Personality Disorder) is going to be, you know given all this and you know, if they didn’t have infertility they could just go out and have a baby and no one would have anything to say to them about that. But you know, those kind of issues are challenging.”

“Occasionally if there are issues that concern me about their mental health or their preparation for what they’re about to go into, then it gets trickier. And on rare occasions, I’ve had to say to an agency, ‘you should not work further with this person, or I would advise you not to work further with this person because they’re not stable enough to be cooperative participants.’

Various counselors encountered ethical dilemmas in assessing third party reproduction.

These participants also spoke to the complexity of assessment and the various factors involved:

“So I think pre-denying treatment is probably the biggest ethical concern we face and we just did it this week. We had a gestational carrier who disclosed, who said she filed for divorce a month ago and she was just about to start another cycle with a recipient couple. And we had to stop it because we were really concerned about the impact of the divorce about the carrier, in particular on the carriers’ children as well, and if that divorce would somehow influence that process between her and the intended parents. So we stopped the case.”

“I think that is where the more guidelines we have along the way the easier it will be, especially when it comes to third party reproduction. I think that is where there are a lot of slippery slopes, what is ok and what isn’t. Can the father use donated sperm to the son? Can the best friend be an egg donor to the other friend? Can the sister donate to her sister? Can the woman who has had six children be a good surrogate? Can someone who has had postpartum depression be a surrogate? These are really difficult questions.”

Participants also recognized their responsibility to protect all parties involved in third party reproduction:

“Coercion is something important to figure out especially when there are known donors.... There is another woman who finds this known donor for her, but she has some financial power over her so it is really not a fully willing donor. So really to also be willing to protect some of those women is important to me. They will tell me ‘No, I don’t want to be a donor, but if I am not a donor this (some financial arrangement) won’t happen. We can’t allow that (coercion) to happen.”

Counselors variously pointed out pressures from various parties involved in third party reproduction, including intended parents, third party reproduction agencies, and physicians. Participants pointed out their responsibility to be a gate keeper and their confusion caused by multiple parties involved:

“There’s a lot of pressure that comes to bear from like the couple that wants to use that person or the agency. You know there’s a lot of different pressures coming in

to force cases along so the nurses and the psychologists become the people who stand the line and have to make some tough decisions.”

“So, the agency sends a couple that needs the assistance of an egg donor. Who’s my client, the agency or the couple?”

Participants recognized ethical challenges regarding fertility preservation and the use of frozen embryos after one party’s death. One complicated case was offered to illustrate the ethical challenges for all parties involved:

“The other one that pops to mind that was an interesting ethical issue, too, also controversial, is... we do fertility preservation for cancer patients and one of our cancer patients had died and her husband came in within months of her death to discuss using her frozen eggs to create a baby with a gestation carrier. And he was in the midst of grieving her death.....I also spoke with him about really thinking about the decision he was about to make and putting himself in the deceased woman’s family’s shoes and his family’s shoes and his future child’s shoes and think about whether this was in all of their best interest going forward. How might he feel if there was a miscarriage.....if there was something medically, you know, wrong with the child. And to just think deeply about all of the issues involved and if he still felt like it was the right decision, then come back and we’ll talk to him.”

Counselors spoke to their internal struggles when they decided to deny infertile clients for fertility treatments:

“On those rare occasions when I had done a psychological assessment and had to tell somebody that I wasn’t going to approve them. I mean that was...certainly there was anger and upset and I mean that was very hard. Very hard for me and for them.”

“What would be the hardest would be if I interviewed an individual or a couple and based on numerous things that I would have to say to the doctors I don’t think this is a good candidate to go forward with this particular procedure....How upsetting it is...upsetting for me and upsetting for them.”

“So you know, delivering bad news to somebody who’s already distraught was really hard.”

Subcategory 2): Concerns for unborn children. Participants (N=12) typically reported their responsibility to safeguard unborn children's best interest and reported taking unborn children's well-being into consideration when assessing infertile clients' readiness and appropriateness for fertility treatments:

“Probably the biggest thing that sticks with me is the fear of creating kids who might not have a good life. We have had that happen, where we come to find out later, we helped a woman get pregnant and there have been some very bad outcomes....”

“The male is 60, and they are choosing to go through IVF. There is a piece that there is no real reason you shouldn't support that, but there is sort of an ethical reason to the rights of the future child, yeah, of you helping them and supporting them and making a decision and knowing that there is a strong possibility that their child won't see (their parents) live for another 15 years.”

“That was a time when a young, gay Chinese man, whose family was in China...and his extended family did not know he was gay, and he wanted to have a child through, with a gestational surrogate, and pretend to his family that he got married and had a child. He did not intend to raise the child; he intended to send the child to China to be raised by his family.And he really had no interest in being a parent to this child.”

Counselors recognized the philosophical questions about the creation of life:

“The central question... is it better to have just been born even with just a terrible life, or should you not have been born at all?”

Counselors also reported ethical concerns when assessing the fit for parenthood for infertile individuals with mental health issues:

“Another ethical challenge is if the personality disorder issue or they're treating their partner like crap, where you don't really want to get in the way of somebody's dream but at the same time maybe this is not a good idea, you know. You know if somebody is treating other people like garbage now, how might they treat a child and so you have to think about it.”

“We have a patient who has a history of psychosis of probably over a decade and wants to do assisted reproduction..... it’s not like she’s well maintained on her meds so she tends to have breakthrough episodes and you know how that will affect her ability to be a mom.”

Participants also identified offspring’s rights to know their biological parents through third party reproduction. Examples below illustrated ethical challenges when intended parents decided not to inform their future children about the use of donated sperm, eggs, or embryos:

“And it’s frustrating when they (intended parents) say ‘we’re not going to tell the child’. And I say, ‘you may be having some conflict of interest. There’s many ways a child can find out instead of from you, like from DNA testing and blood tests and stuff’.”

“Of couples who don’t have any plans to tell their children that their father or mother is not their genetic parent. And that is another ethical piece as well as critical in that I have to keep my own opinions to myself but also prepare them for the reality that they probably will find out in our age of genetics. And when that happens then everything I know about family secrets tells me that that that will be critical, that will be a crisis, that could or could not end well.”

Subcategory 3): Personal ethical dilemma about gate-keeping roles. Seven participants reported personal dilemmas about their responsibility to deny fertility treatments and decide who can be parents:

“We don’t get to decide how people have children if they don’t have infertility, but suddenly, because they do have infertility, I think there’s not an agreed upon line about what right we have as professionals to impose our values on the people that are wanting to get pregnant.”

“You know that 85% of the world does not have someone looking at them when they decide, consciously or unconsciously, to have a baby. You know, they’re not under the same kind of scrutiny. But, you know, someone who is infertile or someone, I guess, who has a treatment provider could say no. You know, there’s an adoption agency who could say no. How do you kind of deal with that, those gray areas. You know, and that’s tricky.”

“I can’t be the judge of whether or not they (infertile clients) should be parents. Or, even if someone has severe mental health issues, I still need to be there and support them, I don’t feel that it’s my job to be God and say ‘you can’t have a baby or shouldn’t have a baby’.”

Meanwhile some participants reported debating between their role to support infertile clients and their responsibility to protect unborn children:

“What is my role in protecting somebody who is not here yet... So is my role to always support the client, help them feel comfortable or something, or is my role to recognize that, if I am working at an infertility clinic, I am participating in the creation of life and do I have, do I have a responsibility to that creation of life?”

Category B: Concerns about clients’ decisions on or controversial requests for fertility treatments. Within this category, seven participants identified instances where they disagreed or were concerned about infertile clients’ decisions on fertility treatments. One participant offered an example in which her infertile clients terminated therapy because of the counselor’s disagreement:

“There are sometimes when I disagree with the way a person is approaching or the decisions they’re making. I think that can get into kind of an ethical issue... someone who had to use donor sperm, and the couple asked his brother to be the donor which would be an obvious person to donate. But there was such conflict between the two couples and I just thought, wow, this is a just... this is a really bad recipe you know, here. I was just... just saying what I saw, you know. And the woman ended up firing me and going to another therapist cause she didn’t like what I was saying.”

Several participants discussed ethical challenges regarding infertile clients’ controversial requests for fertility treatments:

“We had a woman who wanted to use a gestational carrier because she didn’t want to get fat, not because it was not healthy for her to carry a pregnancy, because she didn’t want to. Yeah, it’s rather controversial. Things that come up for us as a clinic, we sit down and talk to each other about and if we need to, we will bring the legal folks in.”

“We had a woman who came in who had done IVF at another clinic. She was five months pregnant and she wanted to have an abortion. Umm... because the pregnancy started out as twins, she had a reduction, but she was mad that she started out as twins..... Yeah, so she was just mad that this didn’t work out in the exact way that she wanted it.”

One participant reported instances where family-building was part of a contractual marriage agreement between older American men and foreign young women. These couples requested fertility treatments to fulfill this agreement:

“We do have men who found women overseas. They go online and they find women overseas and marry them and bring them to the U.S. ...and these men are typically thirty-forty years older than these women and so sometimes the men have fertility problems and they tell women, we’ll have a family with you and they can’t. And they need assisted reproduction and then so then it’s part of this marital agreement that they’ve made that we get pulled into..... we have to look at the situation versus, you know, what he promised to her and what she wants is not necessarily what we can deliver.”

Participants stated their reactions toward some infertile clients’ sense of entitlement in requesting fertility treatments:

“I have a real ethical problem with the idea that everyone who comes to the clinic automatically has a right to whatever treatment he or she asks for.”

Category C: Concerns about clients’ care from other providers. Five participants identified ethical concerns when infertile clients reported not receiving quality care from physicians and therapists:

“You had a client who said they had a bad experience with a previous therapist, but because it’s such a small world, and because I’ve heard these things repeatedly, that has been challenging.But there are times when something happens that, again, I don’t know if you would really consider it reportable, and I consulted on this actually, once, and it really wasn’t reportable, but in my mind it crossed an ethical boundary.”

“It’s been hard for me to not feel angry at her provider (physician) and angry about the care she’s gotten and I’ve been an advocate in the way that I usually am, but she’s not very sophisticated medically and, and neither is her husband and so it’s difficult for them to advocate for themselves, and there’s all sorts of other obstacles to them getting, even getting different care.”

Participants also reported their conflicts or disagreements with physicians. Counselors considered these conflicts as an ethical challenge and pointed out the power differential between psychologists and physicians:

“I and the nurses would agree that sometimes the biggest challenge is the physicians. And I need to be able to collaborate with them and whatever their work is with the patient. And on some occasions I actually don’t agree with what they’re telling. I have my place in the hierarchy. So that is challenging.....My allegiance is to the patient, not to the physician, but if it’s me in a kind of conflict situation, which is challenging..... If I feel if somehow I’m not in harmony, that’s a challenge that sort of shades into ethics.”

“Some physicians are struggling to be able to see the patient’s emotional health and functioning as part of the picture because they just kind of have this set like, well here’s the medical problem and here’s what we do physically. And they don’t have such a good grasp of the other parts. So but it’s hard to sometimes bring that (patients’ emotional health) to the medical providers because they just they just don’t have that kind of thinking. It doesn’t integrate well so that can be a struggle.”

Some participants identified their own internal debate as to whether counselors should push infertile clients to seek treatment from another provider:

“One is when you feel like somebody is in, like they’re going to a doctor and it’s not going well and then how much do you push them to get a second opinion.”

Category D: Dual relationships. Three counselors reported potential dual relationships with infertile clients as an ethical concern in their practice. One counselor reported some infertile clients requested to have social relationships after the termination of counseling relationships:

“When they want to possibly have a social relationship after the fertility is resolved. I have to say no. There are boundaries, so that’s another one (ethical concern).”

Participants also recognized the potential relationships when working with lesbian clients or members from small communities:

“There may be lesbian clients, who I know their friends. Again it’s a smaller community.,.....And I’m Jewish, and in the Jewish community, I mean any community that’s a small community, if you see someone in one way, it’s likely that you’ll know somebody else in another sphere that knows them. And then, the whole thing of what happens when you run into each other in another setting.”

Domain 4: Effect of Counselors’ Personal experiences on Counseling Process

This domain addresses counselors’ personal experience (i.e., fertility, infertility, pregnancy, or beliefs) and its effect on the counseling process (i.e. relationship, trust, empathy, etc.). All participants reported instances within this domain, which was sorted into two categories: A) managing countertransference and transference, and B) issues with counselors’ self-disclosure.

Category A: Managing countertransference and transference. Eight participants reported their need to manage countertransference about their own fertility or infertility:

“I mean sometimes when I’m telling a couple that through egg donation they will still get to experience the pregnancy. I think every time I say that, I realize that because I adopted, I did not get to experience a pregnancy.....So when I tell couples that (egg donation), I do have an immediate thought that I missed out on that. So again, you have to be, to keep yourself in check. To make sure that you don’t, you know, let your own sadness impact things.”

“I think dealing with my own issues of countertransference can be challenging at times. Whether it’s someone having an experience that maybe strikes a chord with something maybe I experienced. You know that’s something- maybe a piece that’s still painful. You know, there can be that. Um, and you know, um, that’s hard.”

“You have to be a little bit careful that you don’t, sometimes with my own experience and being infertile, you know making sure that I keep myself out of it. You know, that I don’t get my own experience in there too much.”

Counselors identified challenges with handling countertransference and transference issues during their own pregnancy:

“Last year I became pregnant. Sort of, I mean not completely unexpectedly...It wasn’t necessarily something I was planning.So that was a very challenging year clinically, just in terms of trying to manage my infertile clients’ transference and my countertransference. You know, so that was an interesting time.”

Counselors reported having contemplated how their lack of infertility experience might have affected the counseling process:

“I don’t have children, that I’ve never really wanted to have children. It just hasn’t been part of my life ambition..... but sometimes I wonder if I would be more effective if I had either had children or wanted to have children or gone through assisted reproduction or something like that.....but nobody has ever said that to me. So I don’t know.”

Counselors also identified countertransference issues when at times disagreeing with infertile clients’ decisions on fertility treatments or family building:

“You know, here again this may be countertransference of where I’m feeling very, ‘Whoa! I don’t think that’s a good idea’, you know.”

“There are sometimes when I disagree with the way a person is approaching or the decisions they’re making. So that bothers me and it’s hard for me sometimes to filter.”

Category B: Issues with counselors’ self-disclosure. Participants generally observed infertile clients’ curiosity about counselors’ fertility or infertility. While most participants self-disclosed their fertility or infertility, some participants took a non-disclosure approach in response to clients’ covert or overt curiosity or inquiries. Based on counselors’ different approaches, this domain was divided into the following

subcategories: 1) disclosure of fertility or infertility and clients' reactions; 2) non-disclosure and clients' reactions.

Subcategory 1): Disclosure of fertility of infertility and clients' reactions.

