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*Troubling Unexplained (In)fertility:  
A Critical Autoethnography of Loss and Hope*

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PhD Counselling Studies  
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2026

# Declaration

I declare that this thesis has been composed by myself, that the work within it is my own unless otherwise stated, and that it has not been submitted for any other degree or professional qualification.

Marie Meechan

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## **Abstract**

This PhD project critically examines a re-remembering and re-writing of my personal experiences of being diagnosed with unexplained infertility (UI), and of being unable to conceive and give birth, after twelve years in reproductive medicine settings. It investigates this issue through an autoethnographic social constructionist perspective, using my feminist voice and the map I discovered through these experiences, considering both cultural and societal contexts, as well as my religious environment related to the UI experience. The primary research question examines my personal experiences and the impacts of UI by asking: What is the experience of unexplained infertility (UI)? The sub-question later explores how counselling and psychotherapy can support these processes. This leads to a discussion towards the end of the thesis about the broader topic of counselling infertility. Using vignettes re-remembered and rewritten from my journals over twelve years, I reflect on how I became an object of assisted reproductive technologies and a commodity within the reproductive medicine industry. I also share two examples from my private practice as an infertility counsellor. My writing features three perspectives: my personal experiences as a co-sufferer of UI, my role as an infertility counsellor specialising in this area, and my perspective as a researcher. My study critiques the medicalisation of being unable to conceive and give birth naturally, and questions the UK medical diagnosis, particularly the term “unexplained”. I also challenge the prevailing assumption that all couples can conceive with sufficient and ongoing medical intervention, emphasising the need for a critical examination of when to recognise the limits of such interventions. This exploration aims to highlight the emotional and psychological implications of these medical narratives and to advocate for a more nuanced understanding of infertility that respects individual experiences and choices.

Drawing on both my own journals and client examples intertwined with literature and knowledge from the field, my thesis highlights the emotional impacts of undergoing Assisted Reproductive Technologies (ARTs). Critically exploring these various faces and forms of UI reveals different insights and highlights aspects of UI that are not necessarily covered in my own narratives, yet share common themes: shame, stigma, identity issues, and disenfranchised grief. Therefore, this research offers a nuanced understanding of the challenges faced in UI from an insider's perspective, while also critically examining from the researcher's perspective, intertwined with that of the specialist counsellor working exclusively with infertility. Thus, my project ultimately advocates for a more compassionate and supportive approach within both the medical model and among all professionals working with UI and infertility patients/clients. This critical autoethnography not only contributes to the existing literature on the experiences of UI and infertility but also serves as a call to action for improved mental health support for individuals and couples grappling with the complexities of unexplained (in)fertility (UI) and infertility.

## Lay Summary

This PhD project examines my personal experiences alongside those of some clients from my counselling practice, where I provide specialist therapy for unexplained (in)fertility (UI) and the broader topic of infertility, or as I prefer to call it: 'fertility impairment'. The unexplained (in)fertility (UI) diagnosis was once a personal experience that became medicalised. Yet, the emotional aspects and overall experience are still under-researched and undervalued, despite infertility affecting 15 to 20 per cent of couples worldwide. When diagnosed with UI or infertility, managing assisted reproductive technologies (ARTs) often triggers an emotional rollercoaster. Using a distinctive autoethnographic methodology, I explore these experiences from an insider's perspective to deepen our understanding of the social constructs surrounding unexplained (in)fertility (UI), while considering the cultural, societal, and religious influences shaping our broader knowledge of infertility. With a feminist approach, I delve into the complexities of UI and examine how its impacts can persist before, during, and after medical treatments, even after childbirth. I question whether these are experiences shaped by medical and social constructs, genuine lived experiences, or both. Rather than seeking definitive answers, I delve into the meanings behind the medicalisation of infertility and the accompanying feelings of shame, stigma, disenfranchised grief, and issues of identity. Ultimately, this PhD research adds to the limited conversation aimed at improving the experiences of those facing unexplained (in)fertility (UI) and all fertility impairments, while offering a more compassionate and supportive approach to counselling, medical practice, and all professionals working with individuals and couples affected by UI and infertility.

## Acknowledgments

*Thank you...*

My clients from my counselling practice, fellow fertility impairment warriors, as you navigate these profound challenges, including your precious reproductive losses. This thesis is, in part, a heartfelt tribute to each unique badge of honour you carry from your remarkable fertility journeys. Your resilience and courage inspire me. It is my privilege to serve you and to share your examples.

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My wee Mummy and my brother James, who passed into God's arms during my Master's (MSc) and PhD studies. I miss you both terribly. I wish you were still here with me. I felt your presence strongly in spirit throughout this research and in everything I do. You're just on the other side; never too far from me.

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Noah, my heart, my light, the greatest blessing of my life.

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# Chapter One

## Introduction

“Motherhood begins internally in the conflictual, intense cauldron of childhood sexuality and object relations, and is overdetermined, filled with fantasy, and complex: any woman’s desire for children, whether immediately fulfilled, fulfilled belatedly, or never fulfilled, contains layers of affect and meaning”.

(Chodorow 2003, 1184)

### May 1977

#### **Singing in unison and not missing a beat**

*The sound of skipping ropes thwacking the ground in rhythm. We girls practice until we get the words, the moves in, out, backwards, forwards, one foot, both feet; the rhythm is just right.*

*‘Three, six, nine, the goose drank wine,  
The monkey chewed tobacco on the streetcar line.  
The line broke, the monkey got choked,  
And they all went to heaven in a little rowboat,  
Clap-Clap! Clap-Clap!’*

*We are well-rehearsed and take pride in our performances. I would play here all day long if I were allowed to, without eating a thing. I am happy. We are good at this. My friends and I do it every day, during school breaks and again as soon as we get home. We weave in and out of the ropes, changing positions while remembering every word of the rhyme, singing in unison, and not missing a beat.*

*And then I hear the same words I hear every day called out by my mum from our tenement flat window, one up, on the left, slightly open so she can listen to us, “James and Marie, time to come up for your tea”. The girls sing in rhyme, “James*

*and Marie, time for your tea, James and Marie, time for your tea, time for your tea, James and Marie...". They continue singing in rhythm, the skipping doesn't stop; they simply change the words as I skip out my last skip of the day, run to the entrance of the back close where I meet my big brother James, who is just one year older than me and usually plays rounders with the boys nearby, in the same shared back gardens, some parts laid in concrete and others in grass. We race up the concrete stairs, grabbing the walls of our Glaswegian 'close', which smells of fresh disinfectant—the one my mum uses to mop the stairs and landings. The 'close' is decorated with thick, heavy tiles in racing-car green halfway up the walls, while the upper walls are plain and flat, painted cream. Large plants in different shades of green sit proudly on the windowsills, climbing up the enormous window halfway up the old 'close', watching us whizz past. James wins, only just!*

*My Mummy looks cross as she changes my baby sister's nappy, pulling at it. My wee brother, a two-year-old toddler, is sleeping in his big wooden cot in the living room. Mummy seems irritable and instructs my big brother to go clean up, and then says to me, "Marie, come here and help me with this. I need to finish dinner and get it on the table". I skip over to help. She leaves me alone with my baby sister. I like changing her nappy. I love helping with my baby sister, but my mummy doesn't seem happy doing it. It's making her upset. I wonder why. As I fix my baby sister after changing her, I say to my mummy with excitement, "Look at me, Mummy, I'm practising changing for my very own baby one day". She quickly looks around at me while still stirring something on the cooker. I see her from the gap between the kitchen and the living room; my Mummy's face turns red. It scares me. This is*

*something new, seeing my mummy angry. She says sharply, “Don’t have children, Marie, it’ll ruin your life.”*

*I dare not say anything like that again. Ever.*

### ***The loss of Mummy’s smile***

*I miss my mummy’s smile; I miss her laugh even more. She doesn’t laugh anymore. I wish I could make Mummy laugh again the way I used to.*

### **Personal Experience and Diagnosis: A Feminist Inquiry**

In medical terms, infertility is increasingly recognised as a significant endemic condition, currently affecting fifteen to twenty per cent of couples worldwide, as confirmed by infertility experts Marcia Inhorn and Pasquale Patrizio (2015). However, the ‘emotional rollercoaster’ associated with infertility and the lack of psychological support remain under-researched (Inhorn and Patrizio 2015). My goal in this project was to develop a deeper understanding of the social construct surrounding the unexplained (in)fertility (UI) diagnosis, based on my own experiences and those of three of my clients (one heterosexual couple and one individual), exploring the entire UI experience—the condition and the diagnosis. I explore and interpret UI through a feminist lens using a critical autoethnography of the ‘non-resolution’ of this ‘unexplained’ illness, investigating why and how the impacts of UI are prolonged before, during, and after medical treatments—and why they continue even after childbirth. I therefore question whether UI and infertility are ‘a thing that is experienced’ or ‘something that is medically and socially constructed,’ or whether both can coexist. I am not seeking a definitive answer; instead, I aim to find meaning

both in the medicalisation of this personal experience and in the social, cultural, and religious shame, stigma, disenfranchised grief, and identity issues that accompany it, with the hope of improving the experience of UI and infertility for others.

Accordingly, I have explored the UI experience from an insider's perspective. Since the experience of UI and infertility is primarily recognised in research as an illness subject to medical diagnosis, it often closely aligns with 'assisted reproductive technologies' (ARTs) and more recently 'new reproductive technologies' (NRTs). Consequently, research in this area mainly falls within the broad quantitative field of biomedical sciences. Marcia Inhorn and Frank Van Balen (2002) have provided insights into global developments in infertility and unexplained (in)fertility (UI) in the 21<sup>st</sup> century, investigating childlessness, gender, and reproductive technologies from a feminist, political, and social perspective for many years. Over the past three decades, recognition of the emotional effects experienced by individuals undergoing these reproductive interventions has "slowly gained the attention of social scientists largely as a result of the feminist movements," state Inhorn and Van Balen (2002, 9). Previously, UI and infertility were considered trivial concerns, dismissed as a "yuppie complaint of little concern to the rest of the purportedly overpopulated developing world," as noted by Inhorn and Van Balen (2002, 7). However, I have observed that, through many years of scholarly observation, more recent studies have increasingly highlighted the emotional impact of UI and infertility within the process of medicalisation.

