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A Study on Infertility Disclosure and Social Support: Communication Variance Between Familial Dyads

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A STUDY ON INFERTILITY DISCLOSURE AND SOCIAL SUPPORT: COMMUNICATION VARIANCE
BETWEEN FAMILIAL DYADS

by

Emily VanWiel

A thesis submitted in partial fulfillment of the requirements
for graduation with Honors in the Communication Studies

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All requirements for graduation with Honors in the
Communication Studies have been completed.

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A Study on Infertility Disclosure and Social Support

Communication Variance Between Familial Dyads

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Advised by Professor Sylvia Mikucki-Enyart

University of Iowa

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Abstract

The present study examines whether avoiding disclosure of infertility to in-laws causes an increase in fertility related distress, as well as communication rules about said disclosure between partners. There are many current studies about disclosure and social support for women with infertility as well as studies about communication with in-laws but not much research combining these theoretical frameworks. Further research about communication rules and fertility related stress in the event of disclosure to in-laws could improve therapeutic care and guidance for infertile women. It could also improve therapy for couples by examining the strain in relationships caused by communication with in-laws. This paper will review the existing literature and theories contributing to this study as well as presenting the quantitative methods and potential findings.

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Introduction

Infertility is a medical diagnosis that, although a physical condition, can often have as much impact on a patient's emotional health. Many studies have been done regarding the medical aspect of infertility, such as its causes and potential treatment options, but the field of study on emotional treatment and outcomes is much more narrow. With an ever-changing social stigma surrounding fertility, we are able to understand the implications of this diagnosis and expand the breadth of what we consider treatment and recovery, both for women and couples. To start, it is important to understand the medical definition of infertility, which is the inability to conceive or to remain pregnant after one year of trying for women under 35 years old, or after six months of trying for those over the age of 35 (CDC, 2015). An important distinction in the social effects of women is whether they have previously had children, *secondary infertility*, or whether they are diagnosed as infertile and have never been able to conceive, *primary infertility*. Of all diagnoses, roughly 60% of women are diagnosed with secondary infertility, which produces similar emotional burdens but not always the same social consequences as being childless (Greil, Shreffler, Schmidt & McQuillan, 2011; Behjati-Ardakani, Navabakhsh & Hosseini, 2017). Roughly 48.5 million individuals worldwide experience infertility (Agarwal, Mulgund, Hamada & Chyatte, 2015) and about one in eight couples in the United States have utilized infertility services (CDC). With this large of a population, the present study has the potential to impact many lives and improve our current knowledge of infertility.

Through quantitative research of women who have been diagnosed as infertile, we hope to uncover theories of social support and how women choose to disclose their diagnosis, specifically when it comes to their in-laws. This study is particularly important considering that there is not much previous research on disclosure and social support for particular social groups.

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Theoretical Background

This study seeks to combine past theories about infertility disclosure and social support with theories surrounding communication amongst in-laws. Specifically, we draw current knowledge of the affects of disclosure on fertility related distress from two key studies. One study by Jenifer Bute sought to understand why women choose to disclose or avoid discussion of their infertility and found that social stigma played a large role regardless but that women utilize either disclosure or avoidance as a coping mechanism for infertility. The second study examined whether full disclosure or disclosure to selective groups that offered higher social support was associated with lower fertility related distress. The findings from the study showed that among women who felt low levels of social support and women who felt high levels of social support, full disclosure among all groups was associated with the lowest levels of stress.

We wanted to combine these findings with communication theories and disclosure patterns specific to in-laws. The theoretical framework that contributed to our study was Morr Serewicz's Triangular Theory, which describes the relationship between a couple and an in-law parent as a set of three dyadic relationships. There is the relationship between the parent and child, child and spouse, and spouse and in-law. In this situation the child is considered a linchpin, since they have close ties with both members of the triad. This theorizes that the linchpin is often seen as a mediator between the spouse and in-law dyad and that tension in this dyad affects relational satisfaction in all three.

We consider all these theories in our literature review and assume them to be true for the purposes of this study. Our research seeks to combine these theories and propose a connection between disclosure to in-laws and fertility related stress in a couple. Our research methods

replicate certain aspects of these studies while examining whether the findings remain steady in the context of infertility.