Participants ($n=15$) typically reported disclosing their fertility or infertility but keeping the information limited. Counselors shared their infertility experience or reproductive issues more publically (i.e., information published on their websites or brochures or shared on presentations); counselors briefly disclosed their infertility with infertile clients in the first session, and some counselors only addressed their experience when asked directly by infertile clients.

“I would say that pretty much across the board I disclose that I've had infertility. It's on my website. You know, it's part of how I introduce myself. I think most people who come to me have seen my website.”

“If someone is coming in for infertility, I very briefly share that the reason that I came to this was because of my own experience, and if they want to know more about my experience I'll share it, but I wait and let them ask.”

“One of the things that I never did was to have pictures in my office of my children. Because I thought that would be hard and I didn't want to be talking about my children to people who didn't have children. If someone asked me directly, and sometimes clients did ask me directly, have you ever had fertility issues yourself? Umm...I would say no.”

Counselors typically recognized that they disclosed more personal infertile experiences to infertile clients than to fertile clients. They also stated being cautious about their disclosure and using self-disclosure as an intervention in therapy.

“General psychotherapy clients, I self-disclose virtually zero. With infertility patients that's not the case. I'm still, I would say, pretty cautious about it because I believe it's way too easy for therapists to accidentally make it about themselves, and they didn't come to hear about me.”

“The other thing I find is I tend to disclose more about my own infertility experience, with infertility clients than I say I would about life experiences with, you know in other things. Again, I try to really think about when is it going to be helpful for me to share things with this person. So it’s not all the time.”

Participants typically observed positive effects of their self-disclosure, such as increasing infertile clients’ trust, enhancing connection, normalizing clients’ reactions, instilling hope, etc.:

“I have found that for the most part, disclosing helps a lot, a lot. Because as much as people who, counselors who, don’t have experience with infertility, who haven’t experienced infertility themselves - as much as they are educated on it, there’s something about having gone through this that certainly increases trust with the client, and I think it increases my ability to connect with them because, again, I... having been there, it helps a lot.”

“Most people with fertility issues at one point or another are embarrassed to be talking about this. They think it’s a bad thing about them....So it affects their self-esteem and then they start projecting that onto a therapist, especially if the therapist isn’t so actively involved or doingI think in general it (self-disclosure) makes people feel more comfortable. They feel less distant and less judged, and, it helps me, or it helps them see me. This is less about mental illness and it’s more about trying to support them through difficult experience.”

“It (counselors’ self-disclosure) adds to the person’s feeling of being understood and supported. I think when people feel that they’re not in it alone, I think they feel hopeful, they feel more hopeful and I think if they feel more hopeful umm...or positive, we cope with things more effectively. So I think it’s a good dynamic.”

However, some counselors noted the complexity and potential risks of self-disclosure:

“I think it’s complicated. I think it affects things in a lot of different ways. Usually the first thing that I hear people say is that they feel comfortable with me because they know I’ve been through it too. Like there’s a sense of like, you know of camaraderie, of comfort, but then it can also go the other way because if I eventually have success and they don’t, then I think that sets up some feelings of theirs, like ‘why her, and not me?’.”

“Well because of the disclosure issues, I think I really have to be careful to maintain a professional boundary..... There could potentially be a feeling of kind of dual relationship there.”

When counselors became pregnant at a certain point of their practice, they encountered various challenges, such as discussing their pregnancy or fertility treatments with infertile clients and managing countertransference and transference:

“It’s tricky because I have been doing this work through the time of being pregnant and not being pregnant. So being pregnant and doing this work is a nightmare. And obviously they know you are fertile once you are physically pregnant. And having patients ask me ‘did you go through this or not, to have that pregnancy’.”

“So that was a very challenging year clinically um, just in terms of trying to manage my infertile clients’ transference and my countertransference. You know, so that was an interesting time.”

“I had at least one client who was with me through actually both my pregnancies (through IVFs) and there was a lot of processing we had to do because she had gone through IVF herself.”

However, participants described various approaches in addressing their own pregnancy with infertile clients. One participant reported not discussing personal matters with infertile clients; one participant stated disclosing her fertility treatment even before pregnancy; one participant decided to resign from her work in a reproductive clinic after becoming pregnant:

“I have to say, you know I understand you are really curious about this, but I don’t discuss my own history with people I’m working with. And the only thing I have seen is, you know, I think these (infertile) women said oh why not, and I said, well because I am really here to help you and to focus on you. And kind of leave it at that.”

“I chose to say to them (participants’ infertile clients), ‘look I’m trying to get pregnant and I am going to go through infertility treatment and I am going to go through IVF. And there’s a chance that I will get pregnant from it. We need to

talk about it and see how you feel about it and whether you could continue working with me while I'm pregnant'."

"I have not had infertility problems, so that wasn't really a problem. I was pregnant for part of the time I worked there (a reproductive clinic). . . . I put in my notice. . . . I kept thinking I don't know how exactly I am going to talk to people (infertile clients). I actually felt like I couldn't work there if I was physically pregnant. And that is sort of a self-disclosure in and of itself that you are not having fertility problems."

Subcategory 2): Non-disclosure and clients' reactions. In working with infertile clients, five participants stated that they decided not to disclose their personal experience because of their theoretical orientation, training, or their intention to protect clients:

"Never disclose. Never disclose. . . . I was trained by some pretty smart clinicians, and it is really important that we don't bring that particular experience into our counseling. This is about our clients; it's not about us. And I think there are many other ways to input empathy, input understanding. You know you don't have to be schizophrenic to take care of a schizophrenic."

"And whether I do or do not have issues with infertility. I don't want to burden the patient with that. And I think it is a real trap for new therapists. Because sometimes it feels like this will help me make a connection to a patient, when in fact this patient has a burden of knowledge about the therapist, and sometimes feels like they need to help the therapist, or they want more information, and then you have moved outside of the vows of therapeutic relationship, and I think that is a real misstep."

"I have children and it was not through fertility so that is something I have always tried to protect my stories because in general coming from a psychodynamic perspective. . . . this is one area where I try and be very mindful like even when I am in the hallways I don't like nurses asking about my children, I really just like being here for them (infertile clients)."

One counselor stated although not having the intention to disclose her fertility experience with infertile clients, she did mention her children due to her need to cancel sessions.

"I don't self-disclose at all about my fertility experiences. I've never had infertility. In fact, I had the exact opposite, I got pregnant very easily. . . . I do tell

my patients that- when I start (a counseling relationship), I do have kids and that I need to on occasion cancel.”

Participants observed various reactions from infertile clients in response to counselors’ non-disclosure. Some stated that their infertile clients did not react negatively:

“I mean I don’t have those issues (infertility) to share with people and it hasn’t ever seemed to be an issue. I mean nobody has ever said get me a different counselor because she doesn’t know what she’s talking about or how can she possibly know, you know?”

“The short-term treatment people, you know, usually do not want to get that involved in the therapeutic relationship. They want help, they want to feel better. So I don’t see them kind of as going as deeper with kind of wondering sort of my experience.”

Counselors observed clients’ discomfort and wondered how clients might interpret their non-disclosure:

“There is actually one patient that I am thinking about and she really wanted to know more about me.....She worked with me in my private practice, but she really didn’t know much about me. She was very uncomfortable.”

“I think sometimes she (an infertile client) may know and sometimes she knows that not disclosing is also a form of disclosure, when we have talked that she wants to have more children. So there are ways of things I am not volunteering to her, or she is thinking about egg donation, she knows that I did not do egg donation because when I talked about it and I say well this is what we know about research, she knows that is not my experience. So sometimes by not disclosing, it is a form of disclosing as well.”

Domain 5: Adjustment of Approach in Working with Infertile Clients

This domain consists of participants’ adjustment of their counseling approach in infertility counseling and their adapted strategies to resolve their encountered challenges. Most counselors stated their need to modify their counseling approach in order to serve infertile clients effectively. All participants reported instances of adjustment and adapted

strategies within this domain; these adjustments and strategies were aggregated into five categories: A) psychoeducation and solution-focused interventions, B) counselors' approach in proposing different fertility treatment options, C) compassion and promotion of self-acceptance, D) broader framework for infertility counseling, E) counseling agendas based on clients' needs, and F) consultation.

Category A: Psychoeducation and solution-focused interventions. Ten participants described their work with infertile clients as being more psychoeducational and solution-focused than with other clients. Counselors typically considered themselves more of an *educator* in infertility counseling than in non-infertility counseling:

“I’d probably do more educating, giving more support in planning and decision making.”

“In a lot of ways, I’m a mentor and an educator”

“I think for me it’s adding a little bit more even education about how fertility works, which is interesting as a psychologist to talking with them about more medical areas but to help them understand the facts about fertility and to help them also not then engage in, you know, beating themselves up.”

Participants also stated being more direct with infertile clients as to educate clients about fertility treatment options and facilitate decision making:

“So, teaching decision-making skills and giving some perimeters of: what do other people do? It’s a challenge and also it’s to be expected in working with this population. And again, I think it goes along with that you need to be more directive than you otherwise are because there’s information that’s just information, that everyone goes through who goes through this, and without telling them what to do, just telling them what they’ll need to be thinking about, or how people have thought about it, or where they might get information and think about it. So that really bridges the strategies or interventions, that it’s a lot of teaching about decision-making.”

“I’ve gotten a little more specific with people in encouraging couples to make a timeline, and on that timeline to identify their resources including financially.....

You know, work backwards and if you only have this much money, then let it inform your choices of how to become a parent. So that you can achieve that if you want.”

“I counsel people to talk about: ‘are you going to do 1 or 2 embryos? Make sure you’ve spoken with your husband about this beforehand. Make sure you are clear about the various possibilities on the decision tree.’ So there aren’t regrets or not feeling informed later.”

Participants typically reported adopting a solution-focused approach when infertile clients brought issues (i.e. decision-making, marital conflicts, etc.) into counseling.

Participants also spoke to the importance of offering infertile clients *structure* in resolving their infertility struggle.

“I really start in the present with a problem-solving approach, using, you can call it solution-focused or strategic therapy, but I really stay in the present and find out what’s their medical history and where are they right now, what’s most difficult for them now. And I’m much more directive in suggesting areas that we talk about that they wouldn’t otherwise know.”

“I know it (infertility) feels really miserable and what we can figure out is how to help you through this and how to help you at decision points, but we’re going to just take it a chunk at a time and figure out coping strategies for that period of time.”

“So I provide some structure for what seems like just this endless limbo. And I think that that’s really important. I don’t think it’s just my stylistic preference because it isn’t how I do general psychotherapy. But when it’s health related, I, there are treatments to consider, there’s life, quality of life to consider, there’s things that we know are going to come up, it’s pretty, um, there are differences between people, but the decisions that they face are all the same and so, I just think let’s cut to the chase and save them years of figuring it out.”

“I would advise them to really consider as a couple what’s more important. Do they want their marriage to survive, and what would contribute to that? Or is this a deal breaker? I mean it really is, you can’t force people to be a parent, but the, it really goes back to the problem solving.”

Category B: Proposing alternative fertility treatment options. One of the strategies typically identified by participants ($n=9$) was their need to propose alternative fertility treatment or family-building options in various circumstances. However, participants also pointed out the risks in introducing alternative fertility treatment options when infertile clients were not ready.

When infertile clients had persistently failed treatments, some counselors suggested their clients to try different fertility treatment options or encouraged clients to set a limit on the number of treatments they would try. Meanwhile, participants were also aware of their desire to help when witnessing clients' repeated failed treatments.

“They (infertile clients) can get sort of get stuck on, ‘we have to keep trying’ or, ‘we have to keep trying the same thing’. While you’re watching it not work and not work and not work, and I’m wishing I could help them, you know make an adjustment or try this or try that or try a little differently, or find a slightly different path.”

“And the further they (infertile clients) go (with fertility treatments), people say to me, ‘I never thought I would even be thinking about this, but now that all these other things have failed, I’m not ready to stop’. So, then, you’ve already done all this, you’ve already spent all of this money, all of this time, made all these sacrifices in order to have a baby, which you are definitely longing for, how do you decide you’re done with this approach?”

“I mean that was one of the challenges for me when it was clear to me that they had done enough fertility treatment.....And part of what was hard was...these are pretty distressed people that I’m working with if they’ve been through numerous fertility treatments.”

When mental health issues compromised infertile clients' capacity to cope with the stress of fertility treatments or even hindered the clients' ability to collaborate with physicians, some participants redirected infertile clients to focus on their mental health issues. The redirection included relinquishing their fertility treatments temporarily. The participants

also revealed that their interventions might not work, and they identified the mental health issues as a challenge in infertility counseling.

“Um, you know in terms of people when their psychological issues are, like I was saying maybe there’s a personality disorder, or like maybe they’re really depressed, or there’s another issue. I try to refocus those treatments onto, let’s deal with the mental health issues first, then let’s go back and deal with the infertility. So I try to refocus the client, which is challenging and does not always work. As you know, there’s so much that doesn’t work!”

Counselors also recognized the need to “*push*” infertile clients to explore different solutions to infertility, including different fertility treatments, third party reproduction, adoption, or the option of childlessness. Participants intended clients to be exposed to more options in resolving their infertility:

“One thing that I say to people is that if you want to have a child, you know, most people end up figuring out a way to be involved in a child’s life. You know so it might not be the way you thought.”

“Sometimes I will kind of push people to explore the plan B, you know.So to have the plan B or the plan C..... to help people kind of open up to the possibilities and how they would handle that? How do other people handle that? To wrap themselves around the possibilities because I think when people are grieving they get very much, ‘Oh I can’t do that’, ‘Oh I couldn’t bear that’. And you know, but they could, you know anyway so.”

“My goal is also to give them options. To make sure they can leave here knowing that there are options out there to build their family.”

“I think that the solution to infertility is not necessarily having a baby. Um it’s helping them understand that um, you know how to sort of cope with it while they’re trying to resolve it. And resolving it might end up being, being child free.”

However, participants also pointed out the risks of proposing alternative fertility treatment options when infertile clients were not ready:

“You have to be careful as a therapist not to get too far ahead of where they are. One of the things I’ve learned the hard way is to never, ever bring up a treatment

option that they have not considered since the loss. You know, you really cannot be, even if in your mind you are thinking about it, you cannot really take them faster than they are able to go.”

Category C: Compassion and promotion of self-acceptance. Eleven participants recognized infertile clients’ self-criticism as a reaction to their infertility, and counselors typically identified the promotion of self-acceptance as one of the strategies but also challenges in infertility counseling:

“I try and facilitate and accommodate my work with couples or women, is to acknowledge the loss and just let the bereavement take its course and normalize that bereavement for that patient, so she knows she is not crazy or quote un-quote abnormal that this is a normal reaction to loss, and so that’s I think that has been a challenge.”

“So my challenge there is really to help that person not only get through this infertility process with more comfort and self-compassion but to also help her open up to the reality that life isn’t you know as she has come to believe as controllable. And to help someone be the water not the rock. You know to go with these changes and difficulties without being devastated or so fiercely angry. You know so there’s a kind of hardness that people bring into this issue (infertility) that breaks them. So you know part of it is to help them learn to be soft, softer and receiving of what life brings.”