## **Rationale for this project: Inspiration and ontological perspective**

This project is a critical autoethnography involving re-remembering, re-writing, telling, and showing (Adams, 2015) my personal narratives from the original journals I kept during my twelve-year journey of being unable to conceive and have a baby, primarily as a patient in Assisted Reproductive Technologies (ARTs). The moment that led to this project's existence began when, one day, while packing to move house, I found, dared to open, and read those old journals for the first time since I wrote them, which I had never intended to do. I journalled back then for two reasons. Firstly, because I have always kept diaries and journalled since my childhood, which helped me feel less alone growing up in a Catholic family that never 'aired their dirty laundry in public'; real feelings were never spoken, especially not to our parents, teachers, nuns, or priests. Secondly, journalling throughout my twelve-year struggle with unexplained (in)fertility, mostly in isolation, proved especially helpful during those 'rollercoaster' years of this personal experience that led to a medical diagnosis.

The only time I was 'allowed' to openly share specific thoughts with someone as a child was when I was inside a confessional box at my local Catholic church, confessing what I believed to be 'sins' I had committed, to a priest who sat in a separate box behind a grated, hollow window frame with a curtain on his side, so we could not see each other as I bowed my head in shame; something I learned to do from a young age. Still, I knew who he was, and the priest knew who I was, as well as the family I was from. Even then, I would only reveal enough to receive a minimal 'penance,' that is, prayers for forgiveness of my 'sins'. Therefore, I only expressed my 'real' feelings to my diary as a child and have continued to write in journals ever

since. Zoi Simopoulou (2019, 142), an expert writer who takes an existential approach to therapeutic work with children and young people's experiences, including living losses, speaks to 'isolation' and 'otherness' from the perspective of "reciprocity in seeing". She explains, "What I observe observes me. What I see sees me back. If being seen confirms my otherness and verifies my existence, so it does for the one who sees me". Simopoulou (2019, 143) continues, therefore, that when her observer confirmed her gaze, and along with that her 'otherness', her 'being', and in the act of giving the other person space, he 'gave her back an identity'. She said, without that other, she did not "exist as a see-er or an observer" (Simopoulou 2019, 143).

Therefore, because the priest behind the curtain could not see me and I could not see him when I was a child sitting in the confessional box, perhaps Simopoulou's (2019, 143) perspective of 'being seen' or not 'being seen' in my situation heightened my sense of feeling alone as a child, since she confirms, without the other, "I do not exist". According to Simopoulou (2019, 143), I needed the other to "validate my presence, my purpose, my experience and to give meaning to it". I wonder then, in these moments as a lonely Catholic child, if this might have partly contributed to my isolation, and why I resorted to writing in my diary so much.

Speaking of writing, by the time I read the journals of my years in unexplained (in)fertility, I had already embarked on a different career path, moving away from the corporate world of sales and marketing to become a qualified infertility counsellor, inspired by my personal experiences. My UI experiences ignited a deep passion that grew over the years to learn more about all aspects of unexplained (in)fertility and

infertility: to support others in the ways I wished I had been supported. After reading my journals, I unexpectedly began to ‘write to them,’ which I initially considered ‘risky’ because I was uncertain whether opening those old wounds would be too painful for my heart to endure again. Nevertheless, the possibility of healing made it seem worthwhile, especially since I found this process beneficial in my private counselling practice, where I continue to work exclusively with clients facing fertility impairments.

This reminds me of Wyatt and Gale (2018), who suggest we take a chance and ‘write to it’. Ultimately, ‘writing to’ my original journals became what I bring to this study as ‘*Marie’s* re-remembered and rewritten memories,’ in the form of vignettes that initially inspired this PhD project. Therefore, my research examines the experience of unexplained (in)fertility both as a personal journey within my religious, cultural, and societal context and as part of the unexplained (in)fertility (UI) medical diagnosis. Accordingly, my primary research question asks: “What is the experience of unexplained (in)fertility?” You might wonder why I put the ‘in’ of the word (in)fertility in brackets.

### **The Trouble with ‘in’ and ‘unexplained’ in unexplained (‘in’)fertility (UI)**

I trouble the ‘in’ and the ‘unexplained’ of ‘unexplained (in)fertility’ (UI), which to me signifies the in-between state of being while undergoing medical treatments. My trouble with this term is the liminal and paradoxical nature of the UI situation, which seems ambiguous; neither clearly pregnant nor non-pregnant, fertile nor non-fertile, caught between two identities. Therefore, does the UI diagnosis mean one is *in*

fertility or *out* of fertility, or somewhere in between? Or does the term ‘unexplained (in)fertility(UI)’ simply mean that nobody knows? Speaking of the terms unexplained (in)fertility (UI) and infertility, to clarify from the outset that most literature mainly discusses UI and infertility together under the broad term ‘infertility’ rather than as two separate topics. This is because UI is regarded as a secondary aspect of the infertility diagnosis when no medical issues are found in either the male or female partner in a heterosexual couple. Conversely, ‘infertility’ is recognised as a condition caused by a specific medical problem in either the male or female, identified through routine medical tests such as blocked fallopian tubes in women or low sperm count in men—medically known as ‘oligospermia’—when sperm count drops below 15 million per millilitre of semen (WHO, 1999), usually after an initial consultation with a general practitioner (GP).

However, unexplained (in)fertility (UI) is typically included in studies under the ‘infertility’ category as part of the same diagnosis. Moreover, research on UI remains limited, yet approximately 15-30% of the estimated 186 million people worldwide diagnosed with infertility are identified as having ‘unexplained’ (in)fertility (UI) (Inhorn & Patrizio, 2015). Although I work with same-sex couples and single individuals in my private counselling practice, I cannot address their situations in this project because UI, which is the area I am exploring here, only affects heterosexual couples who have been unable to conceive naturally. Additionally, I do not have the scope to explore these separate matters here, as they belong to different fields of knowledge. However, I will write about these crucial issues in a separate paper in due course.

Having explained these key aspects of the topic and recognising that UI and infertility generally fall under the same category in most research, I hope this offers clearer insight into my exploration of UI. Hence, I provide a brief overview to establish the foundation for the most relevant theories on UI and infertility related to this study. From this, I dig deeper into the factors that led to my current inquiry and an original approach that will contribute to an ongoing, yet underexplored, conversation about the subjective experience of unexplained infertility (UI), which I build upon. Therefore, I focus on relevant literature to explore when and how knowledge of UI and infertility attracted the attention of social scientists, and why it had not done so previously, ultimately aiding in the interpretation of my own and my client's narratives in this project.

Therefore, as I build a deeper understanding of why this research is rooted in my personal experience, I later, in Chapter Six, introduce my related sub-question: "How can counselling and psychotherapy support the processes of UI and infertility"? This is also where I introduce three of my clients through two client examples. The main themes of this project are loss and hope, and within these, I explore related themes such as stigma, shame, disenfranchised grief, and issues of identity throughout the study.

### **Defining the Unexplained: Historical and Contemporary Views on Infertility**

Sir Mathew Hale (1677, 17), an English jurist and judge, described infertility in the seventeenth century as "Commonly the same distemperature of the Air that occasioned the Plague, occasioned also the infertility or noxiousness." The most

recent definition of 'infertility' in the Oxford Dictionary (2024) is "unproductiveness, barrenness; not capable of producing offspring." As I explore the historical meanings and definitions of 'infertility,' from 1677 to the present day, I notice a consistent association with ideas of unproductiveness or inability, often connected to the quality of soil or land. Notably, Hale's (1677) characterisation of infertility as akin to the plague highlights a deeply ingrained stigma and shame linked to this term and those associated with it, as if like a label attached to them, that has persisted over time.

What strikes me is that, despite the passage of centuries, the core definitions of "infertility" have remained remarkably consistent. Both historical and contemporary definitions emphasise a lack of productivity or capability, even perhaps suggesting that a woman's uterus is likened to barren, unfruitful soil or unproductive land, which probably adds to the notion that societal perceptions of infertility have not evolved significantly and remain stigmatised. This raises a question for me about why UI and infertility continue to be largely unspoken topics in our society. The main evolution seems only to be the medicalisation of UI and infertility, which, while it has introduced new terminology and frameworks, has not fundamentally altered the underlying stigma, shame, identity issues, disenfranchised grief and isolation people suffer inside the UI and infertility experience.

Today, the World Health Organisation (WHO 2023, 15) still defines "infertility" as "a disease of the reproductive system characterised by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse." However, continuing to describe "infertility" using words such as 'failure' and 'disease' remains controversial. Nonetheless, unexplained (in)fertility (UI) has

been a diagnosis assigned to couples since 1950, after ruling out other medical causes of infertility such as semen analysis, tubal obstructions or blockages, and ovulation investigations (WHO 2018). Depending on the age distribution of women in studies of infertile couples, between 15% and 30% will be diagnosed with UI, as no abnormalities are found in all clinical examinations conducted on the couple (Gelbaya et al. 2014; WHO 2018). The same study also stated that a review of human studies published between 1950 (when the term UI was introduced) and 2013 (Gelbaya et al. 2014) has been an ongoing subject of debate regarding whether the diagnosis of UI should be made at all, based on the argument that other causes of infertility might explain or define a diagnosable problem. Yet, despite the 'unexplained' label, UI patients are often reassured by clinicians that 50% of them will conceive within the next 12 months after a year of medical treatment, and 12% 'should' conceive in the following year, thus giving false hope to many diagnosed with UI (Gelbaya et al. 2014).

Furthermore, Gab Kovacs (2010), a Professor of Obstetrics and Gynaecology, argues that the term "infertility" is outdated and should be replaced with "subfertility." Kovacs (2010) explains that the chance of conception depends on the success rates of specific treatments and the number of cycles attempted. He asserts, based on his own medical "analysis," that if couples continue with medical intervention, they *should* eventually conceive. He provides the example of a woman who successfully conceived after 37 cycles of in vitro fertilisation (IVF), which involves placing eggs and sperm together in a petri dish or test tube outside the woman's body in the hope of developing embryos that are then implanted into the woman's uterus; as Kovacs (2010,1) puts it, "if at first you don't succeed, try, try, try again."

## **The Financial and Human Costs of Assisted Reproductive Technology (ART)**

To put this into perspective, in the UK, for example, 37 IVF cycles would cost on average £259,000 (calculated from a range of clinics across the UK), which is beyond the financial reach of many people. More realistically, based on my own client base, a heterosexual couple would typically not undergo more than 6 IVF cycles, costing around £42,000 in the UK. I do have clients who have endured more than 10 IVF cycles, even up to 16 cycles; however, this is the exception.