When considering the effects that disclosure and in-law relationships have on patients with infertility, it is important to take a critical look at the theoretical framework not only on both of these variables, but on the history of infertility treatment and therapy. It is our hope that this research may improve our understanding of stressors for patients with infertility so that treatment in the future can continue to guide clients towards healthy emotional solutions as well as physical treatment.

Literature Review

Treatment

In the past, infertility has been examined solely as a medical issue, however due to the personal and emotional factors involved with infertility it is imperative to include the social sciences in this examination (Bos & Van Rooj, 2007). Conrad and Schneider coined the term ‘medicalization’ to describe how certain things become categorized as part of health and illness and belonging in the field of medical institutions (2010). What makes infertility so unique is that as a physical condition it has no symptoms and is often undiscovered until actively trying to get pregnant. Even once diagnosed there can be no physical symptoms presented, and diagnosis often leads to emotional consequences rather than the physical that can be expected of a typical “illness”. Even treatment leads to emotional consequences, such as feeling a loss of control, helplessness, shame, fatigue and increasing distress (Greil et al). Currently, treatment options include medications and surgery for men or women to restore fertility, sperm retrieval,

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intrauterine insemination, in vitro fertilization, intracytoplasmic sperm injection, assisted hatching, donor eggs or sperm, or a gestational carrier (Mayo Clinic, 2018).

While these options exist, treatment and recovery looks different for every couple, with some choosing not to pursue any treatment options at all. Infertility is a highly personal diagnosis with many possible paths to recovery, so it is important that every couple's unique circumstances are taken into account. Most doctors incorporate patient centered care, meaning that psychosocial care is provided as a part of their routine care and treatment, where they have someone designated to provide support and answer their questions (Boivin, Bunting, Collins & Nygren, 2007). Even with support, some couples decide not to pursue treatment, which can come at a high social cost, especially among family. Some factors that influence a couple's choice to seek treatment are: financial cost, the potential of particular treatment for side effects, and the treatment options based off of the diagnosis—some issues are simply harder to solve medically (Gibson & Meyer, 2000). Even further, there is always the possibility that the treatment will be unsuccessful and for some couples this possibility is even higher. If the prognosis is severe, it can be even more emotionally strenuous to continue seeking treatment with every failed attempt creating a greater feeling of loss, depression and shame (Gibson & Meyer, 2000).

Despite all of the factors that affect a couple's decision to seek treatment, it can be difficult to reconcile this decision with family members and in-laws. In countries with patriarchal views, childlessness is still frowned upon, though progress has been made in recent years. Still, infertility is viewed with a secret stigma (Greil, McQuillan & Slauson-Blevins, 2011) and many couples still feel pressure to have children; if not from society in general, from their personal relationships. Having children is seen as the ideal so not seeking treatment is viewed as voluntary childlessness. However, the population of infertile couples who do not choose to seek treatment

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is likely fairly large, especially considering the aforementioned potential emotional consequences of failed treatment. In fact, of roughly 70 million cases of infertility worldwide, only about 40 million seek treatment (Boivin et al, 2007). There are other routes to having children, and it is becoming more common for couples to not have children at all. According to Greil et al., “Evidence suggests, however, that the characterization of infertile woman as totally immersed in the process of trying to become pregnant describes only treatment seekers”(2006). Currently the research that we have about infertile couples primarily addresses populations that seek treatment, so inherently any data existing may be slightly biased. We preface the majority of the literature surrounding infertility with this in mind and make no presumptuous correlation between those who seek treatment and those who do not.

Therapeutic Approaches to Treatment

For those couples who do choose treatment, a main portion of this is a therapeutic relationship (Boivin et al, 2007). Counselling is an important part of navigating infertility so that it does not consume all parts of a couple’s lives. Especially when discerning who to disclose fertility issues to, speaking to a counsellor can help separate an individual or couple’s emotional response to infertility from what information is constructive to share with other social groups. Often, people share frustrations that they have with familial responses to their disclosure and sorting those out with a professional can help avoid distress between the spouse, family and in-laws (Martins, Peterson, Costa, Costa, Lund & Schmidt, 2013). Counseling are extra services related to a medical illness in order to assist a patient in understanding the variety of choices and consequences of each choice moving forward (Boivin et al, 2007). Counseling interventions are typically based on theoretical frameworks, one of which is examined below.