“And you know so that (promoting self-acceptance) is very hard to do when a person’s heart is breaking, you know so I feel that it takes a lot of patience and kind of light touch, you know.”

Participants typically stressed the importance of being compassionate and empathic toward infertile clients in order to promote clients’ self-acceptance:

“I felt compassion, great compassion for their pain and their suffering as they went through it.

“Usually with an infertile patient my approach would be to say they have to widen their expectations of what’s reasonable because they’re already down on themselves for how upset they are and I’m trying to normalize how upset they are as understandable under the circumstances.”

“The purpose of the empathy is to help the person accept what’s really happening.”

Category D: Counseling agendas based on clients’ needs. Echoed Domain 2:

Challenging Counseling Issues, participants ($n=10$) typically reported the need to have flexible counseling agendas to address infertile clients’ diverse needs:

“It’s frequently a kind of counseling that’s not linear in the sense of having people come in once a week or twice a week in kind of regular ways, but frequently you have to adapt as a therapist to kind of the cycles of the ups and downs. And sometimes people take a break for 2 or 3 months. They don’t want to think about it and they don’t want to deal with it. They want to reclaim their lives back and take a break. And then they come back and all of a sudden they’re going through a very dense cycle and they will need to see you as much as possible.”

One participant offered an example that one infertile couple used their fertility treatment consultation meeting to discuss divorce due to their dramatically different opinions on fertility treatment options. This counselor reported altering the focus of the consultation meeting to meet this couple’s needs and also recognizing the participant’s own internal tension and anxiety:

”It is a very challenging position to be in to have to, you know, change the way you thought about how a conversation was going to go, going into it, to switch gears in terms of the goal of the appointment, to try, you know, in that little amount of time you have to make as much to repair as much as you can in the relationship enough that they will actually go to couples counseling, to at least to help them see that as a good idea so they can give couples counseling a try. It sort of keeps you on the edge of your seat.”

When asked to elaborate on the rationale to keep counseling agendas flexible, participants typically pointed out that most infertile clients were healthy and high functioning individuals. As a result, counselors mainly focused on the *present* in counseling:

“They (infertile clients) are not necessarily coming for individual mental health issues. They are coming because the stress is happening and blocking them from a reasonable goal.”

“It is a lot, a much more focused way of counseling, because it is much more focused on the present, it is much more focused on the coping.”

Category E: Broader framework for infertility counseling. Participants ($n=10$)

typically recognized their different counseling approach with infertile clients in comparison to their work with fertile clients:

“It (infertility counseling) is different than my orientation typically is with individual patients that have other problems, because my training was mostly in systems theory and psychodynamic, but with fertility clients it’s much more supportive counseling.

Counselors reported that regardless of their training backgrounds they adopted broader and more diverse approaches:

“I think in order to do work with people who are struggling with infertility, I sort of modify that approach so um, you know, I would say I’m more sort of broadly psychodynamic, but I wouldn’t necessarily be just sticking in that more process oriented model.”

Various participants offered examples of their integration of various counseling theories to better serve infertile clients:

“Specifically when people present with that (infertility) as their presenting issue I see it more as kind of a brief therapy model where their goals are around learning coping strategies. I would, my first approach is sort of that brief practical orientation but then I bring in other kinds of approaches to help with that. For instance, it might really be of use to someone to learn to have more mindfulness training around their anxiety or depression symptoms. I do use a lot of guided imagery, more with infertility patients than anyone really. Of course Cognitive-Behavioral techniques.....”

“So there is that more hands-on a lot of coping skills. I do a little bit a CBT, we talk about cognitive distortions, we talk about reframing, mindfulness, that’s another big big big piece, that I bring into my work. Especially when it comes to take care of self; we do a lot of mindfulness.”

Category F: Consultation. Two participants reported utilizing consultation to address their ethical concerns and countertransference issues. One participant stated that she consulted about her clients' prior negative counseling experience:

"I don't know if you would really consider it (clients' prior negative counseling experience) reportable, and I consulted on this actually, once, and it really wasn't reportable, but in my mind it crossed an ethical boundary."

Summary

This study aims to explore the unique professional challenges experienced by counselors in working with infertile individuals and couples and the counselors' adapted strategies in addressing these challenges. A brief summary of the qualitative analysis is offered next. In total, five broad themes (domains) and 19 categories emerged from the data and addressed the major research question. The first four themes focused on counselors' experienced challenges, which participants generally or typically encountered when working with fertile clients, and the last theme addressed counselors' adapted strategies to resolve their encountered difficulties.

In general, participants identified challenges related to infertility counseling education. Counselors typically recognized the importance of medical knowledge and the need of fertility counseling training in order to effectively serve infertile clients. However, the lack of formal training opportunities for infertility counseling was also observed. A few participants reported that some of their infertile clients were *damaged* by unknowledgeable or untrained counselors.

Among the wide range of client issues, participants identified which counseling issues were challenging to address in their clinical work. Participants typically considered clients' reactions toward infertility or fertility treatment as challenging, such as: intense

emotional reactions, repeated losses and grief, loss of control, as well as identity crisis. Counselors also suggested that comorbidity of mental health issues and infertility often complicated the assessment for fertility treatments and intensified clients' reactions toward infertility. Pre-existing mental health issues might exacerbate due to infertility and fertility treatments, and unidentified depression or anxiety might be triggered in the process of fertility treatment. In addition, infertile clients' relationship difficulties were typically acknowledged by participants, especially conflicts in marriage or intimate relationships, and isolation in relationships. It was observed that, at times, infertile clients' desire to have children might override their desire to maintain their marriage or relationships. As a result, some infertile couples ended their relationships, which participants reported challenging to address in counseling.

Participants identified various ethical concerns in infertility counseling. Ethical challenges in assessment were salient for most participants, including assessing appropriateness and readiness for fertility treatment, concerns for unborn children, and personal dilemmas about their gate-keeping roles. Various counselors recognized their concerns about clients' decisions on and controversial requests for fertility treatments, while some found ethical dilemmas when infertile clients reported not receiving quality care from other providers.

One domain identified by participants regarded the effect of counselors' personal experiences, with a focus on their own fertility/infertility and pregnancy. Participants typically admitted encountering countertransference as a result of their own fertility or infertility at certain points of their practice with their infertile clients. It was noted that in response to infertile clients' overt or covert curiosity about counselors' fertility or

infertility, most participants reported sharing their personal experience but kept it limited; some counselors decided to not disclose any personal matters. Participants suggested working with infertile clients became more challenging during counselors' own pregnancy.

The last domain explored participants' adapted strategies. Participants generally recognized the need to adjust their approach in working with infertile clients. Several categories emerged within this domain, including psychoeducation and solution-focused interventions, proposing alternative fertility treatment options, promotion of self-acceptance for infertile clients, adoption of a broader framework in infertility counseling, a flexible counseling agenda based on clients' needs, and consultation.

Chapter 5: Discussion

Introduction

This chapter includes five sections, beginning with: an overview of the study which includes the research question, the sample characteristics, and the data collection process. Next, the major findings are presented with the research question. The researcher will also discuss how the results are consistent or inconsistent with the findings of previous studies. The strengths and limitations of the study are the next section, and another section includes the recommendations for future research of infertility counseling, based on the findings of the study and the literature review. Last, the implications for training, credentialing and practice of infertility counseling are presented.

Overview of the Study

This study is an explorative and preliminary investigation into counselors' experience in offering infertility counseling. One broad major research question is examined: what challenges do counselors experience in working with infertile clients and what strategies do they adapt?

To answer the research question, a total of 34 mental health practitioners from the Twin Cities and Chicago Metro areas responded to the research invitation, with the response rate of .50. Among respondents, 17 counselors, who met the research criterion and were able to participate in an in-person interview, were included in the study. The participants were interviewed by the researcher, with respect to their clinical experiences in offering infertility counseling (i.e., individual counseling, group counseling, couples counseling, or assessment for third party reproduction or fertility treatment). The participants included licensed psychologists, licensed marriage and family therapists,

licensed clinical social workers, and licensed clinical professional counselors. Interview questions addressed participants' encountered challenges when working with infertile clients (i.e., overall challenges in infertility counseling, issues with facilitation of infertile clients' reactions, issues with self-disclosure, experienced ethical dilemmas in infertility counseling, a memorable case, etc.) as well as their adapted strategies to resolve their experienced difficulties.

Major Findings by Research Question and Conclusions

The research question asked participants to report their encountered challenges in working with infertile clients and their adapted strategies. From the data analysis, four major themes emerged and addressed the encountered challenges. One major theme answered the adapted strategies. The identified challenges not only spoke to the complexity of client issues but also to the uniqueness of infertility counseling challenges.

Encountered Challenges

The participants identified their experienced challenges in the following four areas: the infertility counseling education, infertile clients' issues, ethical concerns pertinent to infertility counseling, and the effect of counselors' personal experiences on the counseling process.

Theme 1: Challenges Related to Infertility Counseling Education. Twelve counselors in the present sample identified challenges regarding infertility counseling education. The participants' responses were aggregated into three categories: the importance of medical knowledge, the need of infertility counseling training, and observed reactions of clients toward unknowledgeable providers.

Eight counselors spoke to *the importance of medical knowledge* and advocated infertility counseling to be a specialty. This finding is consistent with various researchers' suggestions as to the importance of medical knowledge in working with infertile individuals (Burns, 2005; Edelmann, 2008; Peterson et al., 2007; Savitz-Smith, 2003; Williams et al., 1992). The result also corresponds to the ASRM qualification guidelines (1995) for mental health professionals in reproductive medicine and the ESHRE guidelines for infertility counselors (2013). Both the ASRM and ESHRE suggest training in the medical and psychological aspects of infertility.

The need for medical knowledge result is consistent with William et al.'s assertion (1992) that the medical knowledge of infertility helps counselors have a better understanding of multiple stresses of infertile individuals, and helps counselors to direct infertile clients toward proper medical treatments. This result in the current study indicates that medical knowledge increases counselors' understanding of infertile clients' subjective experience in dealing with infertility and fertility treatment. With medical knowledge, counselors can better empathize with infertile clients' struggles. Medical knowledge also assists counselors with more effectively facilitating infertile clients' decision making and navigating the ethical issues concerning fertility treatment.

Participants reported observing that medical knowledge enhanced infertile clients' trust and connection with counselors. This finding has not been reported or suggested in any previous study. It is possible that clients' trust and connection are the outcome of the above effects (i.e. counselors' understanding of clients' stress and subjective experiences in dealing with infertility, counselors' empathy of clients' struggles, and counselors'

effectiveness in facilitating decision making). Thus, medical knowledge may become the foundation of a therapeutic relationship in infertility counseling.

Geller (2004) and Lund (2001) claim that most counselors do not have an awareness of the significance of reproductive trauma. Edelmann (2008), Kurpius and Maresh (1998), Watkin and Baldo (2004), as well as Williams et al. (1992) state that most counselors do not have adequate knowledge of infertility and fertility treatment. The participants in the current study also observed that most therapists' lack an understanding of infertility. Hence, this finding validates of the assertions of the above researchers.

Among the 12 participants who reported instances in this domain, eight participants also recognized *the need of infertility counseling training*. Different from medical knowledge which could be acquired from self-study or informal training, the participants spoke to the need for formal infertility counseling training. The finding is consistent with the ASRM qualification guidelines (1995), which suggest that mental health professionals in reproductive medicine attain training in the medical and psychological aspects of infertility, one year of supervised clinical experience in offering infertility counseling, and continuing education in infertility counseling.

However, as the participants recognized that more well-trained counselors were needed in order to offer effective and ethical services to infertile clients, the counselors also observed the unavailability of formal infertility counseling training for practitioners, such as courses through graduate school, practicum, internship, or residency. From the results of the current study and previous research, it is speculated that the lack of well-trained infertility counselors may be a result of the unawareness of the significance of infertility and the unavailability of infertility counseling training.

In the last category of this theme, five participants reported having observed *infertile clients' reactions toward unknowledgeable therapists*. Although various researchers have suggested the importance of medical knowledge (Burns, 2005; Edelman, 2008; Peterson et al., 2007; Savitz-Smith, 2003; Williams et al., 1992) and ASRM has advocated infertility counseling to be a specialty, no prior research has spoken to the effects of unknowledgeable counselors on infertile clients.

Knapp and Myer (2000) and Price and McLeod (2012) suggest that current models and theories of grief counseling are not designed to address infertility and multiple losses, and their statement is validated by the result of this study. Participants observed that some untrained counselors had difficulties with effectively addressing the special grief issues of infertility despite these counselors' specialty in grief and loss. The participants also observed inappropriate interventions by unknowledgeable counselors, such as overlooking the impacts of infertility, minimizing infertile clients' struggles, offering inappropriate recommendations on fertility treatment or family building options, and failing to explore fertility treatment options and the medical and sexual aspects of infertility. The participants reported their clients were *damaged* by these ineffective and inappropriate interventions.

Holley et al. (2012) found that approximately 75% of infertile patients are not informed of the availability of mental health services by the reproductive clinics. Thus, infertile clients may be potentially unaware the availability of trained infertility counselors and possibly turn to general counselors to address their infertility issues. Nonetheless, based on the Ethical Principles of Psychologist and Code of Conduct amended by the American Psychological Association (APA) in 2010, the *Principal A:*

Beneficence and Nonmaleficence states psychologists' responsibility to benefit their clients and avoid doing harm; the *Ethical Standard 2.01: Boundaries of competence* emphasizes that psychologists only offer services to clients within the boundary of their training, education, and competence. The result of the current study suggests that some mental health professionals may not recognize their lack of competency to address infertility issues and may attempt to offer counseling to infertile clients, which may potentially bring harm to infertile clients. It is speculated that some untrained counselors, without awareness, are engaged in potentially unethical practices with infertile clients.

Additionally, in the recruitment process for this current study, a total of 68 licensed mental health professionals in the Twin Cities and Chicago Metro areas, who identified and advertised infertility as their specialty, were invited to participate in the study. Thirty-four counselors responded; but, among them, 14 practitioners had none to limited experience in offering infertility counseling and, as a result, were excluded from interviews. These 14 practitioners' training or education on infertility counseling was unknown.

Currently, given the high prevalence and pervasive impacts of infertility, the CDC has announced infertility as a *public health priority* (2012) and is developing National Health Action Plan for the Detection, Prevention and Management of Infertility. Combined with the findings of this study, well-trained infertility counselors are evidently much needed, not only to offer effective and ethical services to infertile individuals but also respond to the appeals of the CDC.