Nonetheless, Inhorn and Patrizio (2015) inform us that the ongoing effort over the past decade to make safe, cost-effective, and accessible IVF for all who need it—through low-cost IVF (LCIVF)—remains a significant challenge. Inhorn and Patrizio (2015, 426) state, “Given these present realities, it is important for the global reproductive health community to engage in 21st-century activism which seeks reproductive justice for those living with infertility around the globe.” This global demographic overview broadens my research perspective, helping me understand the broader picture and more significant issues, which in turn inform my own narratives, shaped by my clients.

This highlights a concern for me: while I understand and agree with the global injustice of limited access to affordable reproductive medicine clinics and the need for more accessible treatments, I also firmly believe it is essential that this is introduced alongside proper support for people to prepare for, understand, and manage the emotional highs and lows of medical procedures. This includes access to well-informed therapists who specialise not only in preparing patients for treatments but also in addressing the emotional impacts of unsuccessful IVF cycles, including miscarriage.

As someone who has experienced unexplained (in)fertility challenges myself, conducted research, and is a specialist infertility counsellor, I critically explore and share the profound effects these medical treatments have on individuals and couples navigating the complexities of UI. Therefore, when Kovacs (2010, 3) confidently states, “there is no couple who cannot potentially conceive, so the term ‘infertility’ should no longer be used,” I question why there are still so many involuntarily childless people in the world struggling with identity issues. As Pfeffer and Woollett (1983, 82), feminist writers in the field of the sociology of reproduction, suggest, “it seems that once you find yourself involuntarily childless, all other identifying marks are washed away”. Gayle Letherby (2016,11), professor and expert feminist writer and researcher on childlessness and infertility, has carried out extensive research on involuntary childlessness and states, “Such people not only have to live with their own losses and absences but also live with an identity which is different and often discredited or seen as lesser”. And I would add to that often in silence, shame, and stigmatisation.

While Kovacs (2010) optimistically discusses the technical and medical aspects of unexplained (in)fertility/subfertility, my PhD project will explore the entire experience of unexplained (in)fertility (UI) through my own re-remembered and re-written memories from my original journals, including epiphanies spanning twelve years, focusing on the emotional impacts of undergoing multiple Assisted Reproductive Technologies (ARTs) such as IVF and ICSI. Therefore, throughout this thesis, I explore and narrate the voices, faces, and forms of UI who have lived through loss and hope. I hope to establish a meaningful connection with my readers,

striving to evoke a response from a space where I, alongside my clients, can be heard and seen as I explore recurring themes such as disenfranchised grief; Doka (2019) coined the phrase “disenfranchised grief”, introducing the concept in 1989 and explaining that it occurs when a loss is “socially unrecognised”, e.g., a miscarriage or “unsanctioned,” e.g., the death of a gay or lesbian partner (Doka 2019, 26). Doka (2019, 27) states that disenfranchised grief is one of the unacknowledged, unrecognised losses that do not fall under “society’s typical grieving rules”, like the loss of a loved one or kin. Alongside this, I also bring ambiguous and nonfinite loss (living loss) and chronic sorrow (Boss, Pauline, Susan Roos, and Darcy L. Harris, 2021), along with stigma, shame, and the process of rebuilding a new identity after experiencing UI in this study.

This thesis does not include a literature review chapter, as I embed relevant literature throughout each chapter, following a critical autoethnographic approach. I continue this journey of discovery by presenting more excerpts from *Marie’s* re-remembered memories from her past journals, which cover 12 years of her life in UI and reproductive medical interventions, from an insider’s perspective. I also present two of my client examples, and I respond to them in the present. I revisit my (*Marie’s*) journals from many years ago and share them for the first time, beginning with the epiphany I opened this chapter and thesis with, which I journalled about sixteen years ago. I share my re-remembered and rewritten memories from my original journals throughout this thesis, presented as vignettes. I respond—mostly immediately after each vignette, except for this one, to which I respond later in Chapter Four—with two intertwined voices in the present: one, a specialist infertility counsellor, and the other, a researcher critically exploring experiences of

unexplained (in)fertility (UI). I use my own past voice (*Marie*) in the first person. All first-person sections will be in *italics*, while all third-person text will be in black. The remaining chapters of this thesis will unfold as follows:

## Chapter Two

Here, I outline the philosophy, methodology, methods, and design that underpin this project, providing the foundations that support it. I also elaborate in more detail on how this critical autoethnography, viewed through a feminist lens, concentrates on the embodiment of the UI experience and diagnosis at an individual level, revealing my ontological and epistemological aims within the project.

## Chapter Three

In this, the first of my three core chapters sharing and responding to *Marie's* re-remembered and re-written memories as vignettes, I critically examine the practices of medical intervention and related issues linked to UI, including being an object of assisted reproductive technologies (ARTs), and a commodity within the medicalised infertility industry, where the themes of stigma and disenfranchised grief are most prominent alongside the overarching theme of loss.

## Chapter Four

In the second of my core chapters, drawing on the *Marie* vignettes, I explore themes of shame and disenfranchised grief related to my Catholic faith within the broader context of loss. I explore the disorientation and ruptured identity of a Catholic woman facing UI. This chapter aims to provide a nuanced understanding of

the painful journey of navigating UI through the lens of religious observance and faith.

### Chapter Five

In the third and final core chapter, exploring the *Marie* vignettes, I guide us through the transformative journey of rebuilding hope after complex loss, emphasising the intricacies of disenfranchised grief and clarifying the interaction between faith, identity, and, specifically, hope, as a new faith emerges through a feminist framework (map). This process supports the development of a renewed identity following a prolonged experience of reproductive loss.

### Chapter Six

Here, I shift from *Marie's* narratives presented as vignettes to two client examples from my private infertility counselling practice, illustrating the different faces and forms of UI beyond my own experiences, while maintaining my ontological stance as the central perspective of this work. Here, I introduce my sub-research question: How can counselling and psychotherapy support the processes of UI and infertility? I also highlight some core tasks of therapy for UI, illustrating the significance of the language of UI. In doing so, it also provides me, the therapist, with a deeper understanding of *Marie's* experiences, which in turn informs my approach to counselling my UI clients.

### Chapter Seven

The work in this chapter brings it all together in a discussion. Thus, I reflect on and further discuss key aspects of *Marie's* re-remembered memories, which led her

to discover her newfound feminist identity. This leads to a further discussion, which also addresses my sub-question on a broader level. I connect these reflections with the literature I reviewed at the outset. Despite the variety of faces and forms of the UI experience, core themes weave like a thread through all of them: loss and hope, within which stigma, shame, disenfranchised grief, and identity are prevalent.

### Chapter Eight

I conclude with further insights into UI beyond motherhood, as well as key insights from this study, including the perspectives shared by *Marie* and my clients and how they relate to the relevant literature. This, in turn, informs my recommendations derived from this study.

For now, I turn to Chapter Two.

## Chapter Two

### Philosophy, Methodology and Design

“Once you label me, you negate me  
Once you place a label on me and put me into a compartment or a category of some  
kind, I must then become what it is that you have labelled me to be”.

(Sorn Keter Guard Verman, Mark Warren. *SIFREI HA-IYYUN (JUDAISM, KABBALAH, MYSTICISM)*. Harvard University, 1984).

#### **September 2000**

#### **Navigating voice in the diagnosed: silenced by unexplained infertility (UI), all in a ten-minute appointment**

*I always knew I wanted to be a mother, even as a child playing with my dolls and pram. I dreamt of caring for my very own ‘real’ baby one day. I have always been sure of this, although I have kept it a secret, only sharing it with my diaries and journals, since the day my mum warned me in anger, “Don’t have children, Marie, it’ll ruin your life”.*

*Returning to our picturesque stone cottage in Surrey, England, after getting married in Scotland and honeymooning in Italy, it feels like this is the most important moment of my whole life. The time has arrived, and I am ready. As I build up to this moment—a four-year relationship that was going very well—I remember the excitement and anticipation.*

*I am standing in our pretty garden. It’s still sunny and quite warm for late September. I’m surprised to notice the plants are still blooming vibrantly in our newly*

*landscaped garden. I don't know much about plants or gardening, let alone those we planted not long before we left to get married; we chose them for the symmetrical layout and colours in lilacs, purples, and creams, all looking quite beautiful, a pleasant surprise to me considering I didn't even expect to see those plants again after our first attempt at gardening, and being away for over a month; "my good luck as always" I thought. I could hear my mum's voice as she often says when things 'just always work out for me'... "Luck O the Irish Marie, you always land firmly on both feet" (Both my parents are of Irish origin, Donegal; their grandparents and all descendants as far as we know are Irish). Despite her obliviousness to my working hard for everything and making things happen in my life rather than just somehow landing on my feet by chance, I miss my mum so much. I don't seem to see her and dad as much these days, as my trips to Scotland are less frequent, only because I'm so busy with work and life down here.*

*I look up towards the white French doors at the back of our house, which open outwards onto the patio with potted plants lined up on it as if standing to attention, colour coordinated to match the other plants sitting neatly behind the dark rustic railway sleepers along the right edge of the garden; the ones we planted and somehow survived. My husband walks towards me, smiling, holding two freshly brewed Earl Grey teas in our recently purchased, lovely, deep blue pottery mugs in one hand and some mail in the other. As he approaches, I take a deep breath, my fists clenched and my stomach churning with anticipation, much like the nerves before a public speech. The moment feels monumental, and as my husband leans carefully to set the steaming mugs of tea on the painted white wrought iron table, I*

*can hardly contain myself. I seize the moment and, with a rush of emotion, blurt out the words I've been longing to say my entire life: "I want us to start trying for a baby".*

*With his deep green eyes now piercing through mine, he pauses to sit down fully and spills a little tea onto the table. After a brief moment, he smiles and says, "As long as you schedule it around my busy tournament season, we could make that work". "So that's a yes, you agree then?" "Yes, if it doesn't interfere with my summer travel schedule, I'm in", he replies with a wider smile and a chuckle. "Oh, and as long as you give birth in winter", he adds as he starts opening the mail. "What?" I laugh. I'm left slightly puzzled, uneasy, and thinking, okay, that's not the enthusiasm I was expecting, but I feel I'm not processing something here, perhaps I'm not ready to...*

*Nevertheless, I was confident I'd be pregnant quickly since there was a history of all the females in my family getting pregnant easily; I would be next, and I could hardly wait. I might explode with excitement as I imagine seeing that positive result on the pregnancy test soon; I replay it in my mind; all that I have prepared for, my yearned-for baby, would be arriving soon. I was elated. From that moment on, I could hardly think of anything else except that I might be pregnant. I would now be doing the opposite of all I had learned in my Catholic school, family, and community growing up, which was to NOT get pregnant: 'Whatever you do, do NOT get pregnant' was ingrained in me. Still, I was sure I would conceive in the first month of trying. That's just how it goes in my family.*