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The Relational Model of Development is based around the theory that women grow and develop through relationships (Gibson & Meyers, 2000). According to this model, counseling focuses on empathy and the importance of deep connection. By showing the patient empathy, the ultimate goal is that the woman develops empathy for herself, resulting in higher self-esteem. Beyond this, couples therapy according to this model focuses on relational growth so that the couple with show more empathy for one another and be able to work through problems of infertility with a deeper understanding of the other.

In Group therapy, according to the Relational Model of Development, the group must first find relational similarities so that they can establish mutuality. From then on, they can engage in conflict or negotiation about their experience without breaking this bond of mutuality because they have a common ground (Gibson & Meyers, 2000).

Though therapy is widely considered an important part of treatment for infertility, it is not always necessary to a healthy recovery. Three particular groups stand out as benefitting the most from counseling: patients that require a third party for reproduction, patients whose social circumstance requires treatment rather than medical circumstances, and patients who experience high levels of distress (Boivin et al, 2007). The last qualifier is fairly ambiguous, and many factors can cause unusually high amounts of stress. For example, social pressures to have children can be unusually high in certain populations, especially among certain religious groups, those who do not have a good network of support or from family members who are particularly invasive or unhelpful (Martins et al, 2013). In relation to the present study, should avoidance of disclosure to in-laws prove to be an added stressor, additional therapeutic treatment may be more strongly considered as a part of their treatment plan.

Social Consequences of Childlessness

The social consequences of childlessness are arguably much smaller than for past generations and for various cultures around the world. Most developed countries consider voluntary childlessness a legitimate choice (Greil, Blevins and McQuillian, 2010). For women with secondary infertility, many other factors have caused smaller family sizes and so the need for justification is not as high as it is with primary infertility and childlessness (Bos and Van Rooj, 2007). Despite this, women in the United States still feel pressure to have families and experience a disconnect from their peers with children because of infertility. Most people's concept of family is formed through having children rather than the act of marriage, and gender roles are often solidified by parenthood (Behjati-Ardakani, Navabakhsh & Hosseini, 2017; Greil et al, 2010). Unsurprisingly, the experience of infertility is frequently summarized as feelings of loss and isolation (Gibson & Meyers, 2000).

Disclosure and Social Support

When considering how couples choose to disclose their infertility to in-laws, we must first look at general patterns of disclosure. One study revealed that almost 22% of participants hid their fertility problem from a close relationship and 35% reported hiding their fertility problem from a distant relationship (Martins et al, 2013). According to a study by Jenifer Bute, patterns of disclosure are complex and vary among groups. There are multiple responses to disclosure amongst women: some women disclose due to stress and feel an increase in social support when venting. Others feel that the stigma associated with infertility is too high and that disclosure will cause more stress and judgement. Still others feel that although the stigma is high, the stigma against being voluntarily childless is higher and disclose as a mean of justification for having born no children (Bute, 2009).

Couples who do choose to disclose their infertility to various social groups are met with an equally complex reaction. Many individuals have negative experiences, such as misinterpretation, stigmatization, rejection or abandonment from their partner or family afterwards (Martins et al, 2013). In addition, unhelpful or unsolicited advice can add stress or pressure to a couple. In fact, many cite that their reasoning for not disclosing is that the burden of keeping it a secret is less than the potential for a negative response or unsolicited negative support (Martins et al, 2013). For women who report low social support, disclosure is associated with higher levels of Fertility-Related Distress (FSD), which may explain reluctance to disclose for some. For women and couples with high levels of support from partners, families and close friends, disclosure is positively associated with fertility adjustment (Martins et al, 2013). Even with high levels of support from these groups, however, the positive fertility adjustment is only indicated for those who choose to disclose it to these specific groups. In fact, those who identified high social support yet still kept their infertility a secret from close relationships felt a higher amount of stress. Conversely couples who indicated low social support and *did* disclose it felt a higher amount of stress as well (Martins et al, 2013).