Theme 2: Challenging Counseling Issues. Infertile individuals and couples are found to endure multiple consequences of infertility, including psychological, physical,

financial and social issues (Atwood & Dobkin, 1992; Burns, 2005; Gibson, 2007; Gibson & Myers, 2000; Rosen & Rosen, 2005; Watkins & Baldo, 2004). All participants of the present sample reported that their infertile clients brought multiple and complex issues to counseling, validating the previous research. Most of the prior studies' results were generated from infertile individuals' self-report while this study offered perspectives from practitioners. Among the client issues, the participants identified some issues as more challenging to address in counseling while other issues were more manageable. The recognized challenging issues were aggregated into categories, such as clients' reactions toward infertility and fertility treatment, co-existing mental health issues, and relationship difficulties.

A total of 14 participants considered *clients' reactions toward infertility and fertility treatment* challenging to treat in counseling; issues consisted of intense emotional reactions, repeated losses and grief, loss of control, and identity crisis. Among the client issues, intense emotional reactions as well as repeated losses and grief were the two most recognized challenging issues.

The participants pointed out that their infertile clients had intense reactions toward infertility and fertility treatment, such as sadness, anger, depression, anxiety, fear, desperation, etc., and these reactions were consistent with prior research. In the literature review, various studies explored the impact of infertility and fertility treatment on infertile individuals and couples. Gonzalez (2000) finds infertile women have a sense of failure, grief responses, and feelings of depression toward their infertility. Greil et al. (2011) find that the duration of infertility, fertility treatment experience, and treatment outcomes are associated with infertile women's distress. As Jaffe and Diamond (2010)

and Lee et al. (2010) suggest, repeatedly failed infertility treatment is similar to recurrent trauma events and often triggers grief responses. Harris and Daniluk (2010) found that failed treatment often intensifies infertile individuals' initial grief and loss caused by infertility. Pasch et al. (2012) and Lee et al. (2012) suggest that failed fertility treatment lead to a high level of depression and anxiety.

The participants in the study reported their own internal struggles in facing and facilitating infertile clients' intense reactions, and the counselors identified the effects of clients' emotions on counselors themselves. The participants found it challenging to console clients who were deeply discouraged and highly distressed and anxious, and the counselors reported that a great amount of empathy was needed for these clients. The participants also reported witnessing infertile clients' emotional roller-coaster and finding the emotional changes in their client to be "emotionally draining" for themselves at times. The counselors characterized infertile clients as "the hardest patients to work with" as a result of their high level of distress in comparison with fertile clients; the counselors also described the sessions with infertile clients as "most intense." The participants furthermore reported that processing grief and sorrow with infertile clients after failed treatment was challenging, and the counselors identified that, at times, infertile clients' grief, hopelessness, and powerlessness were "hard to sit with." Several participants pointed out their own struggles in "holding hope" for clients with persistently failed treatment or multiple losses.

Jaffe and Diamond (2010) and Covington (2006) suggest that counselors may experience "vicarious grief", vicarious trauma, or compassion fatigue when observing infertile clients' repeatedly failed treatment, multiple losses, intense grief, and strong

emotional reactions. Although the participants did not report signs of vicarious trauma or compassion fatigue, the results illuminated counselors' internal struggles and emotional reactions in witnessing and facilitating clients' intense emotions as well as counselors' difficulty in holding hope for infertile clients who had experienced multiple failed cycles of treatment. The result may suggest that infertile clients' intense emotional reactions, grief and repeatedly failed treatment not only impact infertile clients themselves but also affect counselors. It may also imply that counselors face a challenge in finding balance between processing grief and emotional reactions as well as instilling hope when working with infertile individuals and couples. It is unknown how counselors address their own internal struggles and the effects of clients' issues.

Among the participants, 11 reported that infertile clients' *co-existing mental health issues* added challenges to infertility counseling. A wide range of co-existing mental health issues were observed by the participants. Issues may have been pre-existing or may not have been previously identified; issues may have developed after the diagnosis of infertility, during fertility treatment, or even after successful fertility treatment (i.e. postpartum depression or anxiety). This current finding is consistent with prior literature. Baldur-Felskov et al. (2013), Yli-Kuha et al. (2010), and Burns (2007) suggest that stress associated with fertility treatment may worsen pre-existing mental health issues and even may increase the risk for hospitalization. Guerra et al. (1998) found 59.6% of women and 24.1% of men had co-existing mental health issues (i.e., adjustment disorder, depression, anxiety, etc.). The counselors in the present study further articulated infertile clients' defensiveness and reluctance when counselors directed attention to the co-existing or unidentified mental health. It is possible that these clients

wished counselors to focus on infertility and did not consider mental health issues as presenting concerns.

Burns (2007) suggests that a personality-disordered patient can be challenging to work with in infertility counseling, which is validated by the result of this study. A total of 7 counselors singled out personality disorders as one of the most challenging issues in infertility counseling. The counselors reported that a variety of their clients with personality disorders became suicidal during fertility treatment and the clients' ability to collaborate with their fertility treatment teams was compromised. The participants also expressed concerns about these clients' future parenting, as well as the welfare of their family and future children. It is possible that personality disorders further complicate consequences of infertility, intensify infertile clients' emotional reactions, and decrease their ability to manage stress.

Prior research suggests that infertile individuals and couples encounter relationship difficulties and isolation as a result of their infertility and fertility treatment (Atwood & Dobkin, 1992; Gibson 2007; Lampman & Dowling-Guyer, 1995; Rosen & Rosen, 2005; Watkins & Baldo, 2004). Specifically, gender differences on reactions toward infertility and fertility treatment are observed among heterosexual couples (Edelmann & Connolly, 1998, Galhardo et al., 2011; Indekeu et al., 2012; Klemetti et al., 2010; Stuart-Smith et al., 2011), and relationship difficulty as a result of gender differences is speculated. Sexual dissatisfaction and sexual dysfunction are common issues of infertile couples (Tao et al., 2011). Emotional distress from fertility treatment and associated impacts on intimate relationships are related to infertile couples'

termination of fertility treatment (Daniluk & Tench, 2007; Domar et al., 2010; McDowell & Murray, 2011).

Consistent with the literature, thirteen participants identified infertile clients' relationship difficulties as a challenging issue to address in counseling. The counselors articulated their difficulty in assisting infertile couples in navigating through marital and relational conflicts. The counselors observed that some couples terminated their relationships because of the disagreement on family building or stress from fertility treatment. One counselor reported that an infertile woman proposed a divorce to her partner in the fertility treatment assessment meeting. It is possible that marital or relational conflicts at times become so intense that the infertile couples are disabled from addressing their grief, loss, stress, and decision making. The participants reported that counseling may be the only space where infertile clients can process their losses; however, the counselors also stated that the infertile clients' sense of isolation might prevent them from seeking professional support. The effect of isolation of infertile individuals' perception of professional help needs to be further examined. The above findings on challenging counseling issues imply that infertility counselors need to be flexible and versatile in working with infertile couples, and counselors need a wide variety of counseling skills to address infertile clients' multiple challenging issues. Counselors' tasks in therapy include, but are not limited to, addressing relationship difficulties, processing grief and loss, instilling hope, assessing comorbidity, facilitating decision making on fertility treatment, etc. Furthermore, the above challenging counseling issues were identified by the counselors with training in infertility counseling and extensive clinical experiences in offering infertility counseling to infertile individuals

and couples. It is speculated that counselors with limited training on infertility counseling or with less clinical experiences may encounter more or different challenges.

Theme 3: Ethical Dilemmas in Infertility Counseling. The next theme identified by the participants is pertinent to *ethical dilemmas in infertility counseling*. A total of 16 counselors reported ethical concerns in four areas, including assessment, clients' decisions or controversial requests for fertility treatment, clients' care from other providers, and dual relationships. Among these categories, the participants typically endorsed ethical dilemmas in assessment (i.e., challenges in assessing appropriateness and readiness for fertility treatment; concerns for unborn children; personal ethical dilemma about gate-keeping roles).

Twelve participants reported difficulties assessing the effect of co-existing mental health issues, third party reproduction and fertility preservation. The participants also illustrated their internal struggles when denying clients for fertility treatment and described it as an "upsetting" experience for clients and for the counselors themselves. Another 12 counselors reported feeling responsible to safeguard the welfare of unborn children, and the participants particularly expressed concerns about the fitness for parenthood of infertile individuals with personality disorders or severe psychosis. A philosophical question was raised by the participants about unborn children:

"The central question... is it better to have just been born even with just a terrible life, or should you not have been born at all?"

The counselors further explained their own personal ethical dilemmas about gate-keeping roles. The participants debated their responsibility to deny fertility treatment or, in other words, to grant a person's dream for parenthood.

Increasing research has focused on ethical issues associated with reproductive technologies and the ethical dilemmas faced by infertile individuals when deciding on fertility treatment. However, few empirical studies on the ethical issues encountered by counselors in infertility counseling have been conducted. Furthermore, the debates about counselors' obligation to protect unborn children and to assess fitness for parenthood for infertile individuals and couples continue to exist (Gordon & Barrow, 1999; Horowitz et al., 2010; Jaffe & Diamond, 2010; Kader & Greenfeld, 2006; Peterson et al., 2012), and the participants of the current sample share the same debates.

The ASRM ethics guidelines suggest that reproductive clinics may deny fertility treatment if intended parents' childbearing ability is deemed inadequate and the assessment of a parent's childrearing ability should be made jointly by members of reproductive clinics (Ethics Committee of the ASRM, 2009). The ASRM also asserts that the well-being and interests of future children supersede prospective parents' requests for treatment (2009). Yet, Josephs (2005) claims that ethically counselors cannot absolutely deny infertile individuals' requests for fertility treatment, even when these individuals may present with severe mental health issues. Horowitz et al. (2010) also points out the difficulty to determine criteria of "good enough" parenting. A recent study by Frith et al. (2011) also shows mixed opinions on counselors' gate-keeping roles. The researchers explored counselors' experienced ethical dilemmas by interviewing 22 psychologists who had extensively assessed infertile individuals' and couples' fitness for fertility treatment. Frith et al. found that most participants considered it their obligation to ensure unborn children's welfare. However, some participants found it difficult to gather sufficient information from prospective parents; participants were concerned about the ambiguous

criteria for “good enough” parenting and also debated about their responsibility to make such significant decisions for infertile individuals’ lives. Likewise, the participants of this current study seemed to share similar concerns with those in the study by Frith et al. However, in the current study, participants were not asked to articulate their approach in denying and approving treatment. Two participants mentioned adapting a team approach in assessing patients’ fit for parenthood, and two participants mentioned being asked to make denial decisions by their affiliated clinics. It is unclear whether counselors’ personal dilemmas about gate-keeping roles were considered in their responsibility in denying and approving fertility treatment.

The results of the current study not only shed light on ethical dilemmas in assessing infertile individuals’ fitness for fertility treatment or parenthood but also illuminated counselors’ internal struggles (i.e., emotional reactions when denying treatment, confusions about their obligation in third party reproduction, debates about their responsibility to grant or deny fertility treatment, considerations of their responsibility to the unborn children, etc.). The participants said it was “hard” and “upsetting” for counselors themselves when they disapproved infertile individuals’ or couples’ requests for fertility treatment. Possibly it is challenging for counselors to reject clients who already suffer from multiple losses as a result of infertility. It can be potentially emotionally provoking for counselors to witness another layer of grief and loss being added to these infertile individuals or couples.

Theme 4: Effect of Counselors’ Personal Experience on Counseling Process. The last theme of challenges identified by the participants is *the effect of counselors’ personal experience on counseling process*. All participants offered instances which were sorted

into two categories: managing countertransference and transference; issues with counselors' self-disclosure. Eight participants identified the need to manage countertransference and transference about their own fertility or infertility. Several counselors recognized that, as a result of their own infertility, at times they had emotional reactions (i.e., loss, grief, sadness, etc.) when listening to clients' infertility stories; some participants reported having speculated that they may have been able to offer more effective services if they were infertile.

Covington and Marosek (1999) and Applegarth (1999; 2006) suggest that most counselors may enter the field of infertility counseling as a result of their own infertility experience or pregnancy loss. However, Jaffe and Diamond (2010) observe that not every infertility counselor has personal experience with infertility. Most participants of the present study did disclose their fertility or infertility to the researcher when being asked about their entry into the field of infertility counseling and their motivation to work with the infertile population. While most participants became involved in infertility counseling because of their own reproductive trauma, a few of the counselors did not have infertility issues and some were diagnosed with infertility after several years of work with infertile clients.

Applegarth (2006) and Jaffe and Diamond (2010) assert that counselors may confront more challenges in addressing infertile clients' grief and loss and may experience countertransference when counselors' infertility issues remain unresolved. It is noteworthy that in the current study, regardless of the participants' fertility or infertility, the counselors reported experiencing countertransference. Although countertransference could be related to the counselors' unresolved infertility issues, countertransference could

also be associated with the intimate nature of therapy. The participants pointed out infertile individuals often felt isolated and were not understood by family members and friends. As a result, counseling might become the only space for clients to process their struggles, grief, and loss. In Domain 2, the participants also reported their own internal struggles and reactions when witnessing infertile clients' intense emotions, multiple losses, grief, and repeatedly failed treatment. Additionally, all participants reported their clients' curiosity or inquiries about counselors' fertility/infertility experiences or motivation to be infertility counselors. The counselors needed to decide how to respond to clients' overt or covert curiosity, along with the content and amount of self-disclosure. Thus, countertransference could be a result of the effect of clients' curiosity about counselors' fertility/infertility experience and counselors' repeated exposure to clients' intense reactions, grief, loss, and recurrent traumatic experiences.

The counselors recognized that it was challenging to address infertile clients' transference and manage their own countertransference during counselors' own pregnancy, and this result was consistent with the previous studies. Applegarth (2006) claims that counselors' pregnancy may lead to countertransference and transference issues in counseling. A recent study by Tonon et al. (2012) examines the effect of therapists' pregnancy on general counseling clients. The researchers found that clients of a pregnant counselor usually experience strong and mixed emotions (i.e., envious and fearful of abandonment) and may project therapists as a mother figure. Infertile clients may potentially have stronger reactions at counselors' pregnancy because it is a reminder of their own infertility and may create feelings of competition. Counselors need to be aware of the effect of their own pregnancy on clients.

Closely related to countertransference and transference are issues of self-disclosure. As aforementioned, infertile clients' curiosity was typically observed by the participants, and a counselors' physical pregnancy needed no disclosure of therapists' fertility. Fifteen participants disclosed their infertility or fertility with infertile clients. Although the participants identified that they tended to be more engaged in self-disclosure with infertile clients than with fertile ones, the counselors suggested the amount and content of self-disclosure to be limited. Various positive effects of counselors' self-disclosure were reported, including increased trust and connection, plus normalization of clients' reactions and hope. The counselors reported their awareness of potential risks of self-disclosure, but no negative effect was noticed. Five counselors reported not disclosing their personal experience (i.e., fertility/infertility, pregnancy, or other personal matters) because of their theoretical orientation and intention to protect clients. Among these counselors, a few did not observe any adverse reactions from clients while some reported noticing clients' discomfort.