## **September 2003**

*Thirty-six negative pregnancy tests later, my excitement has slowly morphed into what now feels like hard work, mustering up that enthusiasm after feeling crushed each time the single line appears on each new pregnancy test, month after month. From the hope as each new monthly cycle begins, to then feeling hopeless at the sight of each negative test. This is becoming exhausting. My husband and I need some reassurance/support. We arrange an appointment to see our GP for all the tests. When we are called back for the results, we expect good news. We sit in front of the GP, who greets us with his carefree smile and rosy cheeks. He is wearing a smart navy suit and tie, with a blazer-style jacket hanging on the back of his chair. He looks confident in what he is about to deliver. I am ready to take in his every word. With his smile widening, he informs us that it is great news, "All tests on both of you came back inconclusive," he says, "Everything is in good working order; nothing medically wrong with either of you," he assures us.*

*He then adds: "However, because you have 'failed to conceive' beyond 24 months, you are being diagnosed with unexplained infertility". Wait... what? I think, as I can't seem to say it out loud. He continues, "which is also great as you qualify to go straight onto the IVF waiting list immediately. This can take up to around a year, but with this diagnosis and the pressure taken off, many conceive while waiting on the list; it happens a lot", he said, reassuringly. The doctor and my husband continue a light-hearted conversation about how wonderful all of this is. I hear the laughter between these two men grow louder, but then it fades into the background as the voice in my head gets very loud and repeats slowly, as if struggling to process, "UNEXPLAINED INFERTILITY?" What is that? I have never heard of it. What did you*

say that means again, or did you say what it means?' Am I being diagnosed with nothing? "Failure to conceive... FAILURE!... Is this my fault, our fault?... Have we done something wrong?". I want to ask these questions, but I seem to have lost my voice.

*I try, but I can't speak; the questions go around my head in a loop. Please, one of you, throw me a lifeline. The clock is ticking, time is running out, the appointment is nearly over, and I have things to say and questions to ask. Let's double-check, says the voice in my head. There might be a little problem we can fix, something tangible. I am not getting this. Is a medical diagnosis not something objective? Let's use this time constructively to find something to fix, and then perhaps we can call it a diagnosis, my inner voice is screaming, begging; I feel desperate. This anti-diagnosis you've just given us is merely confirming that nothing is medically wrong. So, you're saying you couldn't find anything medically knowable or measurable. Therefore, why not just stay with the not knowing and at least tell us the answer is that we haven't a clue why you're not conceiving as a couple? If you must name it, then call it the 'haven't a clue diagnosis'. "Please don't leave me hanging like this," says my inner voice. Meanwhile, in the room, as if in slow motion, the laughter, the loudness, the inappropriateness about the quantity and quality, and the motility of my husband's sperm, are more important here as they both continue to laugh even louder. In my head, the word 'FAILURE' is still screaming at me.*

*...I am frozen in an endless moment,  
Drowning in a sea of unanswered questions.  
Feeling like a failure at what should be natural,  
The beauty of motherhood floating away... I can't reach it...*

*Why has no one ever mentioned fertility issues in all I have been taught? How was this overlooked? I have always believed that having children was a certainty for me; unquestioned. But in these past few years of trying, and the reality of unexplained (in)fertility has become an all-consuming desire, the one thing that dominates my thoughts and emotions... having a baby is all I can think about. It was not meant to be like this. It feels like a conspiracy.*

*...My lifelong dream, stolen  
I am but invisible  
The clock is now ticking  
and I have lost my voice...*

*Ten-minute appointment. Over.*

In this chapter, I outline my chosen philosophical foundations, methodological framework, and research design that underpin this study. Regarding the opening vignette, I respond to it later in this chapter by responding with my intertwined voices, as explained in Chapter One; however, for now, I opened this chapter with the above vignette here specifically to serve as an appropriate introduction to this chapter, illustrating the complex emotional multi-layered experience of unexplained infertility (UI) and the various perspectives of those in the GP's room; demonstrating how personal narratives intersect with broader cultural and societal contexts. Thus, for this project, I chose to employ a critical autoethnographic approach, coupled with an evocative approach, to explore this work through a feminist lens, bringing the whole experiences of UI. This chapter also outlines my ontological and epistemological positions throughout this work, offering a foundation for understanding the intricate dynamics of navigating UI.

Also, a note on vignettes? I chose vignettes for my project because, unlike simply telling a story, a vignette is “momentary; it lives in the wink of an eye” Ken Gale (2014, 998). I think of narratives in the form of vignettes as messy, real, always in the moment, unlike a story, which I believe is more of a linear form of trying to ‘show and tell’ (Adams 2015) a narrative. I think of Gale’s (2014, 998) description of “vignetting”, on the other hand, as a way I can engage in:

“Bringing the world into becoming through drawing attention, through blurring the peripheral for a moment to sharpen and clarify the central, through interfering with false binaries to represent in the play of making temporally and spatially hesitant the real”.

I see ‘vignetting’ as richly textured, like many different threads woven into a fabric, creating depth and nuance rather than a simple, linear structure. As I relive and rewrite the memories I re-remember from my journals, bringing together these layered threads, you, the reader, can also get close, witnessing it unfold moment by moment. Gale (2014, 1001) describes this as “wistfully lost in dense clouds where words and images somehow lose their separation and all that is apparent is a touch, a smell, a breath of air and a diminishing of spirit.” In my research into the experiences of UI when my body “would not do what I wanted or hoped it would or might do,” I wonder, as Gale describes, “How can I ever imagine that my body is organised and yet how fragile I become when I sense it fraying around its edges” (2014, 1002). This fragility can be felt while living with UI. I believe it would be more challenging to bring you this close to my re-remembered, re-written journals without “vignetting”.

## **Building Foundations: Social Construction - Ontology and Epistemology**

“We see autoethnographic practice as always shifting, always about movement, intensity and potentiality; it never resides, it lives in the creation of the next moment, the next step into the not yet known”.

(Gale and Wyatt 2019, 1)

Before I started writing this chapter, I took time to reflect on the profound depth of the foundations I was establishing for this project. At the same time, I recognised my hesitation to venture into the “not yet known” (Gale and Wyatt 2019, 1) aspect of this writing. The deep foundations I was ‘digging’ for this project mirrored my experience in property development, especially when I was designing a house on a plot of land. This resonated with me not only because of my background and ongoing interest in property development, but also because I had strongly related to it while planning this thesis. Just as I worked with builders, starting with a blank canvas, designing, and constructing the house, I carefully laid down solid foundations to support a lasting structure. Similarly, I aimed to build my thesis like a house.

I start by laying a solid foundation with my philosophy, grounded in the foundations of my chosen paradigm, social constructionism, and cemented in qualitative research that views the nature of reality as subjective. Therefore, I am a part of it and cannot detach myself from it, just as I believe I am a part of the house I designed and co-constructed. Through the social constructionist perspective, my research develops from the ground up by questioning the fabric of society and the social norms that have shaped my beliefs within the culture in which I was raised. I aim to challenge these social norms as I work within this paradigm, demonstrating that reality is subjective and created by individual perceptions and interpretations

rather than an objective entity waiting to be uncovered. Thus, I acknowledge that I am an intrinsic part of the reality I study, and my own experiences and biases cannot be separated from the research process.

Working with social constructionism enables me to challenge the idea of a single, objective reality. As Kenneth Gergen (2003, 15) states, “Knowledge is not ‘out there’ waiting to be found. Instead, we socially construct knowledge in relationships, through formal channels, such as academic journals, and through informal, interpersonal interactions with others.” Ontologically, the social constructionist approach asserts that realities are multiple and shaped through social processes, interactions, and cultural contexts. Thus, I understand that the concept of ‘truth’ is influenced by power dynamics, values, and social norms that shape our lives. Moreover, examining my research through the lens of social constructionism reveals that, epistemologically, it suggests knowledge as co-created, similar to building a house. I aim to achieve this through the dialogical approach utilised in my project, which involves sharing experiences rather than merely reflecting an external reality. This approach helps me recognise the co-constructed nature of knowledge. Thus, alongside Laura L. Ellingson and Carolyn Ellis (2008, 459), I also wish to “embrace troubling the taken-for-grantedness of the world in order to give voice to oppression and move people to action or new beliefs and understandings”.

Through the social constructionist lens, my research critically explores the societal norms and narratives that have shaped our understanding of unexplained (in)fertility and the broader topic of infertility. The medical model tends to hold power over this medicalisation, which began as a personal experience. I now reclaim some

of the power and challenge these social norms and historical narratives, as Ellingson and Ellis (2008, 449) articulate, recognising that “reality is socially constructed.” This empowers me with the aid of my chosen methodology in autoethnography to question and counter accepted claims about “the way things are” or “the way things always have been” (Ellingson and Ellis 2008, 450). I aspire to become one of the “social construction theses” that are “liberating chiefly for those who are on the way to being liberated . . . [those] whose consciousness has already been raised” (Hacking 1999, 2). In turn, my research does not seek to discover definitive answers, but rather to share insider narratives from the experiences of UI, employing a ‘showing and telling’ approach (Adams 2008), and to explore the emotional impact of these experiences, ultimately creating a new dialogue that can lead to transformative change.

Also, I feel motivated to explore what I already understand while also seeking what is “not yet known” (Gale and Wyatt 2019, 1) about the nature of knowledge in counselling and psychotherapy within UI. I aim to do this by ‘writing to’ my different voices—my client examples who have experienced UI, myself as a researcher exploring personal and client experiences, and as a specialist infertility counsellor—while critically examining this study through a feminist lens. I think of fertility impairment as a messy and confusing complex social phenomenon, and the impact it has on people as they live in a perplexed state in many ways and often for a prolonged period.

This makes me think of Zoi Simopoulou and Amy Chandler (2024, 1022) and their writings on provoked perplexity in qualitative research. My qualitative critical

autoethnographic inquiry has allowed me in my reading and ‘writing to’ my journals, to embrace the “messiness and complexity” in the moment-to-moment re-living those moments in the “liveliness” as a “state of being” – a meaning in itself” (Simopoulou and Chandler 2024, 1022). Their (2024, 1022) approach inspired me to “encompass more nuanced realms such as the felt or embodied, as well as that which is co-experienced or in-between” in my work and as I also believe much of my work with my clients’ is “co-experienced or in-between” often in a ‘perplexed state of messiness’ and is always “viscerally known in-the-making” as I re-write *Marie’s* and my clients’ experiences in this work (Simopoulou and Chandler 2024, 1022).