On the other hand, women are frequently met with requests for information about their fertility or their plan for children, which can lead to different patterns of semi-forced disclosure rather than more natural or chosen patterns of disclosure. Some women said that information requests sometimes eliminated the burden or discomfort of bringing it up, most specifically from close friends whom they felt offered high levels of social support. Some utilized the opportunity to silence their peer groups by disclosing their fertility problems in a more abrasive way to avoid future occurrences. Some used more indirect methods such as humor or stating that they were “trying” as a way of avoiding the disclosure (Bute, 2009). It is unclear whether any of

these disclosure methods is favored among disclosing to in-laws or if any patterns of information solicitation are most common among in-laws. This information may come to light in the present study, although we are not testing this question or it may be examined in future research.

Communication Rules for Private Information

One theory amongst communication experts is Communication Privacy Management, which examines how individuals and groups balance privacy with disclosure (Morr & Canary, 2008). The primary assumption of this theory is that couples develop a set of rules that guides them in managing their private information (Petronio, 2002). This theory is backed by a study from 2015 that explored how couples co-own information about a miscarriage. Parents experienced the miscarriage differently but both have ownership of the experience. Almost all partners established that they shared the emotional pain, but that the physical pain of miscarriage was the woman's and so she was the primary owner of that information, which set up a system of informal rules in which the woman had the final decision in whether to disclose that private information (Bute & Brann, 2015). Nearly all couples also agreed that no matter who was the primary owner of the information, it was important to check with a partner or at least tell them when they told someone new about the miscarriage (Bute & Brann, 2015). Although women were repeatedly cited as the primary owner of this private information, it bears interest to see if the same is true when disclosing to in-laws.

Patterns of Private Disclosure Between In-Laws

Merging into another family always requires adjustment, but especially for communicating with the new family. *Family privacy rule orientations* refer to the deeply ingrained practices that are unique to every family and dictate what the family talks about and how private personal information is. In the beginning of a marriage, the salience of family

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privacy rule orientations is at an all time high and the orientations of an individual's family affect the quality of their relationship with their in-laws and their likeliness to disclose private information (Petronio, 2002; Morr & Canary, 2008). As we have seen earlier, many couples develop rules that place women as the primary owners of their infertility information (Bute & Brann, 2015), so if the woman's family privacy rules are conflicting with the in-laws or are generally more private it could affect their decision to disclose.

According to a study on the introduction of a new family member into the group showed that a sense of belonging was achieved after disclosure of the family's private information so that the new member now shared in ownership (Morr & Canary, 2008). For in-law families who had a high permeability or welcomed new members and disclosed private information openly with them, disclosure of identity from the new member was received positively by the in-laws. For those with low permeability, disclosure of identity from the new member was received negatively (Morr & Canary, 2008). This study proves the tension that exists between overcommunicating with in-law groups and wanting to be perceived as a true member of the group. These tensions can make disclosure of a couple's private information, such as miscarriage or infertility, very difficult to navigate. For some familial groups, the disclosure secures membership in the family and is expected, which can bring pressures of its own. For others, disclosure would result in dissatisfaction from in-laws if this pattern did not match their family privacy rules.

Triangular Theory and Communication with In-Laws

Morr Serewicz's triangular theory studies in-law relationships as three distinct dyads, with the dyadic relationship between a spouse and an in-law being involuntary. Both parties view this dyad as less significant than their voluntary dyad, either with their spouse or their child

(2008). The mere premise of this helps explain why communication between in-laws can seem strained or more distant and less likely to receive disclosure of infertility. Another consideration within triangular theory is that the “linchpin” in the triad, for example a man who is voluntary related to both members of the triad as a spouse and a child, is often viewed as a mediator for potential conflicts with their spouse and parent. When the in-law dyad is in disagreement, it typically places the linchpin in the middle of the conflict and can negatively affect both relationships. When considering this in the lens of infertility, if an individual knows that disclosing their infertility may cause negativity or conflict with their in-law, they may avoid disclosure as a precaution to preserve positivity in their marriage (Morr Serewicz, 2008).