While literature suggests self-disclosure should be done cautiously as a part of a therapeutic intervention (Stricker, 2003), there is no agreement on the necessity of self-disclosure in infertility counseling. However, Lyon-Pages (2004) identifies the provoking nature of counselors' pregnancy and recommends counselors to process the effect of therapists' pregnancy with clients. Nevertheless, the participants of the current study reported different approaches in addressing their pregnancy with infertile clients. One counselor re-directed infertile clients to focus on their own concerns; one counselor disclosed her process of trying to conceive even before pregnancy; one reported not knowing how to discuss her pregnancy with clients and, as a result, resigned from her

work. The various approaches indicate a challenge in addressing the effect of counselors' pregnancy with infertile clients.

Jaffe and Diamond (2010) suggest that infertile clients often enter counseling to deal with the life crises caused by infertility, not because of pre-existing mental health issues; the researchers also recommend infertility counselors to be more interactive. Consistent with Jaffe and Diamond's appeal, most participants of the present study had more self-disclosure to infertile clients than to fertile ones; the counselors also observed their infertile clients mostly were mentally healthy and high-functioning individuals. The results of the current study furthermore reveal the positive effects of counselors' self-disclosure and the interactive approach of counselors in working with infertile clients. One participant pointed out that infertile clients often experienced difficulty sharing their infertility struggles with friends and family members. Thus, it is possible that counselors' openness and appropriate self-disclosure suggests a sense of understanding and acceptance for infertile clients. It is also speculated that counselors with less knowledge of infertility may approach infertile clients' curiosity or questions about therapists' fertility differently and may potentially be less interactive when working with infertile clients.

Adapted Strategies

When asked to identify strategies and interventions adapted to address the aforementioned challenges, all participants identified their need to adjust their counseling approach in order to provide effective services. Among them, ten counselors stated being more *psychoeducational and solution-focused* with infertile clients than with fertile ones. The counselors described being more "directive", "specific", and "structured" as to

educate infertile clients about options of fertility treatment or family building, to facilitate decision making, and to teach coping strategies. Regarding the rationale of this adjustment, the participants reported that their psychoeducational and solution-focused approach could promote self-acceptance and instill hope for infertile clients and ensure clients to make informed decisions.

Research suggests that termination of fertility treatment can be painful for infertile couples and infertility counselors need to explore alternative family building options when infertile couples have experienced persistently failed outcomes (Boden, 2013). Consistent with prior studies, nine participants recognized the need to *propose alternative fertility treatment options* but also found this intervention challenging to conduct. The counselors identified various situations when they might propose different family building options or recommend clients to temporarily stop fertility treatment, including when clients persistently failed fertility treatment or clients displayed significant impairment disabling them from collaborating with fertility treatment teams. The participants also recognized that alternative interventions needed to be conducted carefully at the right time.

A total of 11 participants reported the importance of *compassion and promotion of self-acceptance* when working with infertile clients. However, the participants also recognized it was not an easy task to promote self-compassion when clients already experienced multiple losses and grief. Ten counselors recognized the need to keep *counseling agendas flexible* to respond to infertile clients' multiple issues. The participants reported that counseling with infertile clients often focused on the "present" and the frequency of sessions might vary based on clients' fertility treatment progress.

Ten participants recognized their adaption of *broader frameworks for infertility counseling* regardless of their initial training background. The counselors reported being more integrated and diverse regarding counseling theories and techniques.

Covington (1999) proposes counselors should serve as a resource for infertile clients, and Thorn (2013) suggests that counselors have responsibilities to offer psychological support, explore fertility treatment options and associated consequences, and facilitate decision making. Consistent with Covington's and Thorn's suggestions, the participants of the current study took on multiple roles and tasks. The roles of the therapists of this study went beyond traditional counseling. The participants functioned as an educator, a therapist, a consultant, and an advocate simultaneously. Corresponding to their multiple roles, the participants took a more interactive, solution- focused, flexible, and integrated approach in infertility counseling which was different from their orientation with fertile clients. The results implied that the counselors made adjustments on traditional counseling theories and approaches in order to offer more effective services. Various researchers (Gibson, 2007; Gibson & Myers, 2000; Williams et al., 1992) have suggested that traditional counseling theories may fail to account for the complex psychosocial consequences of infertility and multiple losses associated with infertility. Although the participants did not report questioning the effectiveness of traditional counseling models, they did report the need to make various adjustments.

Burns (2005) asserts that infertility is "an interruption" of normality, which is unacceptable and suggests the goal of therapy is for clients to recognize the unacceptable nature of infertility. One strategy identified by most counselors was compassion and promotion of self-acceptance. The counselors spoke to the importance for clients to

recognize their loss and grief and to be gentle to themselves in the process of healing. Hence, both counselors and clients need to recognize the significant and pervasive impacts of infertility, and counselors need to demonstrate compassion and empathy toward clients' suffering. Unfortunately, counselors without training in infertility counseling may fail to do so and, as a result, may do damage to clients.

In Domain 1, the participants recognized that some clients were damaged by unknowledgeable counselors' inappropriate interventions and ignorant suggestions (i.e., "why not adopt" or "relax"). Yet, at the same time, proposing alternative fertility treatment options is an intervention identified by the participants of the present study. The result suggests that counselors needed to evaluate clients' capacity to cope with fertility treatment and assess clients' readiness for different family building options, and then conduct the alternative intervention with empathy; this finding is consistent with Jaffe's and Diamond's recommendation (2010). Jaffe and Diamond suggest that when counselors suggest different family building options, counselors need to articulate their concerns and rationale with support and empathy. The result again demonstrates the uniqueness of infertility counseling and the need for infertility counseling to be a specialty.

Study Strengths and Limitations

One of the major strengths of this study is the utilization of a qualitative methodology to explore counselors' experiences, in depth, in counseling infertile individuals and couples. While most current studies focus on consequences of infertility and reactions of infertile individuals, this research is one of few empirical studies that explore counselors' experiences in offering infertility counseling. This study offers

perspectives on counselors' experienced challenges and adapted strategies, adding to the knowledge of infertility counseling. Additionally, the results of this study not only verify the significance of infertility issues but also specify the uniqueness in infertility counseling.

A number of limitations pertinent to the research design, the sample demographic and clinical characteristics, and the recruitment process are observed. First, the qualitative nature of this study limits its generalization and interpretation. Knox, Schlosser, and Hill (2011) suggest the generalization of qualitative studies to large groups should be cautious due to small samples used in analysis. In addition, the analysis was performed by a research team consisting of three female graduate students with some clinical or personal experiences with infertility. It is possible that different research teams with different levels of training, clinical or personal experiences may generate slightly different results.

The participants of the study had received formal infertility counseling training (i.e., practicum, internship, mentorship through work, ongoing education/workshops, consultation, etc.) and at least one third of their caseload dealt with infertility-related issues. Thus, counselors with less training on infertility counseling or with less clinical experience in working with infertile clients may identify different challenges. In addition, the participants' different backgrounds were also observed, including various disciplines (i.e., clinical psychology, counseling psychology, social work, and marriage and family therapy), years of working experience in offering infertility counseling (i.e., 3-39 years), services provided (therapy only vs. comprehensive services) and work settings (i.e., private practice, medical settings, and community centers). Limited demographic variables are also noted. Most participants were white female counselors, suggesting

minimal racial-ethnic diversity. It is unknown whether male or minority counselors may identify different issues. To facilitate face-to-face interviews, the participants were recruited from the Twin Cities and Chicago metro areas and, hence, were geographically homogenous. Thus, as a result of the above demographic and clinical variables, the interpretation and generalization of the results should not go beyond groups not presented in this study.

Two perspective participants, who expressed interest in participating in the study and met the research criteria, were excluded from the research due to scheduling difficulties to participate in a face-to-face interview. It is unknown if other perspective participants did not respond to this study due to the requirement of in-person interviews.

Research Recommendations

This present study is a preliminary examination on counselors' challenges in working with infertile clients. Future quantitative studies including more participants to explore counselors' challenges in working with infertile individuals and couples (infertility counseling education, ethical concerns, client issues, and the effect of counselors' personal experience) are recommended.

The results of the current study also suggest counselors' countertransference in working with infertile clients and their internal struggles when facing infertile clients' multiple issues, such as emotional reactions when witnessing clients' intense reactions and repeated losses, debates about responsibility to grant or deny fertility treatment, or considerations of responsibility to the unborn children. Rosen and Rosen (2005) also recognize that current research has not focused on infertility counselors' experiences, the effect of client issues on counselors, and the psychodynamic dimensions of infertility

counseling. Thus, investigators need to examine topics, such as factors contributing to counselors' reactions, the effect of counselors' fertility/infertility or pregnancy on counseling process and countertransference, interventions to address counselors' pregnancy with infertile clients, methods to manage personal dilemmas about gate-keeping roles, vicarious trauma responses, or compassion fatigue of counselors.

The participants of the current study identified their adjusted approach (i.e., interactive, solution-focused, structured, or integrated) in order to offer effective services for infertile clients. Bovin (2003) and Applegarth (2006) also recommend more research on the efficacy of individual and couples counseling for infertile individuals. Thus, future research can focus on the following topics to gain clarity about the efficacy of infertility counseling; topics include characteristics of effective infertility counseling, infertile clients' perception of counselors' self-disclosure, features of interventions that infertile clients find helpful or unhelpful, or infertile clients' experience with trained or untrained counselors.

Implications

The results of this study reveal counselors' unique challenges when working with infertile clients. Hence, the study has some potential implications for training, credentialing and practice.

Training

The participants reported the importance of infertility counseling education and also recognized the need to adjust their approach in order to offer effective services. The results spoke to the importance of formal education and training on infertility counseling. However, the lack of formal training opportunities was observed.

In order to enhance general mental health practitioners' awareness of infertility and reproductive trauma, knowledge of infertility is recommended to be integrated into graduate-level courses, such as female issues, marriage and couples counseling, health psychology, or multicultural counseling. The ASRM (2006) has defined infertility as a disease, and the CDC (2012) has announced infertility as a *public health priority*. Infertility is identified by the WHO as a *global public health issue and the 5th highest serious global disability* among women (2009). Pederson (2005) also suggests that culture should broadly include differences caused by age, gender, disease, disability, sexual orientation, race/ethnicity, education, etc. Therefore, infertility needs to be considered as a factor that has a pervasive impact on a person's social and cultural identity; this consideration is suggested to be reflected in multicultural training.

In addition, in order to respond to the high prevalence of infertility and the CDC's call to manage infertility (the National Health Action Plan for the Detection, Prevention and Management of Infertility, 2012), more well-trained infertility counselors are needed. Given that mental health professionals from various disciplines (clinical psychology, counseling psychology, social work, marriage and family therapy, health psychology) can offer infertility counseling, formal training (i.e., practicum, internship, fellowship, and mentorship) in addition to graduate-level education in their respective fields is recommended to ensure competency in infertility counseling. Thus, increasing the availability of formal training is essential. The ASRM's qualification guidelines (1995) for infertility counselors recommend one year of supervised clinical experience in offering infertility counseling. Covington (2006) also suggests an increasing need for training programs. Thus, it is important for senior and seasoned infertility counselors to

become more involved in education (i.e., being a guest-lecturer or adjunct faculty at graduate school) and set up training programs (i.e., practicum, internship, fellowship, and mentorship).

Credentialing

The results of this present study reveal that infertility counselors address unique challenges as a result of the multiple and complex issues of infertile individuals and the distinctive ethical concerns in infertility counseling. Infertility counseling is also unique because of the multiple adjustments that counselors need to make to offer effective services. The participants of the current study suggested infertility counseling to be a specialty and observed unknowledgeable counselors' inappropriate interventions. It is also suspected that some mental health practitioners may indicate infertility counseling as their specialty without appropriate training. Thus, credentialing in infertility counseling is strongly recommended, which is consistent with Covington's suggestion on specialty status of infertility counseling (2006).

Although the ASRM and ESHRE have developed qualification guidelines for infertility counselors, these guidelines are not equal to credentialing, which defines the standards of care in infertility counseling and required qualifications of infertility counselors. The need for credentialing in infertility counseling was also validated by the results of the surveys on the members of ASRM/MHPG, although the members expressed concerns about the requirements to attain credentialing status (Burns & Figlerski, 1999, 2002, & 2005). Covington (2006) further identifies the challenge in creating credentialing in infertility counseling for current practitioners. Because infertility counselors can be trained from different disciplines, practitioners may have different

levels of current training in infertility, and, therefore, expect different requirements for specialization status. For instance, within social work, the National Association of Perinatal Social Workers requires members to receive training in infertility. Within health psychology, post-doc fellowships may offer rotations in reproductive health psychology. Thus, the establishment of credentialing needs to involve practitioners from various disciplines to reach consensus on the requirements of specialty status.

The British Infertility Counselling Association (BICA) has developed the first and only infertility counseling accreditation program in UK in 2009 (BICA, 2012), which allows members to apply for different accreditation levels depending on practitioners' levels of skills and experiences in offering infertility counseling. The BICA's experience in establishing the accreditation program may serve as a valuable resource for the credentialing development in the United States.

Practice

The results of the study reveal unique challenges in infertility counseling as well as counselors' internal struggles or countertransference toward the challenges. Examples include counselors' reactions when witnessing infertile clients' intense emotions, counselors' difficulty in holding hope for clients with repeatedly failed fertility treatment, counselors' personal ethical dilemmas about gate-keeping roles, and countertransference as a result of counselors' fertility/infertility or pregnancy. Jaffe and Diamond (2010) and Covington (2006) suggest that infertility counselors' repeatedly exposure to clients' grief and loss may lead to "vicarious grief", compassion fatigue, or countertransference. Applegarth (2006) claims that counselors' pregnancy may lead to countertransference and transference and supervision is strongly recommended to counselors. The above

challenges and literature suggest a need for supervision and consultation for infertility counselors in order to manage their internal struggles and countertransference issues.

In addition, Rupert and Morgan (2005) suggest private practitioners receive less supervision and consultation and have a higher rate of burnout and compassion fatigue than counselors in agency settings. Clarke (2008) suggests private practitioners need to seek supervision regularly to manage stress and discuss clinical issues. Kadder and Greenfeld (2006) recommend private practitioners seek consultation to resolve encountered ethical dilemmas as needed. It is noted that 11 participants of the current study worked in private practice. Although it is not uncommon for private practitioners to work independently of reproductive clinics, there appears to be a need for the private counselors to seek supervision and consultation more actively than counselors in medical or community settings.