These processes also helped me let go of the harsh judgment I previously held, which kept me feeling stuck and frozen in time, with my only perspective being an ‘unexplainable (in)fertile’ body and self. Thus, I stepped confidently into this research, which led me towards new insights and enabled me to contribute to the often under-researched and undervalued topic of UI. My goal was to achieve what T.S. Eliot (1943) states, to:

“not cease from exploration. And at the end of all exploring  
Will be to arrive where I started  
And know the place for the first time”  
(Eliot, Thomas S. Four Quartets 1943).

In turn, by revisiting my re-remembered memories from different perspectives throughout my journey with unexplained (in)fertility (UI), as well as those of my clients, I wanted to return to familiar ground, but this time enriched with new insights.

This process enabled me to gather, reflect on, and share knowledge in a way that makes me feel as if I am arriving at this place 'for the first time'. Throughout this project, I offer nuanced responses to the vignettes, deepening our understanding of the UI experience by exploring both the known and the unknown within cultural contexts, while drawing on relevant literature. I believe that utilising critical autoethnography as a methodology helped me engage in a process of becoming. By critically inquiring into my re-remembered narratives, I reveal insights I might not have grasped had I not embraced the notion that "Theory and story work together in a dance of collaborative engagement" (Jones, 2016, 219). This sophisticated interplay of narrative and theory creates meaning through a tango of exploration, rather than merely stepping backwards and forwards on the surface of my topic in a cha-cha.

For many years, I was unaware of the silence that had formed within me and of the profound effects living 'inside' UI had on my identity. In more recent years, however, I have felt increasingly emotionally removed from my own UI experience, and this shift sparked growing curiosity. My hesitation to share my experiences until more recent times may have stemmed from a fear of confronting the stigma and shame associated with my UI experience. Also, because it provokes a fear - a fear of the unknown, for me, a fear of 'failure'. Every time I have pushed myself to step outside of what keeps me comfortable in the 'known', since experiencing 'unexplained (in)fertility triggers, that profound fear of 'failing', something I had not previously been afraid of until being diagnosed with UI. This reminds me of Pelias' (2011) desire to 'lean in' as he writes and speaks from his body. I now feel ready to share my personal story and to honour my UI clients' experiences as I 'make visible'

a subjective reality of UI by navigating through it and emerging on the other side, rather than holding on to it in 'concealment and denial' (Adams 2009, 622) as I had done for so long.

Suffice it to say, where there was once only dread at the very mention of UI, I am now able to 'lean in' to my story and share it alongside examples from my clients, reflecting narratives of culture within autoethnography. Thus, I have critically inquired into my own and my clients' experiences, utilising this method appropriately to study UI and infertility. Autoethnographies reject the idea of research as a "view from nowhere; there is always a person, the author, in research/representation" as Adams (2020, 2) states. Additionally, I wish to build on what I have learned from my epistemological position in a continued search for what might be possible to know (Harper 2011). Thus, I am constructing something from the roots of my reality to contribute to my field in counselling and psychotherapy. Then, building from that ontological foundation and developing, growing within it epistemologically as I inquire into the soil (research gaps) of my topic.

Consequently, my ontological position, as I understand reality through the social constructionist paradigm, is rooted in the idea that our understanding of reality is shaped by social processes, interactions, and cultural contexts rather than by absolute or objective truth. This approach emphasises the significance of subjectivism, recognising that individuals interpret the world through their unique experiences, shaped by personal histories and social relationships. In the context of unexplained infertility (UI), I recognise that the experiences of those impacted are varied and complex, each holding unique meanings and emotional dimensions. My

study respects these subjective realities, encouraging a deeper understanding of how individuals and couples create meaning around their UI experiences. Furthermore, this ontological perspective motivates me to inquire into the complexities of identity, power relations, and social contexts that influence perceptions of UI. By recognising knowledge as co-created through dialogue, I seek to create a space where marginalised voices can be included in the broader discourse.

Throughout my research journey, I have encountered extensive literature on the scientific perspectives of medical treatments for UI and infertility, predominantly studied through the dominant positivist quantitative paradigm. This approach analyses numerical, evidence-based investigations from the perspective of the 'experience-far' objective observer detached from the research subject. Hence, I address the gap concerning the 'whole' experience, including the emotional impacts of living with UI. My inquiry into UI takes an 'experience near' approach (Bondi and Fewell, 2016), where I am present and situated within the research as I seek meaning within a set of assumptions about not only my ontological position but also my epistemological perspective: the validity of my pursuit of knowledge and how I understand it; specifically, the nature, sources, and limits of what I can know. In the context of my inquiry into unexplained (in)fertility (UI), my epistemological stance influences how I understand and validate knowledge, guiding my research approach and shaping my interpretation of experiences. By appreciating the subjective nature of knowledge, I was able to explore the complexities of *Marie's* and my clients' experiences and develop a deeper understanding of the diverse realities surrounding UI, and later, in the broader context of infertility.

Accordingly, I remind myself of the importance of bringing these UI experiences into academia through critical autoethnography, taking the opportunity to deepen both my own and others' capacity for empathy towards those in different circumstances from our own (Ellis & Bochner, 2000). I reflect on what constitutes knowledge in counselling and psychotherapy, exploring subjective experiences with depth rather than breadth (Bondi and Fewell, 2016), and by drawing on my own experiences and perspectives. I undertake this from a consistent ontological position within an 'experience near' (Bondi and Fewell, 2016) framework, partly writing to and with my own different voices that have both experienced UI and continue to work within it, while also drawing on examples from my clients.

Furthermore, I seek meaning by exploring both my own and my clients' subjective experiences from different perspectives. I share the findings of this study to help others living with UI feel less alone. I also provide valuable insights to those supporting individuals and couples with UI, such as fellow counsellors, medical professionals, and all those working with people experiencing UI and infertility. Accordingly, I offer a deeper understanding and share insights into the experience of reproductive loss through exploring: 'disenfranchised grief', 'nonfinite loss', 'ambiguous loss', and 'chronic sorrow' (Doka 2002; Bruce and Schultz 2001; Boss, Roos, and Harris, 2021) throughout this thesis. I also explore the journey of UI as it shifts from a state of loss and grief to one where hope is rekindled, alongside developing a new identity after living with stigma and shame. I do this through an autoethnographic inquiry.

## Constructing Methodological Foundations: Autoethnography and Methods

“What makes a particular work an “autoethnography”? “Autoethnography” is comprised of three interrelated components: “auto,” “ethno,” and “graphy.” Thus, autoethnographic projects use selfhood, subjectivity, and personal experience (“auto”) to describe, interpret, and represent (“graphy”) beliefs, practices, and identities of a group or culture (“ethno”). Manuscripts must engage these components”.

Adams (2020, 2)

I pursue autoethnography, always keeping these ‘components’ clearly in mind, along with all I have learned and experimented with from my mentors, Jonathan Wyatt and Fiona Murray. I was immediately drawn to autoethnography when Jonathan Wyatt and Fiona Murray introduced it to me in their ‘Between Counselling and Research (BCR1 and BCR2) classes’. I knew I wanted to use autoethnography for this project, but I grappled for a while with which method would work best. Consequently, I also completed a separate course on autoethnography taught by Jonathan Wyatt. I would update Jonathan on my experimentation with the different methods he had taught us, only to change my mind the following week. This process of shifting between methods continued throughout the entire course, with Jonathan remaining very patient each time I informed him I would be using a new method for my project. I reflected on what represents knowledge in counselling and psychotherapy, and how my research might teach me and my anticipated audience through my exploration of the experience of unexplained (in)fertility (UI).

This sparked my curiosity about whether exploring the topic through a more political and feminist perspective, and critically examining the diagnosis process within the framework of social constructionism via a critical autoethnography, would benefit my audience of fellow counsellors, medical professionals, researchers, and

those experiencing UI. I eventually concluded I must primarily take a critical approach to my autoethnographic inquiry within social constructionism as it gives me the chance to investigate power, from a broader viewpoint, allowing me to explore who holds the power, if anyone, in this diagnosis and ‘trouble’ who gets to decide whether a person is unexplainably infertile; challenging whether this ‘so called’ diagnosis should even exist while also staying with the subjective experiences of UI? Hence, I present my interpretations, drawing on not only the subjective experiences of UI but also critically exploring this medical diagnosis, which raises questions about whether ‘the UI diagnosis’ ultimately benefits patients.

Overall, positioning myself within this research while holding a social constructionist, ontological, and epistemological stance in my inquiry enables me to critique my own and my clients’ experiences more critically. This approach allows me to explore how our social, cultural, and religious backgrounds and influences shape our reactions. So, in this thesis, I investigate how societal expectations and perceptions regarding procreation, power dynamics, medicalisation, and related issues have affected my emotions. I consider whether there is power in the pain of UI, and if there is a sense of meaning to be found in the layers and textures of my own stories and those of my clients. Consequently, I concluded that a combination of the critical method and the evocative approach — which I believe is inherently present in autoethnography — would best suit my project. It took some time, but I am satisfied with my choice.

I also employ, as Kathleen Stewart (2016, 659) describes, a way of “doing something different with theory and its relation to experience.” Hence, I conceptualise a therapeutic exploration of everyday life experiences with this

persistently rebellious medical diagnosis of UI and the accompanying prolonged grief. This involved exploring the tumultuous and repeated journey from loss to hope, both for myself and others, as I believe the most challenging aspect of these experiences is finding the courage to hope again after each new complex reproductive loss. Although I hold onto something, Kitrina Douglas (2020) articulates that, after grief, something beautiful can emerge.

Nevertheless, I searched for meaning through my methods, which included exploring the personal (evocative). “Autoethnography points to the self as embedded in cultural meanings. Doing autoethnography affects the social construction of the author’s self”, say Ellingson and Ellis (2002, 454) while questioning the UI diagnosis (critical) and drawing on my client base. Hence, my framework and plan, which support my project, aim to guide you towards a different perspective on this topic while I address my research question and sub-question. Accordingly, by building my bricks (UI experiences) and cementing them with mortar (expert theories), I construct (autoethnography) this house (thesis), supported by my foundation (social constructionism within qualitative inquiry). In this way, I am creating a solid framework that suits my project, utilising the following methods of autoethnography:

### Evocative

I relate to an explanation by Ellis and Bochner (2011, 275) on how researchers ‘do’ ethnography when studying a culture’s relational practices, beliefs, and shared values in their collective experiences to help “insiders (cultural members) and outsiders (cultural strangers) better understand” the experiences of UI. I address this by incorporating the ‘auto/s’ and ‘I/we’, with the hope that my insider’s meaning-

making from this inquiry will enable me to connect with other insiders who may be isolated in silence or assisting someone silently suffering, perhaps in a medical environment, while also helping the 'outsiders' gain a deeper understanding of the entire UI experience.