It is possible to build strong ties within an in-law dyad, and Morr and Canary’s study from 2008 show patterns of familial acceptance that increase and decrease the likelihood of disclosure from the new family member. Positive disclosure from an in-law to a new family member about others increases the feeling of acceptance and belonging. When an in-law speaks positively about their family members when they are not around, it builds trust and creates stronger ties. However, when an in-law gossips or discloses private information from other family members in a negative way, it decreases trust and decreases the likelihood that the new member will disclose their private information, such as infertility (Morr Serewicz & Canary, 2008). While positive discourse leads to stronger relationships with in-laws, many people have a preconceived notion that relationships with in-laws are always problematic, often due to how they are portrayed in television media. It is certainly possible to have positive relationships with in-laws and have high patterns of disclosure with in-laws, but families have to realize that a newcomer is going to change their routines. It is not usually the in-law that causes strain and

negative relationships, but if both parties are unwilling to change their routines and their group dynamics then it is unlikely they will have a positive relationship (Prentice, 2008).

Gender Disparities in Coping Strategies

Disclosure can be used as a means of transferring important information but it is also frequently used as a coping strategy, most specifically by women (Gibson & Meyers, 2000). So, when examining patterns of disclosure it is important to remember that, as previously cited, disclosure is only a successful coping strategy when the individual feels close and emotionally connected with the person they disclose to. Although only 30-40% of infertility is caused by female factors, both genders tend to associate blame with the woman (Gibson & Meyers, 2000). In many relationships the blame and the physical experience associated with females during fertility treatment also places the burden of communication on the female partner as well (Bute & Brann, 2015). Because of this, it can be more difficult for women to tell their in-laws about their infertility as opposed to their immediate family because they do not have as personal of a connection with their in-laws or they worry about the response since they are not as familiar with them. While this leaves one side of the family more in the dark, it also opens the door for research such as the present study to examine what uncertainties cause the lack of communication with in-laws or how the stress of disclosure affects couples.

The coping strategies seen by heterosexual partners also vary greatly between genders. According to Gibson and Meyers, women tend to share their feelings as a coping mechanism whereas men tend to withdraw to cope (2000). Another study discovered that the experience of infertility is different as a whole. Women report infertility as directly affecting their self-identity, whereas husbands report experiencing infertility through the experience and effect that it has on their wives (Greil, 1991). Women also report more distress, but they also reported that

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discussing it with others and receiving social support was a crucial part in recovering from the loss. Even though women tend to cite social support as more important than men, social support is a significant predictor of lower marital stress for both men and women (Martins et al, 2013).

Although infertility is a joint-experience shared by both members of the couple, some models of recovery have failed because they have treated the couple without recognizing the differences in genders (Gibson & Meyers, 2000). Men and women are statistically an equal source of infertility (Eunpu, 1995; Robinson & Stewart, 1995; Trantham, 1996), but they have very different emotive responses to the shameful feelings associated with infertility. Men tend to feel a “crisis of masculinity” when they are unable to procreate and that the ability to get a woman pregnant is a signifier of manhood (Hanna & Gough, 2015; Throsby & Gill, 2004). Men also cited that they hold a lot of identity in their future family and their plan. Infertility makes them feel like they are unable to take a step forward into the next phase of their life plan, so their structure and sense of identity is damaged (Hanna & Gough, 2015). Since men face such a stigma of “weakness” when it comes to expressing emotion, this feeling of loss may manifest itself differently, making it challenging to compare to female distress. Often, men experience infertility through their partner’s experience (Greil, 1991) so their descriptions of emotion frequently include feeling helpless in how to support their partner as well as feeling disempowered to help their partner become pregnant (Hanna & Gough, 2015).

Research Questions

In light of previous research, the present study hopes to combine theories of ownership when it comes to private information, communication and disclosure to in-laws, as well as levels of stress associated with this disclosure. First, we would like to study how many women disclose

their infertility to in-laws, why some may avoid this disclosure, and how their disclosure to their in-laws may correlate with stress levels.

RQ1: To what extent do women avoid disclosure of infertility with their in-laws?

RQ2: What effect does avoidance have on general levels of distress and fertility related stress?

In addition, we want to know more about what goes into the decision to disclose. We hope to uncover information about what may influence the decision and how a couple may work together to decide. In previous studies, couples have discussed setting rules for disclosure and their maintenance of co-owned private information. We would like to know what rules are made surrounding in-law disclosure and whether one partner owns the information in this sense.

RQ3: Do couples have specific rules or patterns of communication for disclosure to in-laws?