Table 1. Participants' Demographic Information ($N=17$)

Variable	<i>n</i>
Gender	
Female	16
Male	1
Age	
31-40	2
41-50	7
51 \geq	8
Ethnicity	
Caucasian/White	16
Hispanic/Latino	1
Highest degree associated with mental health counseling	
Master's	4
Doctorate	13
Major associated with the above degree	
Clinical psychology	8
Counseling psychology	4
Marriage and family therapy	4
Social work	1
Primary licensure	
Psychologist	11
Marriage and Family Therapist	4
Independent Clinical Social Worker	1
Clinical Professional Counselor	1
Years of clinical experience	
	$M=20.7(SD=8.48)$
1-10	2
11-20	7
21-30	5
31-40	3
Years of infertility counseling experience	
	$M=12.8(SD=8.05)$
1-10	7
11-20	6
21-30	4
Work Setting	
Private Practice with collaboration with medical centers	8
Medical center	5
Private Practice	3

Community mental health center	1
Percentage of infertility-related issues in caseload	
25-50%	2
51-75%	7
76-100%	8
Professional affiliation ^a	
American Society for Reproductive Medicine	14
American Association for Marriage and Family Therapy	2
Minnesota Women in Psychology	1
Theoretical orientation ^a	
Cognitive-behavioral	12
Psychodynamic	10
Interpersonal	9
Person-centered	5
Bowen Family System	4
Mindfulness	4
Narrative	3
Feminist	2
Experiential Family	2
Existential	1
Adlerian	1
Structural Family	1
Integrative Couple Therapy	1
Hypnosis	1
Eye Movement Desensitization and Reprocessing	1

Note. ^aParticipants could provide multiple responses.

Table 2. Domains and Categories

Domain and Category	Frequency
Challenges Related to Infertility Counseling Education	
<i>The importance of medical knowledge</i>	Typical
<i>The need of infertility counseling training</i>	Typical
<i>Observed reactions of clients toward unknowledgeable providers</i>	Variant
Challenging Counseling Issues	
<i>Clients' reactions toward infertility and fertility treatment</i>	Typical
Intense emotional reactions	Typical
Repeated losses and grief	Typical
Loss of control	Variant
Identity crisis	Variant
<i>Co-existing mental health issues</i>	Typical
Other mental health issues	Typical
Personality disorders	Variant
<i>Relationship difficulty</i>	Typical
Marital and relational conflicts	Typical
Isolation and lack of support	Typical
<i>Unrealistic expectations about infertility and fertility treatment</i>	Typical
Ethical Concerns in Infertility Counseling	
<i>Ethical challenges in assessment</i>	Typical
Assessing appropriateness and readiness for fertility treatment	Typical
Concerns for unborn children	Typical
Personal ethical dilemma about gate-keeping roles	Variant
<i>Concerns about clients' decisions on or controversial requests for fertility treatment</i>	Variant
<i>Concerns about clients' care from other providers</i>	Variant
<i>Dual relationships</i>	Rare
Effect of Counselors' Personal Experiences on Counseling Process	
<i>Managing countertransference and transference</i>	Typical
<i>Issues with counselors' self-disclosure</i>	General
Disclosure of fertility/ infertility and clients' reactions	Typical
Non-disclosure and clients' reactions	Variant
Adjustment of Approach in Working with Infertile Clients	
<i>Psychoeducation and solution-focused interventions</i>	Typical
<i>Proposing alternative fertility treatment options</i>	Typical
<i>Compassion and promotion of self-acceptance</i>	Typical
<i>Broader framework for infertility counseling</i>	Typical
<i>Counseling agenda based on clients' needs</i>	Typical
<i>Consultation</i>	Rare

Note. General=16-17 cases; Typical=8-15 cases; Variant=4-7 cases; Rare=2-3 cases.

References

- Adolfsson, A. (2011). Meta-analysis to obtain a scale of psychological reaction after perinatal loss: Focus on miscarriage. *Psychology Research and Behavior Management, 4*, 29-39.
- American Psychological Association. (2010). *Ethical Principles of Psychologists and Code of Conduct*.
- American Society for Reproductive Medicine. (2006). Definition of “infertility”. *Fertility and Sterility, 86*, S228.
- American Society of Reproductive Medicine. (1995). *Qualification Guidelines for Mental Health Professionals in Reproductive Medicine*. Retrieved March 30, 2013, from <http://www.asrm.com>.
- Andrews, B., Qian, M., & Valentine, J. (2002). Predicting depressive symptoms with a new measure of shame: The experience of shame scale. *British Journal of Clinical Psychology, 41*, 29-42.
- Applegarth, L. D. (1999). Individual counseling and psychotherapy. In L. H. Burns, & S. N. Covington (Eds.), *Infertility counseling: A comprehensive handbook for clinicians* (pp. 85-101). Pearl River, NY: The Parthenon Publishing Group Inc.
- Applegarth, L. D. (2005). The therapist’s negative preconceptions about infertility treatment. In A. Rosen, & J., Rosen. (Eds.), *Frozen dreams: Psychodynamic dimensions of infertility and assisted reproduction* (pp. 69-83). Hillsdale, NJ: The Analytic Press, Inc.

- Applegarth, L. D. (2006). Individual counseling and psychotherapy. In L. H. Burns, & S. N. Covington (Eds.), *Infertility counseling: A comprehensive handbook for clinicians* (2nd ed., pp. 129-142). New York: Cambridge University Press.
- Applegarth, L. D., & Kingsberg, S. A. (2006). The donor as patient: Assessment and Support. In L. H. Burns, & S. N. Covington (Eds.), *Infertility counseling: A comprehensive handbook for clinicians* (2nd ed., pp. 339-355). New York: Cambridge University Press.
- Atwood, J. D., & Dobkin, S. (1992). Storm clouds are coming: Ways to reconstruct the crisis of infertility. *Contemporary Family Therapy, 14*, 385-403.
- Australia and New Zealand Infertility Counselling Association. (2013). *ANZICA Donor Linking Guidelines*. Retrieved April, 17th, 2013 from <http://www.fertilitysociety.com.au/wp-content/uploads/20120504-anzica-guidelines-donor-linking-final-version.pdf>.
- Baldur-Felskov, B., Kjaer, S. K., Albieri, V., Steding-Jessen, M., Kjaer, T., Johansen, C., Dalton, S. O., & Jensen, A. (2013). Psychiatric disorders in women with fertility problems: Results from a large Danish register-based cohort study. *Human Reproduction, 28*, 683-690.
- Beck, A. T. (1972). *Depression: Causes and treatment*. Philadelphia: University of Philadelphia Press.
- Beck, A. T., & Ward, C. H., Mendelsohn, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry, 4*, 561-571.
- Becker, G. (2000). *The elusive embryo: How women and men approach new reproductive technologies*. Berkeley, CA: University of California.

- Berg, B. J., & Wilson, J. F. (1991). Psychological functioning across stages of treatment for infertility. *Journal of Behavioral Medicine, 14*, 11-26.
- Black, J. J. (2010). Egg donation: Issues & concerns. *MCN: The American Journal of Maternal/Child Nursing, 35*, 132-137.
- Blyth, E. (2010). Fertility patients' experiences of cross-border reproductive care. *Fertility and Sterility, 94*, 11-15.
- Blyth, E., & Farrand, A. (2005). Reproductive tourism-a price worth paying for reproductive autonomy? *Critical Social Policy, 25*, 91-114.
- Blyth, E., Thorn, P., & Wischmann, T. (2011). CBRC and psychosocial counselling: assessing needs and developing an ethical framework for practice. *Reproductive BioMedicine Online, 23*, 642- 651.
- Boden, J. (2013). The ending of treatment: The ending of hope? *Human Fertility (Cambridge), 16*, 22-25.
- Boivin, J. (2003). A review of psychosocial interventions in infertility. *Social Science & Medicine, 57*, 2325-2341.
- British Infertility Counselling Association. (2012). *Counsellor Accreditation Scheme: Guidance Book, 2012 Version 4*.
- Burkard, A. W., Knox, S., & Hills, C. (2011). Data collection. In C. E. Hills & E. N. Willams (Eds.), *Consensual qualitative research: A practical resource for investigating social science phenomena* (pp. 83-102). Washington, DC: American Psychological Association,

- Burns, L. H. (2005). Psychological changes in infertility patients. In A. Rosen, & J., Rosen. (Eds.), *Frozen dreams: Psychodynamic dimensions of infertility and assisted reproduction* (pp. 3-29). Hillsdale, NJ: The Analytic Press, Inc.
- Burns, L. H. (2007). Psychiatric aspects of infertility and infertility treatments. *Psychiatric Clinics of North America*, 30, 689-716.
- Burns, L. H., & Figlerski, L. (1999, 2002, 2005). *Task Force on Credentialing Report, 1999, 2002, 2005*. Retrieved March 30, 2013, from <http://www.asrm.com>.
- Center for Disease Control and Prevention. (2010). *Infertility*. Retrieved March 10, 2013, from <http://www.cdc.gov/nchs/fastats/fertile.htm>
- Center for Disease Control and Prevention (2012). *Draft of A National Public Action Plan for the Detection, Prevention, and Management of Infertility*. Retrieved March 10, 2013 from <http://www.cdc.gov/reproductivehealth/Infertility/PublicHealth.htm>
- Clarke, M. M. (2008). Private practice psychologists' use of peer supervision groups and experiences of compassion fatigue, burnout and compassion satisfaction. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, 68, pp. 8392.
- Cohen, J. (2006). Procreative tourism and reproductive freedom. *Reproductive BioMedicine Online*, 13, 145–146.
- Cohen, K., & Collens, P. (2012). The Impact of Trauma Work on Trauma Workers: A Meta-synthesis on Vicarious Trauma and Vicarious Posttraumatic Growth. *Psychological Trauma: Theory, Research, Practice, and Policy*, 4, 1-11.

- Coleman, M. N. (2006). Critical incidents in multicultural training: An examination of student experiences. *Journal of Multicultural Counseling and Development, 34*, 168-152.
- Collins, J., & Cook, J. (2010). Cross-border reproductive care: Now and into the future. *Fertility and Sterility, 94*, 25-26.
- Covington, S. N. (1999). Integrating infertility counseling into clinical practice. In L. H. Burns, & S. N. Covington (Eds.), *Infertility counseling: A comprehensive handbook for clinicians* (pp. 491-512). Pearl River, NY: The Parthenon Publishing Group Inc.
- Covington, S. N. (2006). Integrating infertility counseling into clinical practice: A collaborative reproductive health model. In L. H. Burns, & S. N. Covington (Eds.), *Infertility counseling: A comprehensive handbook for clinicians* (2nd ed., pp. 493-507). New York: The Cambridge University Press.
- Covington, S. N., & Marosek, K. (1999, September). *Personal infertility experience among nurses and mental health professionals working in reproductive medicine*. Paper presented at the meeting of American Society for Reproductive Medicine, Toronto, Canada.
- Culley, L., Hudson, N., Rapport, F., Blyth, E., Norton, W., & Pacey, A. A. (2011). Crossing borders for fertility treatment: motivations, destinations and outcomes of UK fertility travelers. *Human Reproduction, 26*, 2373-2381.
- Daniluk, J. C. (1997). Gender and infertility. In S. R. Leiblum (Ed.), *Infertility: Medical, ethical, and psychological perspectives* (pp. 103-125). New York: Wiley.

- Daniluk, J. C. (2001). Reconstructing their life: A longitudinal, qualitative analysis of the transition to biological childlessness for infertile couples. *Journal of Counseling & Development, 79*, 439-449.
- Daniluk, J. C., & Tench, E. (2007). Long-term adjustment of infertile couples following unsuccessful medical intervention. *Journal of Counseling & Development, 85*, 89-100.
- de Lacey, S. (2013). Decision making about frozen supernumerary human embryos. *Human Fertility (Cambridge), 16*, 31-34.
- Department of Health and Social Security (1984). *Report of the Committee of Inquiry into Human Fertilisation and Embryology (The Warnock Report)*. Command of Her Majesty, 9414. London: HMSO.
- Domar, A. D., Clapp, D., Slawsby, E., Kessel, B., Orav, J., & Freizinger, M. (2000). The impact of group psychological interventions on distress in infertile women. *Health Psychology, 19*, 568-575.
- Domar, A. D., Smith, K., Conboy, L., Iannone, M., & Alper, M. (2010). A prospective investigation into the reasons why insured United States patients drop out of in vitro fertilization treatment. *Fertility and Sterility, 94*, 1457-1459.
- Easter, A., Treasure, J., & Micali, N. (2011). Fertility and prenatal attitudes towards pregnancy in women with eating disorders: Results from the Avon Longitudinal Study of Parents and Children. *BJOG: An International Journal of Obstetrics and Gynecology, 118*, 1491-1498.
- Edelmann, R. J. (2008). Infertility: Helping couples to cope. Retrieved September 11, 2009 from the *PsycCRITIQUES, 53*, database.

- Edelmann, R. J., & Connolly, K. J. (1998). Psychological state and psychological strain in relation to infertility. *Journal of Community & Applied Social Psychology*, 8, 303-311.
- Edelmann, R. J., & Connolly, K. J. (2000). Gender differences in response to infertility and infertility investigations: Real or illusory. *British Journal of Health Psychology*, 5, 365-375.
- Ethics Committee of the American Society for Reproductive Medicine. (2009). Child-rearing ability and the provision of fertility services. *Fertility and Sterility*, 92, 864-867.
- Ethics Committee of the American Society for Reproductive Medicine. (2012). Using family members as gamete donors or surrogates. *Fertility and Sterility*, 98, 797-803.
- European Society for Human Reproduction and Embryology. (2013). *Guidelines for Counselling in Infertility*. Retrieved May 3, 2013, from <http://www.eshre.eu/home/page.aspx/2>.
- Eysenck, H. J. & Eysenck, S. B. G. (1975). *Manual of the Eysenck Personality Inventory*. London: Hodder & Stoughton.
- Fisher, J., & Hammarberg, K. (2012). Psychological and social aspects of infertility in men: An overview of the evidence and implications for psychologically-informed clinical care and future research. *Asian Journal of Andrology*, 14, 121-129.
- Frankl, V. (1946). *Man's search for meaning*. New York: Washington Square Press.
- Frith, L., Jacoby, A., & Gabbay, M. (2011). Ethical boundary-work in the infertility clinic. *Sociology of Health & Illness*, 33, 570-585.

- Fukuyama, M. A. (1994). Critical incidents in multicultural counseling supervision: A phenomenological approach to supervision research. *Counselor Education and Supervision, 34*, 142-151.
- Furman, I., Parra, L., Fuentes, A., & Devoto, L. (2010). Men's participation in psychologic counseling services offered during in vitro fertilization treatments. *Fertility and Sterility, 94*, 1460-1464.
- Galhardo, A., Pinto-Gouveia, J., Cunha, M., & Matos, M. (2011). The impact of shame and self-judgment on psychopathology in infertile patients. *Human Reproduction, 26*, 2408-2414.
- Geller, P. A. (2004). Giving voice to disenfranchised grief. *Death Studies, 28*, 904-912.
- Gibson, D. M. (2007). The relationship of infertility and death: Using the relational/cultural model of counseling in making meaning. *The Humanistic Psychologist, 35*, 275-289.
- Gibson, D. M. (2008). Making meaning of infertility and death through the use of spirituality and growth-fostering relationships in counseling. In A. Tomer, G. T. Eliason, & P. P. T. Wong. (Eds.), *Existential and spiritual issues in death attitudes* (pp.397-416). New York, NY: Taylor & Francis Group.
- Gibson, D. M., & Myers, J. E. (2000). Gender and infertility: A relational approach to counseling women. *Journal of Counseling & Development, 78*, 400-410.
- Gibson, D. M., & Myers, J. E. (2002). The effect of social coping resources and growth-fostering relationships on infertility stress in women. *Journal of Mental Health Counseling, 24*, 68-80.