Therefore, I endeavour to sensitise you to my own and my clients' experiences with UI, along with the 'identity politics' that were long silenced (Ellis and Bochner 2000), as *Marie's* experiences were. I share the insights gained from exploring various perspectives on this topic, including the experiences and literature I have gathered for this research. Building on this, I intend to contribute to academic discussions about the experience of unexplained (in)fertility (UI), infertility, and the importance of the vital support needed both within and outside counselling, all through autoethnographic methods that document and critique "past experience to make better hopeful experiences possible" (Adams 2009, 620).

From a significant period spent in medical environments without any emotional support to now, where I can employ the evocative method to explore who I was then and who I am now, in the hope that it will contribute to a deeper understanding in this area of research. Grace Giorgio (Jones et al. 2016, 411) explains, "We use memory to understand who we are, our identity, how lived experiences change us." In turn, I draw on my own memories recorded in my journals to provide "coherence between past and present, self and others, self and culture" (Holman Jones et al. 2016, 411). I articulate the outcomes of exploring the known and the unknown of UI through the cultural context and relevant literature, to produce, as Ellis & Bochner (2000, 733) describe, "meaningful, accessible, and

evocative research grounded in personal experience.” Thus, I wish for you to be closer to my research and to allow relationality and emotion to emerge regarding ‘others’ within my writing, as evocative as it may be (Butz and Besio 2009).

### Critical

I assemble my bricks and mortar (as described above) into a solid structure of critical autoethnography, as Stacy Holman Jones (2016, 228) states,

“Theory and story share a reciprocal, inter-animating relationship. Theory asks about and explains the nuances of an experience and the happenings of a culture; story is the mechanism for illustrating and embodying these nuances and happenings”.

As Holman Jones (2016, 228) affirms, “theory and story” will “exist in a mutually influential relationship” in my work. Consequently, throughout this thesis, these key elements shape my methodology and methods, as part of the development of my ‘thesis house,’ as I envision it, thereby contributing to the overall impact of my work, much like the house I designed contributed to the landscape upon which it was built.

Reflecting on my experience of designing and building a house in a vacant landscape led me to consider how my PhD project started with some ideas after reading and ‘writing to’ (Wyatt and Gale, 2016) my journals. This evoked memories of how I exercised my creativity while constructing a house from scratch. Just as my carefully designed house enhanced its surroundings once finished, I laid strong foundations for this PhD project. These supported a meaningful structure before I

began placing the bricks (experiences of *Marie* and my clients) and mortar (my chosen expert theories) onto these foundations.

I also found that my work aligns with Boylorn and Orbe's (2016) description of critical autoethnography as a method to give a 'voice' to the silenced or oppressed. This approach allowed me to explore evolving identities in UI and promote discussions about different perspectives, highlighting the cultural and personal dimensions of UI experiences and examining intersecting viewpoints (Boylorn and Orbe 2016). In doing so, enabled me to "combine narratives that help us better understand and learn from each other while demonstrating the interconnectedness of the human experience" (Boylorn and Orbe 2016, 15). Therefore, I integrate critical theory to contextualise UI experiences, critically examine social conditions, reveal oppressive power structures, and connect theory with these UI experiences to challenge processes of domination (Boylorn and Orbe 2016, 20). Consequently, aligning with one of my primary reasons for choosing autoethnography— "as cultural analysis through personal narrative"—my goal was to "encourage a critical lens, alongside an introspective and outward one, to make sense of who we are within our cultural communities" (Boylorn and Orbe 2016, 17).

Thus, the critical approach allows me to question this 'so-called' unexplained diagnosis and explore its effects, along with the subjective experiences of living with UI. I see a medical diagnosis as providing 'certainty', an ontological objective truth from a realist perspective. An 'unexplained' medical diagnosis with 'prolonged uncertainty', however, troubles me as I mentioned in Chapter One. Hence, I selected the critical autoethnographic approach, which enabled me to analyse both the power

dynamics associated with receiving a UI diagnosis and the social and cultural experience of living with UI (Reed-Danahay 2017), thereby adding to the limited research on the ‘whole’ experience of UI. Furthermore, a critical autoethnographic inquiry allowed me to challenge critically the social fabric surrounding the UI medical diagnosis. I discuss this in Chapter Three, drawing on the work of sociologists Arthur Greil and Julia McQuillan (2010), who have conducted significant research on the emotional, psychological, and relational effects of infertility. I argue alongside them whether UI should be seen as a sociological issue rather than a medical diagnosis.

Thus, the critical and evocative methods within autoethnography will create opportunities to connect “personal (insider) experience, insights, and knowledge to larger (relational, cultural, political) conversations” (Adams, Holman Jones, and Ellis 2015, 25). I would also add a sociological perspective to this list. This allows me the privilege of sharing ‘the stories untold’ from the multiple subjective truths in UI (evocative), questioning the ‘uncertain’ UI diagnosis itself (critical), and strengthening my framework by drawing on my client base. These methods best align with my research question and sub-question, aiming to bring this rarely explored issue into a limited conversation and possibly even help break the taboo surrounding UI.

### **Experiences and Theories of UI: The Bricks and Mortar**

In building the foundation of my methodology, I have not chosen the performative as a method for my autoethnography due to the scope of this project. I do not elaborate on it further, except to note that I find it difficult not to consider Tami Spry’s (2006) performative ‘I’ when I write and reflect on my research. As an

autoethnographic writer, I feel consciously responsible for critiquing and deconstructing my 'I' to ensure I critically challenge my own positions in the telling—not merely narrating stories as I remember them but questioning and troubling the narrative 'I' (Spry 2006). This approach has helped me stay vigilant and curious, questioning my own understanding as I methodically build upon my foundations in autoethnographic writings. Therefore, this thesis explores how cultural and political contexts shape UI narratives, emphasising the importance of critical and evocative autoethnography in understanding these experiences.

This brings us to the core of my project. Here, an opportunity arises to develop ethical and evocative work (Jackson and Mazzei 2008, 313), establishing a new foundation based on fresh perspectives to contribute to this subject. It has been emotionally demanding, as I “systematically analyse” (Ellis and Bochner 2011, 273) my own and my clients' UI experiences to gain an understanding of cultural perspectives while endeavouring to remain “socially-just and socially-conscious” (Adams 2008, 83). In undertaking this work, I ethically represent myself and others with differing viewpoints throughout this research (Ellis and Bochner, 2011), linking experiences of UI with relevant expert theorists (the bricks and mortar). Hence, I collaborate with feminist critical scholars on this topic, including Sarah Franklin, Gayle Letherby, Marcia Inhorn, Linda Whiteford, Lois Gonzalez, Sharon Covington, Linda Hammer Burns, Darcy Harris, and other expert writers on this topic, such as Pasquale Patrizio, Arthur Greil, and Arthur Frank, among others. Their work employs various methodologies, such as demographic, ethnographic, narrative, and phenomenological approaches.

Furthermore, since this autoethnographic writing process draws on cultural and political theory, I am reminded of Stacy Holman Jones (2016) as I focus on maintaining the 'critical' aspect of 'critical autoethnography', with theory holding a central place in my writing. It is essential to recognise that we cannot tell our stories without considering the contexts of politics and culture. In this critical approach to autoethnography, I explore, as Madison (2012, 5) describes, "processes of unfairness and injustices within particular lived domains. Critical auto-ethnographers are invested in the politics of positionality,". This reflection reminds me of how I learned from Judith Fewell's work (2017, 10) that theory, without my "experience and those of others, is dead on the page".

### **Therapeutic 'examples'**

Thus, alongside Liz Bondi and Judith Fewell (2017), as I carefully consider incorporating my client examples, I am also concerned that including our clients in our writing can turn them into objects of study rather than subjects within a relational context with the practitioner. This brings me to Bondi and Fewell's (2016) argument about the case study approach and their preference for how examples are more relatable. I also favour their term 'examples' rather than 'cases'. 'Cases' seem to be something neatly wrapped up and sorted, whereas examples offer a deeper understanding.

Bondi and Fewell (2016) argue that the term 'case study,' which suggests a pseudo-scientific detachment and implies that the therapist maintains a fixed, objective understanding of the therapeutic process, thereby devaluing the client's

experience. Consequently, in line with my writing and in relation to women becoming 'objects' of reproductive medicine, I write about my clients, providing examples rather than case studies. This approach inherently personalises this research and involves me, ensuring the focus stays on the relational aspects of our therapeutic work (Bondi and Fewell 2017, 14). One in four diagnosed infertile individuals, 15-30% are told their infertility is 'unexplained' (Kersten 2015), yet people still feel isolated in their experience of UI (Burns and Covington 2006).

This prompts me to consider Jane Speedy's (2007, 1) concept of "small, short stories and small-scale narratives," which depict fragments of people's everyday lives rather than epic, global tales. Speedy's (2007) work has taught me to think more deeply about narrative inquiry and psychotherapy—the act of telling and retelling stories and the possibilities for representing those narratives that shape individuals' lives. I reflect on my clients' UI experiences, which we explore together in therapy, and carefully consider how I might retell and represent them here, ensuring I do them justice, partly by using their own words as recorded in my client notes. As Speedy (2007) explains, there are "lit-up" moments, while the rest of the story remains in shadow. I had to decide which moments to 'light up' on my clients' behalf and which aspects would stay in darkness within my notes; perhaps some details are too personal and sharing them beyond the counselling room would feel too intrusive, even with their permission. I feel protective towards them. I can only hope to do justice to their stories—both ethically and reflectively—by retelling fragments of their narratives, which they have entrusted to me during our therapeutic encounters, in a way that honours their dignity and complex losses embedded in their emotional experiences. I do not claim to fully represent my clients. Still, by weaving my

responses into their narratives and my own, I hope to do justice to our shared experiences, while highlighting the themes I have discovered, including loss and hope, shame, stigma, disenfranchised grief, and identity ruptures throughout this study. By doing justice, I mean treating their stories with the same care, nuance, and ethical rigour as I do within the therapeutic relationship—witnessing them not only as co-sufferers but from the perspectives of an infertility counsellor and researcher.