Method

In this study we hope to answer these three main questions through a quantitative interview approach. First, in order to gain participants, we will contact fertility clinics in the area and ask for the clinics to provide information about our study to patients and they can contact us if interested. We will also reach out to groups in the area, such as Iowa City Moms, and provide our information so that women who have struggled with infertility or perhaps are currently struggling with secondary infertility can contact us to participate. We hope that members of these groups can reach out to friends with primary infertility and recommend our study as well. We know that, unfortunately, infertility impacts many people so if these methods do not bring in a large enough sample we can advertise more broadly to the Iowa City area and further to the entire state. Once we have our sample we will debrief them on the purpose of the study. For the

present study, it will not skew interviewee responses if they fully understand the purpose of the study and the focus on disclosure with in-law groups. It may bring more clarity and assist participants in answering questions.

Demographics

After the participant is debriefed, they will fill out a short questionnaire. We want to gain information on key demographics and categorizations that may affect their answers and how they score. Among other questions, we will inquire about age, whether they are experiencing primary or secondary infertility, whether they have sought treatment and to what extent, and whether they are infertile with or without intent of conception. As distinguished before, primary infertility is experienced when a woman is unable to conceive or carry a child to term and has never had children before, whereas secondary infertility occurs after a woman has already born at least one child. The last distinction is between intention. Women who are infertile with intent have tried to conceive for at least 12 months without conception, whereas infertile without intent have discovered their infertility but not while actively trying to conceive a child. This does not mean that they have no desire to have a child at any time, but they were not intending on conceiving a child at the time of their diagnosis (Greil et al, 2011). These factors will not be included in our discussion or utilized to answer any research question, but will be examined to filter for outliers or potential confounding variables.

After completing the questionnaire, participants will then complete the standardized survey. The questions will correspond to one of the three research questions and we will divide them into separate codes to reflect participant answers for each category. The first two research questions are related, so we will look for correlation between scores for disclosure level and

stress level. The third research question will stand alone, but could be expanded further into a qualitative study about what communication rules or patterns exist when it comes to disclosure with in-laws specifically.

Measures

We will base our survey off of related studies, specifically a 2013 study on Fertility Related Distress and general disclosure. The referenced study used a five point Likert scale (1= always, 5= never) to measure the frequency of behavior as it related to perceived social support and patterns of disclosure vs. avoidance. This study also measured fertility related distress using a five-point Likert scale (1= strongly agree, 5= strongly disagree) called the COMPI Fertility Problem Stress Scales. The instrument draws seven items from The Fertiltiy Problem Stress Inventory (Abbey, Andrews, & Halman, 1991) and seven from The Psychosocial Infertility Interview Study (Schmidt, 2010). This scale examines how much the infertility has caused stress in the individual's personal life, their marital relationship and their social relationships.

For the study we will perform a multiple regression analysis for our data to prove that it is statistically significant. Once we have determined our alpha, we will present the correlation as either statistically significant for each research question.

Results

As previously stated we would analysis the data using a multiple regression analysis to assess whether our findings are statistically significant. It is important to consider difficulties that the study may encounter or potential errors that may occur. Particularly with our second research

question regarding variance in fertility related stress, there are other factors that may affect distress that are unrelated to in-laws. For example, women with primary infertility experience more distress as well as older women. In regards to our first research question, many women may avoid disclosure with in-laws but it may have nothing to do with the nature of their relationship. Some individuals simply have lower disclosure patterns for any traumatic event, and some individuals do not regard this as traumatic and so are less likely to disclose. We hope that the initial questionnaire will help eliminate some of these confounding variables, however there is still possibility that it may cause error.