- Goedeke, S., & Payne, D. (2010). A qualitative study of New Zealand fertility counsellors' roles and practices regarding embryo donation. *Human Reproduction*, 25, 2821-2828.
- Goldberg, D. P. (1978). *Manual of the General Health Questionnaire*. NFER-Nelson, Oxford.
- Goldberg, D. P., Gater, R., Sartorius, N., Ustun, T. B., Piccinelli, M., Gureje, O., et al. (1997). The validity of two versions of the GHQ in the WHO study of mental illness in general health care. *Psychological Medicine*, 27, 191-197.
- Gonzalez, L. O. (2000). Infertility as a transformational process: A framework for psychotherapeutic support of infertile women. *Issues in Mental Health Nursing*, 21, 619-633.
- Gordon, E. R., & Barrow, R. G. (1999). Legal and ethical aspects of infertility counseling. In L. H. Burns, & S. N. Covington (Eds.), *Infertility counseling: A comprehensive handbook for clinicians* (pp. 491-512). Pearl River, NY: The Parthenon Publishing Group Inc.
- Goss, K., Gilbert, P., & Allan, S. (1994). An exploration of shame measure: The 'others as shamer scale'. *Personality and Individual Differences*, 17, 713-717.
- Greil, L., McQuillan, J., Lowry, M., & Shreffler, K. M. (2011). Infertility treatment and fertility-specific distress: A longitudinal analysis of a population-based sample of U.S. women. *Social Science & Medicine*, 73, 87-94
- Greil, L., Slauson-Blevins, K., & McQuillan, J. (2010). The experience of infertility: A review of recent literature. *Sociology of Health & Illness* 32, 140-162

- Guerra, D., Llobera, A., Veiga, A., & Barri, P. N. (1998). Psychiatric morbidity in couples attending a fertility service. *Human Reproduction*, *13*, 1733-1736.
- Gurtin, Z. B. (2011). Banning reproductive travel: Turkey's ART legislation and third-party assisted reproduction. *Reproductive BioMedicine Online*, *23*, p555
- Gurtin, Z. B., & Inhorn, M. C. (2011). Introduction: Travelling for conception and the global assisted reproduction market. *Reproductive BioMedicine Online*, *23*, 535-537.
- Haase, J., M., & Blyth, E. (2006). Global perspectives on infertility counseling. In L. H. Burns, & S. N. Covington (Eds.), *Infertility counseling: A comprehensive handbook for clinicians* (2nd ed., pp. 544-557). New York: Cambridge University Press.
- Hakim, L. Z., Newton, C. R., Maclean-Brine, D., & Feyles, V. (2012). Evaluation of preparatory psychosocial counseling for medically assisted reproduction. *Human Reproduction*, *27*, 2058- 2066.
- Hanafin, H. (2006). Surrogacy and gestational carrier participants. In L. H. Burns, & S. N. Covington (Eds.), *Infertility counseling: A comprehensive handbook for clinicians* (2nd ed., pp. 370-386). New York: Cambridge University Press.
- Harris, D. L. (Ed.) (2011). *Counting our losses: Reflecting on change, loss, and transition in everyday life*. New York: Routledge/Taylor & Francis Group.
- Harris, D. L., & Daniluk, J. C. (2010). The experience of spontaneous pregnancy loss in infertile women who have conceived with the assistance of medical intervention. *Human Reproduction*, *25*, 714-720.

- Hashemi, S., Simbar, M., Ramezani-Tehrani, F., Shams, J., & Majd, H. A. (2012). Anxiety and success of in vitro fertilization. *European Journal of Obstetrics & Gynecology and Reproductive Biology*, *164*, 60-64.
- Hills, C. E. (2011). Introduction to consensual qualitative research. In C. E. Hills & E. N. Williams (Eds.), *Consensual qualitative research: A practical resource for investigating social science phenomena* (pp. 3-20). Washington, DC: American Psychological Association,
- Hills, C. E., Knox, S., Thompson, B. J., Williams, E. N., Hess, S. A., & Ladany, N. (2005). Consensual qualitative research: An update. *Journal of Counseling Psychology*, *52*, 196-205.
- Hill, C. E., Thompson, B. J., & Williams, E. N. (1997). A guide to conducting consensual qualitative research. *The Counseling Psychologist*, *25*, 517-572.
- Hills, C. E., & Williams, E. N. (Eds.). (2011). *Consensual Qualitative Research: A Practical Resource for Investigating Social Science Phenomena*. Washington, DC: American Psychological Association.
- Hjelmstedt, A., Andersson, L., Skoog-Svanberg, A., Bergh, T., Boivin, J., & Collins, A. (1999). Gender differences in psychological reactions to infertility among couples seeking IVF- and ICSI-treatment. *Acta Obstetrica Gynecologica Scandinavica*, *78*, 42-48.
- Holley, S. R., Bleil, M. E., Shehab, D., Nachtigall, R. D., & Katz, P. P. (2011). Are depressed infertility patients offered and do they receive mental health services? *Fertility and Sterility*, *98*, S44-45.

- Horowitz, J. E., Galst, J. P., & Elster, N. (2010). *Ethical Dilemmas in Fertility Counseling*. Washington, DC: American Psychological Association.
- Human Fertilisation and Embryology Act, 1990, United Kingdom.
- Human Fertilisation and Embryology Authority. (1991). *Code of Practice: Explanation*. London: HFEA.
- Human Fertilisation and Embryology Authority. (1995). *Code of Practice, 2nd edition: Explanation*. London: HFEA.
- Hunt, J. (2013). Cross border treatment for infertility: The counseling perspective in the UK. *Human Fertility, 16*, 64-67.
- Hunt, M., & Meerabeau, L. (1993). Purging the emotions: The lack of emotional expression in subfertility and in the care of the dying. *International Journal of Nursing Studies, 30*, 115-123.
- Indekeu, A., D'Hooghe, T., De Sutter, P., Demyttenaere, K., Vanderschueren, D., Vanderschot, B., Welkenhuysen, M., Rober, P., & Colpin, H. (2012). Parenthood motives, well-being and disclosure among men from couples ready to start treatment with intrauterine insemination using their own sperm or donor sperm. *Human Reproduction, 27*, 159-166.
- Infertility Treatment Authority of Australia (2001). *Conditions for Approval-Donor Linking: Application by Counsellors*. Melbourne, Australia.
- Inhorn, M. C., & Patrizon, P. (2012). The global landscape of cross-border reproductive care: Twenty key findings for the new millennium. *Current opinion in obstetrics & gynecology, 24*, 158-163.

- Jaffe, J., & Diamond, M. (2010). *Reproductive Trauma*. Washington, DC: American Psychological Association.
- Johnson, L., Bourne, K., & Hammarberg, K. (2012). Donor conception legislation in Victoria, Australia: the "Time to Tell" campaign, donor-linking and implications for clinical practice. *Journal of Law and Medicine*, *19*, 803-819.
- Josephs, L. (2005). Therapist anxiety about motivation for parenthood. In A. Rosen, & J., Rosen. (Eds.), *Frozen dreams: Psychodynamic dimensions of infertility and assisted reproduction* (pp. 33-49). Hillsdale, NJ: The Analytic Press, Inc.
- Kader, N. S., & Greenfeld, D. A. (2006). Ethical aspects of infertility counseling. In L. H. Burns, & S. N. Covington (Eds.), *Infertility counseling: A comprehensive handbook for clinicians* (pp. 508-520). New York: Cambridge University Press.
- Klemetti, R., Raitanen, J., Sihvo, S., Saarni, S., & Koponen, P. (2010). Infertility, mental disorders and well-being: A nationwide survey. *Acta Obstetrica et Gynecologica Scandinavica*, *89*, 677-682
- Klock, S. C. (2006). Psychological evaluation of infertile clients. In L. H. Burns, & S. N. Covington (Eds.), *Infertility counseling: A comprehensive handbook for clinicians* (2nd ed., pp. 83-96). New York: Cambridge University Press.
- Knapp, A. W., & Myer, R. A. (2000). Layers of grief: Counseling the seropositive gay male. *Crisis Intervention & Time-Limited Treatment*, *6*, 141-150.
- Knox, S., & Hill, C. E. (2003). Therapist self-disclosure: Research-based suggestions for practitioners. *Journal of Clinical Psychology*, *59*, 529-539.

- Knox, S., Schlosser, L. Z., & Hill, C. E. (2011). Writing the manuscript. In C. E. Hills (Ed.), *Consensual qualitative research* (pp.145-157). Baltimore: United Book Press.
- Kottick, J. (2005). Therapist anger, despair, cynicism. In A. Rosen, & J., Rosen. (Eds.), *Frozen dreams: Psychodynamic dimensions of infertility and assisted reproduction* (pp. 84-102). Hillsdale, NJ: The Analytic Press, Inc.
- Kurpius, S. E. R., & Maresh, S. E. (1998). Women's health issues: A focus on infertility, gynecological cancer, and menopause. In S., Roth-Roemer, S. E. R., Kurpius, , & C., Carmin (Eds.), *The emerging role of counseling psychology in health care* (pp. 333-355). New York: W. W. Norton & Company, Inc.
- Ladany, N., Thompson, B. J., & Hills, C. E. (2011). Cross-analysis. In C. E. Hills & E. N. Willams (Eds.), *Consensual qualitative research: A practical resource for investigating social science phenomena* (pp. 117-134). Washington, DC: American Psychological Association.
- Lampman, C., & Dowling-Guyer, S. (1995). Attitudes toward voluntary and involuntary childlessness. *Basic and Applied Psychology, 17*, 213-222.
- Lee, G. L., Neimeyer, R. A., & Chan, C. L. W. (2012). The meaning of childbearing among IVF service users assessed via laddering technique. *Journal of Constructivist Psychology, 25*, 302-324.
- Lee, S., Wang, S., Kuo, C., Kuo, P., Lee, M., & Lee, M. (2010). Grief responses and coping strategies among infertile women after failed in vitro fertilization treatment. *Scandinavian Journal of Caring Sciences, 24*, 507-513.

- Lund, D. A. (Ed.). (2001). *Men coping with grief*. Amityville, NY: Baywood Publishing, Co.
- Lyerly, A. D., Nakagawa, S., & Kuppermann, M. (2011). Decisional conflict and the disposition of frozen embryos: implications for informed consent. *Human Reproduction, 26*, 646-654.
- Lykeridou, K., Gourounti, K., Sarantaki, A., Roupa, Z., Iatrakis, G., Zervoudis, S., & Vaslamatzis, G. (2010). What kind of care and support do infertile women undergoing fertility treatment in Greece expect? A questionnaire survey. *Clinical and Experimental Obstetrics and Gynecology, 37*, 201-208.
- Lyon-Pages, I. (2004). The therapist's pregnancy: Its impact on the therapeutic process. *Psychotherapies, 24*, 17-23.
- Mahlstedt, P. P. (1985). The psychological component of infertility. *Fertility and Sterility, 43*, 35-346.
- Marziliano, A., & Moyer, A. (2013). An additional consideration regarding expanding access to testicular tissue cryopreservation: infertility and social stigma. *American Journal of Bioethics, 13*, 48-50.
- McDowell, S., & Murray, A. (2011). Barriers to continuing in vitro fertilization: Why do patients exit fertility treatment? *Australian and New Zealand Journal of Obstetrics and Gynecology, 51*, 84-90.
- McQuillian, J., Greil, A. L., White, L., & Jacob, M. C. (2003). Frustrated fertility: Infertility and psychological distress among women. *Journal of Marriage and Family Therapy, 65*, 1007-1018.

- McShane, P. M. (1997). Ethical issues associated with the new reproductive technologies. In S. R. Leiblum (Ed.), *Infertility: Psychological issues and counseling strategies* (pp. 20-40). New York: Wiley.
- Menning, B. E. (1980). The emotional needs of infertile couples. *Fertility and Sterility*, 34, 313-319.
- Michalopoulos, L., & Aparicio, E. (2012). Vicarious trauma in social workers: The role of trauma history, social support, and years of experience. *Journal of Aggression, Maltreatment & Trauma*, 21, 646-664.
- Mikkelsen, A. T., Madsen, S. A., & Humaidan, P. (2012). Psychological aspects of male fertility treatment. *Journal of Advanced Nursing*, 3, 1-10.
- Miles, M., & Huberman, A. (1994). *Quantitative data analysis: An expanded sourcebook* (2nd ed.). Thousand Oaks, CA: Sage.
- Monach, J. (2013). Developments in infertility counselling and its accreditation. *Human Fertility*, 16, 68-72.
- Moreno-Rosset, C., del Castillo Aparicio, M., Ramirez-Ucles, I., & Martin Diaz, M. D. (2011). Emotional and affective states in infertility: A comparative study of fertile people. *Behavioral Psychology / Psicología Conductual: Revista Internacional Clinica y de la Salud*, 19, 683-703.
- Neff, K. (2003). The development and validation of a scale to measure self-compassion. *Self Identity*, 2, 223-250.
- Ornstein, A. (2010). The missing tombstone: Reflections on mourning and creativity. *Journal of the American Psychoanalytic Association*, 58, 631-848.

- Pasch, L. A., Gregorich, S. E., Katz, P. K., Millstein, S. G., Nachtigall, R. D., Bleil, M. E., & Adler, N. E. (2012). Psychological distress and in vitro fertilization outcome. *Fertility and Sterility*, *98*, 459-464.
- Patton, M. (1990). *Qualitative evaluation and research methods*. Beverly Hills, CA: Sage.
- Pederson, P. B. (2003). Cross-cultural counseling: Developing culture-centered interactions. In G. Bernal, J. E., Trimble, A. K., Burlew, & F. T. L. Leong (Eds.), *Handbook of racial and ethnic minority psychology*. Thousand Oaks, CA: Sage.
- Peronace, L. A, Boivin, J., & Schmidt, L. (2007). Patterns of suffering and social interactions in infertile men: 12 months after unsuccessful treatment. *Journal of Psychosomatic Obstetrics & Gynecology*, *28*, 105–114.
- Peterson, B. D., Boivin, J., Norre, J., Simth , C., Thorn, P., & Wischmann, T. (2012). An introduction to infertility counseling: A guide for mental health and medical professionals. *Assisted Reproduction Technologies*, *29*, 243-248.
- Peterson, B. D., Gold, L., & Feingold, T. (2007). The experience and influence of infertility: Considerations for couple counselors. *The Family Journal: Counseling and Therapy for Couples and Families*, *15*, 251-257.
- Peterson, B.D., Newton, C.R., Rosen, K.H., & Skaggs, G.E. (2006). Gender differences in how men and women referred with in vitro fertilization cope with infertility stress. *Human Reproduction*, *21*, 2443-2449.
- Ponterotto, J. G. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of Counseling Psychology*, *52*, 126-136.