Furthermore, as I engage in writing and rewriting autoethnography, I endeavour to follow Ellis's (2016, 10) suggestion to “observe myself observing,” while exploring my thoughts and beliefs, challenging my own assumptions, and questioning whether I have navigated the extensive layers of my own “defences, insecurities and fears,” as required by me, since I draw on my client base. Nonetheless, I have done my best to ethically utilise narratives, as “equipment for living, as a tool to understand, negotiate, and make sense of situations” (Adams 2008, 175), particularly concerning my clients' experiences.

### **Design and Research in Practice**

You will notice three voices collaboratively responding to and discussing Marie's UI experiences in the re-remembered and rewritten vignettes, as well as in my client examples. The voices of Marie the counsellor, Marie the researcher, and Marie the feminist writer will respond critically in order to represent different perspectives, spaces, faces, and forms of UI. I see this as creating Wyatt and Gale's (2016) ‘assemblage’ and as supporting their notion of “separations of self and others; form and content, place and space” (Wyatt and Gale 2016, 311).

Additionally, I reflect on Alexander's (2012, 133) concept of "shades of difference" and engage fully with this writing from all these perspectives, informing and transforming while establishing mechanisms of meaning-making for myself and others. I agree with Alexander (2012, 133) to be mindful of scholarship in my writing while also grounding my research practically in exploring and responding to *Marie* and my client's examples in their daily living memories, as I searched for "truth to experience and possibility to the imagined"—the former for me as a researcher and the latter for others suffering in the prolonged unknown of UI. Thus, I chose the forest route rather than the village way on this journey, meaning that at times different parts of me meandered, walking the more challenging path and exploring deeper into the journey (Campbell 2017).

In turn, Marie, the infertility counsellor, the researcher, and the feminist writer each listen from their individual perspectives and respond accordingly, in an interconnected manner. I think of *Marie's* reaction to the UI diagnosis as it was highly disruptive, to the point that she becomes frozen in fear and cannot envisage a future for herself in these circumstances. *She* is unable to think clearly and has not sought professional help to support her emotionally through the medical intervention of fertility treatment and everything that accompanied that experience for her. Consequently, to gain a deeper understanding of these significant experiences, Marie, the infertility counsellor, and Marie, the researcher, consult relevant literature, critically and in depth explore it, and respond.

This takes me back to my ontological and epistemological stance within my research, where, through responding to *Marie* and my clients, I explore the social

and cultural contexts and speak to the subjective realities of UI. I address the silencing endured by *Marie* and my silenced clients, primarily caused by experiences with medical interventions. Consequently, I make this writing visceral by responding to *Marie's* re-remembered memories from the past and my clients' experiences in the present, imbuing them with purpose and meaning across these time spans.

Consequently, each time I sit (or stand) to write this chapter, I ask myself: How have I responded to *Marie's* and my clients' narratives, which are full of opposing emotional moments and influenced by discourses beyond just 'them'? I ask myself whether it is possible to give a voice and face to *Marie's* and my clients' individual, unique narratives and if I do justice to their deeply personal (visceral) and emotional UI experiences. Additionally, do the insights I share connect my research question and sub-question? I believe I have expressed the 'selves' of these narratives and responses, past and present, as Katrina Douglas and David Carless (2016, 89) state,

*"The self appears,  
The textual self appears,  
We, writing the self  
And then  
The body appears"*

And what I mean by this is the voice within the medically diagnosed UI body. Jackson and Mazzei (2009, 14) question the more traditional understanding of voice as, "frequently been privileged since it has been assumed that voice can articulate the truth of consciousness and experience. In these paradigms, voice remains close to the true and the real, and because of this proximity, it has come to be seen almost

as a mirror of the soul, the essence of the self.” I challenge this conventional restraint alongside Jackson and Mazzei (2009) and argue that it can help liberate the authentic voices of *Marie* and my clients from this limited notion, since there are many layers of truth within a single voice. Thus, my desire to explore different voices, not just one, through autoethnography grew stronger as I wrote about *Marie's* and my clients' 'selves'. I contemplated my ontological and epistemological positioning as I asked myself what there is to know 'out there' in the world about unexplained infertility (UI) that will fill a gap in my understanding of what it might be possible to know. Encumbered in all of this, of course, is ethics.

## **Ethics**

Throughout my research and writing, I maintained a strong sense of ethical awareness, constantly reminding myself that while I wrote in my own voice, I was exploring experiences through interconnected perspectives: *Marie's* over different time spans, my clients', counsellor, and the broader context of my researcher/author voices. I made a deliberate effort to focus primarily on *Marie's* experiences, while drawing on my clients' narratives to inform my understanding. I was fully aware of the ethical considerations and limitations of this approach.

In speaking to the onto-epistemological foundations and methodological framework for incorporating my clients' experiences in this critical autoethnographic study, I believed that drawing on the paradigm of social constructionism would do it justice while honouring my clients. I chose to explore through this lens to emphasise that knowledge and meaning are co-constructed through social interactions, which aligns with my research. I recognised that it was impossible to write about my own

experiences without acknowledging the 'others' in my work, and, taking this a step further, to honour my client base while allowing them to inform my study. Therefore, I engaged in careful reflection on how to ethically represent my clients in my study.

### **Ethical considerations in relation to my counselling clients**

I carefully thought about the implications of asking this of my clients, and whether it might alter or even harm my therapeutic relationships with them, to the extent that I almost decided not to suggest it at all. I answered any questions they had about my project with openness and honesty, as I always have with them throughout our therapeutic work; I feel protective of my clients. My main concern was not to harm these relationships, which is why I kept their involvement in my project to a minimum, reassuring them that the aim was to use my work with them to inform my own process through my critical and evocative autoethnographic methods.

Because I carefully considered whether to involve my clients in my writing, especially regarding the complex ethical issues involved with this topic, I decided against using dialogical interviews for ethical reasons, as I did not want to put any pressure on my clients. I took all necessary precautions to protect my clients' identities. I used pseudonyms when referring to them in my writing. I avoided any distractions that could divert attention from our counselling sessions, ensuring we maintained full focus on the clients during our work together. It was very important that my clients remained concentrated on their process in counselling, while I continued in my role as a fertility counsellor and coach.

I suggested to the ethics committee at the University of Edinburgh that drawing on my work with my clients purely to inform my research on my experiences of UI and the broader field of knowledge would be the most ethical approach, given that my study also critically explored counselling practise in this field. Following my clients' written consent forms, my ethics application was passed by the committee on 3 April 2023, after a resubmission following the committee's rejection of my first application, in which I requested that my clients give only oral consent. My clients understood that they would not be participants or collaborators in my study. I was not asking them for anything. There was no pressure to 'do' anything, and I may draw on their experiences to inform my work in a respectful, honest, and dignified way.

To uphold ethical standards, I asked five of my clients experiencing unexplained infertility (UI) whether they would consent to my writing about my work with them, specifically regarding my processes for this project. I clarified that the focus would be on the broader context of my experiences in this study rather than on their personal stories, challenges, or therapeutic journeys. I did not seek their feedback on my work during the research or while writing my thesis, as they were not participants or collaborators in the study. However, I assured them they would have the opportunity to read my completed thesis if they wished.

Hence, the integration of my clients' experiences into this autoethnographic study was approached with careful ethical consideration, guided by the principles of social constructionism. This framework allowed me to honour both my own narrative and my clients' narratives, while prioritising the integrity of our therapeutic relationships.

## **Self-care**

As I explored my rewritten journals and re-remembered memories of unexplained infertility (UI), I remained deeply aware of the importance of caring for not only my clients but also myself throughout and beyond this project, right up to the present day. I am fortunate to have had a strong support network, which included my clinical supervisor, fortnightly private counselling, and my two university supervisors. Additionally, my friends and family provided vital support, creating a nurturing environment that allowed me to stay focused on my professional and personal well-being. Their encouragement and understanding have been invaluable, not only during this project but also in my ongoing journey.

## **Exploring the Ethno of Autoethnography**

This research is situated not only within a culture that medicalises fertility impairments, including unexplained infertility (UI), within Catholicism, family, the workplace, and broader society. In all these settings, individuals often face stigma, shame, disenfranchised grief, and identity shifts, especially within specific cultural frameworks such as the Catholic faith, which can intensify feelings of guilt and disenfranchised grief. The societal expectation to conceive can create a profound sense of failure for those diagnosed with UI, leading to uncertainty and isolation for individuals and couples. This culture not only shapes the experiences of individuals but also influences the narratives surrounding fertility impairments, often prioritising medical explanations over personal stories.

For example, the culture of medicalisation and stigma surrounding UI highlights personal experiences by drawing attention to the emotional toll and shifts in identity

for those living with an unexplained diagnosis. Through the lens of my re-remembered and re-written journals, I explored how the label of UI transformed *Marie's* identity from an individual to a patient, for example, causing feelings of stigmatisation and silencing. This change in identity is a central theme in my narrative, reflecting the wider societal implications of unexplained (in)fertility (UI). By sharing the vignette at the start of this chapter, I exposed the complexities of navigating the confusing highs and lows of the emotional rollercoaster of loss and hope, as well as the influence of cultural expectations on personal identity and emotional well-being.

Therefore, this autoethnographic approach allows for a nuanced understanding of the cultural dynamics surrounding UI by intertwining personal narratives with broader societal themes. Reflecting on my experiences as a researcher, counsellor, and co-sufferer of UI, I engage critically with its emotional complexities. This approach offered a deeper connection between personal stories and collective cultural experiences, showing how individual narratives can challenge dominant medical discourses and emphasise the importance of empathy and understanding, not only within therapeutic settings but also in the medical model, society, and culture.

Thus, ethical considerations were paramount in this study, particularly regarding the representation of others' experiences. I am acutely aware of the potential impact my writing might have on my clients, family, and friends. Throughout my writing processes, I sought to balance my reflections with a commitment to ethical storytelling, ensuring that I respected the privacy and dignity of those involved. This

included, where possible, obtaining permission and being mindful of how their stories intersected with my research. The ethical obligation to represent others fairly and respectfully was a constant guiding principle in my work, as I navigated the complexities of sharing personal and shared experiences within the context of UI.