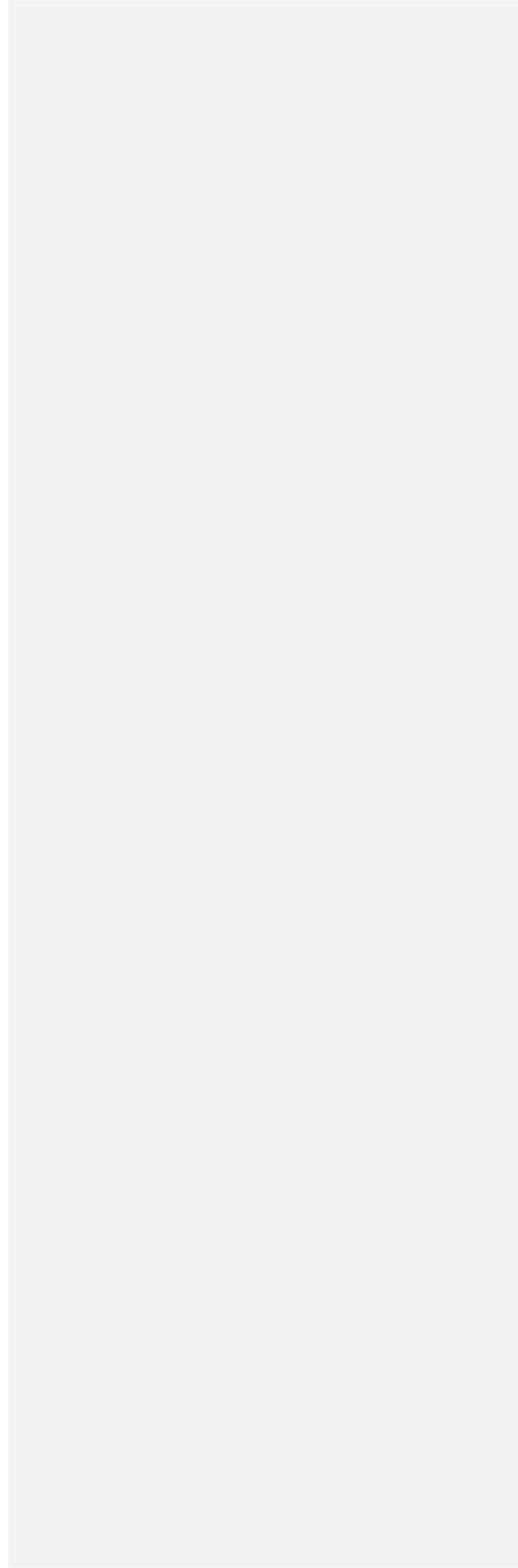
Another major potential for error is the ability to select a representative sample. For many, the topic of infertility is sensitive and traumatic, so naturally some individuals will not want to participate in a study where they must talk about their experience. This naturally may skew our sample towards people who are more comfortable with disclosure and affect how participants avoid disclosure with relatives. Across all infertility studies, it is difficult to access the population of people who do not seek treatment for infertility (Greil, Blevins and McQuillian, 2010). In many studies, research participants are gathered through treatment centers or support groups for women seeking treatment. By only studying women and couples who seek treatment, research may unconsciously be skewed towards certain demographics and attitudes towards infertility. Any findings produced by this study may not be representative of every woman or couple with infertility, but rather may be more representative of couples seeking treatment.

There are two traditions of research in infertility: Quantitative research on those seeking treatment to improve medical and therapeutic treatment or qualitative analysis of men and women outside the treatment context (Greil, Blevins and McQuillian, 2010). The results of research on patterns of disclosure between different family members could have a large effect on

therapeutic treatment and emotional recovery. It is only in recent years that infertility is becoming less medicalized and the importance of emotional therapy as well as physical treatments has been recognized. So far, medical professionals were the ones giving help to women and couples experiencing infertility rather than social workers or professionals trained in other fields. Considering this, it is necessary to research what methods of social support are most beneficial and whether there are patterns for who women and couples choose to disclose their infertility to. As therapeutic treatment is integrated into our understanding of infertility recovery, we need to create a base understanding for professionals performing this work outside of the medical arena. In addition, any research surrounding infertility is important considering how public discourse and our medical understanding of infertility has changed in many recent years. It was not until the 1990s that evidence-based findings were emphasized to couples seeking infertility treatment (Boivin & Gameiro, 2015), so the field is still very new and growing.

New research could affect the way women and couples are seeking social support and could improve their emotional well-being. It could also reduce the stigma of seeking counselling and help when experiencing fertility difficulties by seeing the positive response from peers. In the context of this study, understanding how uncertainty makes communication with in-laws difficult could help professionals in the field navigate these areas with patients. It cannot be generalized that every person's family is emotionally supportive or close with one another, and the same can be true for in-law relationships, so disclosure to these groups can sometimes increase distress rather than decrease. Additionally, the decision of whether to disclose infertility to in-laws can cause unique tension between partners, which bears conducting research on these relationships.

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