- Pook, M., Rohrle, B., Tuschen-Caffier, B., & Krause, W. (2001). Why do infertile males use psychological couple counseling? *Patient Education and Counseling, 42*, 239-245.
- Price, S. K., & McLeod, D. A. (2012). Definitional distinctions in response to perinatal loss and fertility barriers. *Illness, crisis & loss, 20*, 255-273.
- Quinn, G. P., Vadaparampil, S. T., Lowrey, K. M., Caprice Knapp, S. E., & Bukulmez, O. (2011). State laws and regulations addressing third-party reimbursement for infertility treatment: implications for cancer survivors. *Fertility and Sterility, 95*, 72-78.
- Rosen, A., & Rosen, J. (Eds.). (2005). *Frozen dreams: Psychodynamic dimensions of infertility and assisted reproduction*. Hillsdale, NJ: The Analytic Press, Inc.
- Rupert, P. A., & Morgan, D. J. (2005). Work setting and burnout among professional psychologists. *Professional Psychology: Research and Practice, 36*, 544-550.
- Savitz-Smith, J. (2003). Couple undergoing infertility treatment: Implications for counselors. *The Family Journal: Counseling and Therapy for Couples and families, 11*, 383-387.
- Schweiger, U., Wischmann, T., & Strowitzki, T.. (2012). Mental disorders and female infertility. *Der Nervenarzt, 83*, 1442-1447.
- Shapiro, C. H. (1993). *When part of the self is lost: Helping clients heal after sexual and reproductive losses*. San Francisco: Jossey-Bass.
- Shapiro, C. H. (1999). Group counseling. In L. H. Burns, & S. N. Covington (Eds.), *Infertility counseling: A comprehensive handbook for clinicians* (pp. 117-127). Pearl River, NY: The Parthenon Publishing Group Inc.

- Shenfield, F., Pennings, G., De Mouzon, J., Ferraretti, A. P., & Goossens, V. On behalf of the ESHRE Task Force 'Cross Border Reproductive Care' (CBRC). (2011). ESHRE's good practice guide for cross-border reproductive care for centers and practitioners. *Human Reproduction*, 26, 1625-1627.
- Shepard, D. S., & Harway, M. (Eds). (2012). *Engaging Men in Couples Therapy*. New York: Routledge/Taylor & Francis Group.
- Shepherd, J. (1992). Stress management and infertility. *The Australian and New Zealand Journal of Obstetrics and Gynecology*, 32, 353-356.
- Sim, W., Huang, T. C., & Hills, C. E. (2011). Biases and expectations. In C. E. Hills & E. N. Willams (Eds.), *Consensual qualitative research: A practical resource for investigating social science phenomena* (pp. 59-71). Washington, DC: American Psychological Association.
- Speilberger, C. D., Gorsuch, R. L. & Lushene, R. (1970). *The State-Anxiety Inventory Manual*. Palo Alto, CA: Consulting Psychologists.
- Spielberger C. D. (1983). *Manual for State-Trait Anxiety Inventory (Form Y)*. Palo Alto, CA: Consulting Psychologists Press.
- Strauss, B., & Boivin, J. (2002). Counseling within infertility. In J. Boivin J. and H. Kertenich. (Eds), *Guidelines for counseling in infertility* (pp. 4-6). Oxford: University Press.
- Stricker, G. (2003). The many faces of self-disclosure. *Journal of Clinical Psychology*, 59, 623-630.
- Stuart-Smith, S. J., Smith, J. A., & Scott, E. J. (2011). Treatment decision making in anonymous donor egg in-vitro fertilisation: A qualitative study of childless

- women and women with genetically related children. *Human Fertility (Cambridge)*, 14, 97-105.
- Tao, P., Coates, R., & Maycock, B. (2011). The impact of infertility on sexuality: A literature review. *Australasian Medical Journal*, 4, 620-627.
- Thorn, P. (2006). Recipient counseling for donor insemination. . In L. H. Burns, & S. N. Covington (Eds.), *Infertility counseling: A comprehensive handbook for clinicians* (2nd ed., pp. 305-318). New York: Cambridge University Press.
- Thorn P. (2013). The shift from biological to social fatherhood: Counselling men and their partners considering donor insemination. *Human Fertility (Cambridge)*, 16, 40-43.
- Tonon, C. B., Romani, P. F., & Grossi, R. (2012). The therapist's pregnancy and its consequences on the psychotherapeutic process. *Psicologia: Teoria e Pesquisa*, 28, 87-92.
- Van den Broeck, U., Emery, M., Wischmann, T., & Thorn, P. (2010). Counselling in infertility: individual, couple and group interventions. *Patient Education and Counseling*, 81, 422-428.
- Watkins, K. J., & Baldo, T. D. (2004). The infertility experience: Biopsychosocial effects and suggestions for counselors. *Journal of Counseling & Development*, 82, 394-342.
- Williams, L., Bischoff, R., & Ludes, J. (1992). A biopsychosocial model for treating infertility. *Contemporary Family Therapy*, 14, 309-322.
- Wischmann, T. (2008). Implications of psychosocial support in infertility: A critical appraisal. *Journal of Psychosomatic Obstetrics and Gynecology*, 29, 83-90.

- Wischmann, T., Scherg, H., Strowitzki, T., & Verres, R. (2009). Psychosocial characteristics of women and men attending infertility counselling. *Human Reproduction*, 24, 378-385.
- Wittchen, H. U., Lachner, G., Wunderlich, U., & Pfister, H. (1998). Test-retest reliability of the computerized DSM-IV version of the Munich-Composite International Diagnostic Interview (M-CIDI). *Social Psychiatry and Psychiatric Epidemiology*, 33, 568-578.
- World Organization of Health. (2009). *Infertility definitions and terminology*. Retrieved March 10th, 2013, from <http://www.who.int/reproductivehealth/topics/infertility/definitions/en/index.html>.
- Yli-Kuha, A. N., Gissler, M., Klemetti, R., Luoto, R., Koivisto, E., & Hemminki, E. (2010). Psychiatric disorders leading to hospitalization before and after infertility treatments. *Human Reproduction*, 25, 2018-2023.

Appendix A: Inviting Letter

Dear Helping Professional:

You are invited to participate in a study of counselors' experience in working with clients with infertility issues. You were selected as a possible participant because you identify infertility counseling as part of your practice.

This study is conducted by Ju-Ping Huang, M.A., a doctoral student in the Counseling and Student Personnel Psychology Program in the Department of Educational Psychology at the University of Minnesota. This is a dissertation study and is under the supervision of her advisor, Dr. Kay Herting Wahl, Associate Professor.

The purpose of the study is to investigate the professional challenges that counselors may encounter when working with individuals and couples with infertility issues. This study will also explore how counselors assist their clients in dealing with the various consequences associated with infertility.

A 60-minute audiotaped interview will be scheduled at your practice site or a location of your choosing. An informed consent and demographic information sheet, which you will be asked to complete, will be presented to you prior the interview. If you are interested in participating in this study, please contact Ju-Ping Huang at huan0316@umn.edu or 612-229-7463.

The interview will be transcribed verbatim by two graduate students at the Counseling and Student Personnel Psychology Program, and the transcript will be stored in a password protected computer. In any type of report that may be published in the future, there will be no information that will make it possible to identify you as a participant.

There are no direct benefits to you for participating in this study. However, you may indirectly benefit from reflecting on your experience in infertility counseling and from learning of the experiences of other helping professionals who work in the area of infertility. This is a minimal risk study. The only potential risk of your participation is the possible discomfort in reflecting on challenges you have encountered in infertility counseling.

Participation in this study is voluntary. Your decision on whether or not to participate will not affect your current or future relations with the University of Minnesota. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

Contacts and Questions:

If you have any concerns or questions about this study, you may contact Ju-Ping Huang, a doctoral student in the Counseling and Student Personnel Psychology Program in the Department of Educational Psychology at the University of Minnesota, by email huan0316@umn.edu or telephone at 612-229-7563. You may also contact Ju-Ping's

faculty advisor, Dr. Kay Herting Wahl, by email at kwahl@umn.edu or telephone at 612-624-4577.

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Research Subjects' Advocate Line, D528 Mayo, 420 Delaware St. Southeast, Minneapolis, Minnesota 55455; (612) 625-1650.

Thank you for your time and consideration.

Ju-Ping Huang
Doctoral Candidate
Educational Psychology

Kay Herting Wahl. Ed.D,
Associate Professor
Educational Psychology

Appendix B: Demographic Questionnaire

1. Gender: _____

2. What is your current age?

____ 21-30

____ 31-40

____ 41-50

____ > 51

3. Please check the racial or ethnic group with which you most strongly identify.
(Please check only one option):
____ African American/Black
____ Alaskan Native/American Native
____ Asian/Pacific Islander
____ Biracial (Please specify) _____
____ Caucasian/White
____ Chicano/Hispanic/Latino
____ Other (Please specify) _____

4. Please estimate how many years you have practice as a counselor:
_____ years

5. Please estimate the numbers of years that you have worked with clients with
infertility issues: _____ years

6. Please estimate the number of infertile clients that you have worked with
____ 10-25 clients
____ 25-50 clients
____ 50-75 clients
____ 75-100 clients
____ more than 100 clients

7. How much percent of your current clients are dealing with infertility related
issues?
____ 10-25 %
____ 25-50 %
____ 50-75 %
____ 75-100 %

8. What is your main theoretical orientation (choose as many as you want)?
- | | |
|--|---|
| <input type="checkbox"/> Psychodynamic | <input type="checkbox"/> Adlerian |
| <input type="checkbox"/> Existential | <input type="checkbox"/> Person-Centered/Humanistic |
| <input type="checkbox"/> Cognitive Behavioral | <input type="checkbox"/> Feminist |
| <input type="checkbox"/> Narrative | <input type="checkbox"/> Interpersonal |
| <input type="checkbox"/> Bowen Family System | <input type="checkbox"/> Experiential Family |
| <input type="checkbox"/> Structural Family | <input type="checkbox"/> Strategic Family |
| <input type="checkbox"/> Other (Please specify _____) | |

Appendix C: Semi-Structured Interview Protocol

Thank you for volunteering to participate in this research. In the next 60 minutes, I will be asking you a series of questions about your experience counseling infertile couples and individuals. You can end this interview or decline to answer any question at any time without negative consequences. This interview will be audiotaped and transcribed. All identifying information will be removed before data analysis begins. Audio files will be destroyed after data analysis is completed. What questions do you have about the risks and benefits of your participation in this study?

1. Briefly describe your experience in counseling infertile individuals and couples.

Follow up questions:

- How many years have you worked with infertile individuals and couples?
- What types of services do you provide, such as individual counseling, couple counseling, support group, etc.?
- What kinds of issues do your infertile clients bring to counseling?

2. What made you choose the field of infertility counseling?

Alternative question: How did you begin to work with infertile couples/individuals?

3. What formal and informal training/education that you have received prepared you to work with infertile clients? For example, infertility counseling, female issues, couple counseling, and grief/loss.
4. What is your theoretical orientation in your clinical work with infertility issues?

Follow up questions:

- Based on your experience, does infertility counseling differ from other forms of counseling?
- If yes, how do you describe the differences? If no, how so?

5. What challenges or issues have you encountered or observed in working with infertile clients?

Follow up questions:

- Among those challenges, what is the most difficult issue for you?
- What strategies or interventions have you adapted in dealing with those challenges?

6. What challenges or issues have you experienced or observed in facilitating infertile clients' emotional reactions to infertility or infertility-related issues?

7. Please talk about the issue of self-disclosure about fertility/infertility with clients in your professional practice?

Follow up questions:

- How much do you discuss your own fertility with your client?
- Give an example how your disclosure or non disclosure affected the counseling dynamic and relationship.

8. What ethical issues or challenges, if any, have you experienced or observed in working with infertile clients?

9. Please talk about a memorable case in working with infertile clients?

10. Please talk about a critical incident in working with infertile clients?

Appendix D: CONSENT FORM
The Unique Challenges in Counseling Infertile Individuals and Couples

You are invited to be in a research study of professional challenges in infertility counseling. You were selected as a possible participant because you have identified infertility counseling as part of your practice. We ask that you read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Ju-Ping Huang, M.A., a doctoral student in the Counseling and Student Personnel Psychology Program in the Department of Educational Psychology at the University of Minnesota.

Background Information

The purpose of this study is to investigate the professional challenges that counselors may encounter when working with individuals and couples with infertility issues. This study will also explore how counselors assist their clients in dealing with the various consequences associated with infertility.

Procedures:

If you agree to be in this study, we would ask you to do the following things:
A 60-minute audiotaped interview will be scheduled at your practice site or a location of your choosing. An informed consent and demographic information sheet, which you will be asked to complete, will be presented to you prior the interview.

Risks and Benefits of being in the Study

The risks to participations are:
This is a minimal risk study. The only potential risk of your participation is the possible discomfort in reflecting on challenges you have encountered in infertility counseling.

The benefits to participation are:
There are no direct benefits to you for participating in this study. However, you may indirectly benefit from reflecting on your experience in infertility counseling and from learning of the experiences of other helping professionals who work in the area of infertility.

Compensation:

You will not receive any payment or reimbursement for participating in this study.

Confidentiality:

The records of this study will be kept private. In any sort of report we might publish, we will not include any information that will make it possible to identify a subject. Research records will be stored securely and only the principal investigator and the principal investigator's faculty advisor will have access to the records.

The qualitative interview will be audio-recorded with a digital device that will also be stored in a locked cabinet. The principal investigator will collaborate with two graduate students in the Counseling and Student Personnel Psychology program for data transcribing and analyses. Unless you agree to disclose, the graduate students who transcribe and analyze the data will not have direct access to your identifying information.

Voluntary Nature of the Study:

Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with the University of Minnesota. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

Contacts and Questions:

The researcher conducting this study is: Ju-Ping Huang, M.A., a doctoral student in the Counseling and Student Personnel Psychology Program in the Department of Educational Psychology at the University of Minnesota. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact Ju-Ping by email at huan0316@umn.edu or telephone at 612-229-7463. You may also contact Ju-Ping's faculty advisor, Dr. Kay Herting Wahl, by email at kwahl@umn.edu or telephone at 612-624-4577.

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher(s), **you are encouraged** to contact the Research Subjects' Advocate Line, D528 Mayo, 420 Delaware St. Southeast, Minneapolis, Minnesota 55455; (612) 625-1650.

You will be given a copy of this information to keep for your records.

Statement of Consent:

I have read the above information. I have asked questions and have received answers. I consent to participate in the study.

Signature: _____ Date: _____

Signature of Investigator: _____ Date: _____