### **The Nuts and Bolts**

Thus, getting down to the nuts and bolts of my chapters, I decided to structure this chapter to establish the project's philosophical and methodological foundations rather than providing a traditional literature review, since it made sense to me to interweave the essential literature throughout my thesis. Chapters Three, Four, and Five—my three core chapters—were reserved for *Marie's* re-remembered and re-written journals. These serve as the central focus of this research, exploring the medicalisation of UI and infertility through the lenses of the themes that weave throughout this study: stigma (Chapter Three), shame and disenfranchised grief within the context of Catholic faith (Chapter Four), and the transformative journey of rebuilding hope after loss in relation to identity (Chapter Five). I decided to follow these core chapters by dedicating Chapter Six to my clients, where I thought it would be fitting to dig deeper into my client examples, drawing on my infertility counselling practice, and to address how therapy can support individuals navigating UI. Subsequently, I created a discussion in Chapter Seven to connect everything within a broader conversation about the core themes I uncovered during my research. I then dedicated Chapter Eight to synthesising all these elements, with Chapters Seven and Eight further reflecting on the interconnected themes of loss and hope, linking them to existing literature and offering recommendations for future research and practice.

Thus, I loosely structured these chapters, keeping in mind that this research is an autoethnographic enquiry under a social constructionist perspective. This means that many parts of my writing did not make it into my thesis—for example, a literature review I wrote earlier in my project, thinking it would be more suitable at the time, along with other elements such as male infertility and same-sex couple experiences, which I had to set aside since they do not relate to unexplained (in)fertility (UI). Thus, at times during this project, I meandered off my path of an exploration of unexplained infertility (UI) focused solely on heterosexual couples' experiences, with UI being a diagnosis only given to heterosexual couples who cannot conceive naturally, perhaps by my thoughts of the broader range of clients I work with and sometimes wished to provide a more comprehensive study of my wider work in infertility. However, I always got back to my path after a trek through the forest route with the help of my supervisors, who pointed out that I had once again meandered into the broader topic I work in as a specialist infertility counsellor. Nonetheless, I drew on feminist theory, as well as insights from multiple autoethnographers and infertility experts, including counselling infertility specialists. This flexible structure allowed me to explore the topic in depth through critical and evocative autoethnography, uncovering a nuanced understanding of the complex, intricate experiences associated with UI and highlighting both personal narratives and broader implications.

### **Responsibility, Reflexivity and Revisiting the 'I'**

Since I began this chapter with the idea of the 'not yet known' (Gale and Wyatt, 2019, 1), I stay within the realm of the unknown and remain open to it. Also, I

am aware that my work is deeply embedded with ethical considerations and limitations, including how my research might affect ‘others’ as well as the ‘I’ in my writing, which is always evolving (Spry 2006). These reflections also influence this writing. This prompts me to consider how I related what I was attempting to ‘do’ with my methodology and methods with UI to Mazzei and Jackson (2012, 746) in their thinking about:

“a voice without organs, a voice too easily taken as a “thing,” or a voice without a subject in order to think the very limit of how voice is constituted, constrained, manipulated, and held constant in our efforts as researchers to craft a narrative, tell a story, give voice, and make meaning”.

Accordingly, I often noticed guilt emerging in me when I re-remembered and re-wrote my memories and epiphanies. This process placed me in an ethical space where I questioned myself about the others in my research, even though I had obtained their permission (where possible) and tried to limit my writing. Still, of course, it is impossible to write about myself without involving others. I understand the importance of ethically involving others in my work, especially when it involves my clients, family members, friends, or even medical professionals. My wish is that they accept my interpretations, though I strive to do justice to their experiences, expectations, and roles in my work. Thus, I am conscious of moments where something unexpected might arise and I think carefully about it as I respond. I think of Foucault (1973) as I ask myself: What is my ethical obligation? Also, how have I represented the others in my work? (Harper 2011). And how did I go about drawing on my clients’ experiences carefully, respectfully, and ethically? Thus, I often wondered, “Are the risks too high?” (Sparkes 2007, 537). I also considered my responsibility to autoethnography and, alongside Sparkes (2002), question whether it

was “self-indulgent”. And I avoided this by recognising, as Sparkes (2002, 222) states:

“our engagement in active, yet partial, meaning-making, which comes with knowing: that we will change others and our roles as change agents need to be considered with great intentionality and sincerity; we have to be open to change; we have to tell others about our experiences and perspectives; we have to listen to the interpretations of others about our experiences and perspectives; we have to listen to the interpretations of other witnesses; and finally, we have to explore multiple meanings of equity and care and act to promote our understandings of these concepts”

Additionally, I considered the challenge of troubling the ‘I’ in my research to access the multiple layers of storying UI for myself and my clients (Spry 2006). This brings me to Marie, the counsellor’s role in this study. As I consider Flyvbjerg’s (2006, 226) comment that counsellors learn from examples and that it is not ‘one size fits all’, I remind myself that my experiences and those of my clients *serve* as examples. I am committed to interpreting these from the perspective of an infertility counsellor, with the added insights of Marie, the researcher, exploring through the lens of critical autoethnography. This approach contributes to my field by seeking deeper meaning within this area of research, from my ontological stance that recognises multiple truths and layers of context. Consequently, as I drew on my clients’ experiences, I felt confident about the significant potential of this study, which would explore it from an insider perspective (Bondi and Fewell 2016). Thus, I have created an enriching piece of writing about my topic in counselling and psychotherapy, “particularising rather than generalising” (Bondi and Fewell 2016, 43). My wish was to present the theoretical face of my project, giving it meaning and a story, voices behind it.

Reflecting on my research, one of my challenges was to stay ethically mindful of others who would inevitably appear in my writing as I focus on my own experiences. I constantly reminded myself of the importance of involving others thoughtfully and of doing so respectfully, limiting my references to them throughout this study. I also remained aware of drawing on my clients' experiences. I thought extensively about the implications of requesting my clients' permission beforehand, even considering whether it might influence or harm my therapeutic relationships with them. At times, I strongly considered not proceeding at all. Nevertheless, as my clients were happy to be asked and supported my work, I chose to proceed and do my best to represent them and their experiences fairly and respectfully; I feel very protective of them. My primary concern was maintaining these therapeutic relationships, which is why I have minimised their involvement in my project.

Furthermore, I am fully aware that, much like my therapeutic relationships with my clients, my research involved complex emotions, including my own. I reflected on how important those moments are and on how I endeavoured to articulate them ethically and reflexively, with care and thoughtfulness. Consequently, I stayed focused on my own well-being while caring for others directly and indirectly involved in this project as I navigated *Marie's* and later my clients' UI experiences, exploring the socially constructed meanings surrounding UI and how these shape individual identities through the UI 'emotional rollercoaster'. Thus, I present my findings through a critical and evocative autoethnography. Throughout all of this, ethics (Guillemin and Gillam 2004) underpin every part of it, from the foundations I have dug deep into and thoroughly explored to the groundwork laid for this research.

## **From an Individual to Patient Status: The Unseen Physical Impairment**

I also inquire into the effects of an ‘unexplained’ diagnosis of (in)fertility (UI), from the perspective of it being one of only a few ‘unexplained’ diagnoses—others include unexplained fatigue syndrome, unexplained neurological symptoms, and even unexplained gastrointestinal issues (Jason et al. 2000). Nonetheless, I illustrate what it means to live with an unexplained (in)fertility (UI) diagnosis, considering our cultural understanding of the medical model that is primarily understood by society and culture to provide certainty, answers, solutions, and the power to cure or not, as I look through the lens of the medicalisation of *Marie’s* personal experience of being unable to conceive without any discernible reason.

This brings to mind Arthur Frank (2013), a notable sociologist in the field of health and illness, known for his work in the sociology of health. It also reminds me of Rita Charon (2006), an internist and general practitioner who introduced and practises what she calls ‘narrative medicine,’ successfully integrating the teaching of narrative medicine and ‘empathic witnessing’ into the curriculum for medical students in the USA; I explore this further in Chapter Seven. Both Charon (2006) and Frank (2013) are recognised for their contributions from different viewpoints to understanding how personal narratives influence the experience of illness and how individuals make sense of their illness journeys. Like Foucault (2002) and Charon (2006), Frank’s (2013) work does not explicitly address infertility or UI; nevertheless, their comprehensive research on illness strongly resonates with my study. For example, Frank (2013) describes being in remission from cancer as neither being ill nor well, but rather existing in an in-between state, similar to holding a visa while

waiting for a passport, yet not receiving the passport and thus living indefinitely with the 'visa status'.

I liken this 'visa status' to the experience of unexplained (in)fertility (UI) patients, where individuals find themselves in a similar liminal space—neither diagnosed with a specific condition nor able to achieve a sense of wellness or certainty. This highlights the harrowing experiences of women living with UI, who inhabit an “ambiguous liminal space” caught between hope and uncertainty (McCarthy 2008, 319). Much like the 'visa status', UI patients carry an enduring label, navigating the emotional complexities and uncertainties of their situation without a clear resolution (Frank 2000). Therefore, I question, alongside Frank (2000), that had we considered this situation as we might have in pre-postmodern times, there would have been no illness, no medicalisation of the body, and individuals would not have become patients relying on medical analysis rather than on the individual's story. *Marie's* story: her journals of memories are at the very core of much of this inquiry, illustrating how a successful, high-achieving, confident woman changed upon receiving a diagnosis of Unexplained (In)fertility (UI), only to be stigmatised, silenced by that label for many years, after a shift in identity from an individual to a patient status. Therefore, I wonder alongside Arthur Frank (2000, 12), “What is being protected by silence and who suffers by being kept silent?”.

Engaging with *Marie's* narratives from the past and drawing on those of my clients in the present allows me to pursue, as Tony Adams (2008, 32) articulates, “truth that values what narratives 'do' for us as writers, audiences, and, more generally, humans”. This makes me think of the times I was working on my writing for

this Chapter. One day, while I was out walking, I was listening to Brené Brown (2017) on audio about her grounded theory study of emotions. As always, as a psychotherapist working with infertility and a researcher, I get excited at the slightest mention of anything relatable to the complex emotions surrounding complex loss that might connect to unexplained infertility (UI) or reproductive loss in any way possible. I was relieved to have already found Kenneth Doka (2002), who coined the term “disenfranchised grief” and speaks volumes to unacknowledged losses—losses that society fails to recognise or validate, leaving those grieving complicated losses feeling confused, isolated and unsupported. These unacknowledged losses, such as the loss of hopes, dreams, and expectations of parenthood, may not involve an obvious or tangible loss. Doka (2002) emphasises that individuals experiencing these disenfranchised losses may endure significant pain, but in isolation and silence.

As I was reflecting on Doka’s (2002) encouraging words about hidden grief, I was listening to Brown (2017), who referred to herself as a “researcher storyteller.” Hold. Stop. Rewind. I listen once more. Yes, she did call herself a “researcher storyteller” (Brown 2017, 122). At this moment, I realise that I have become a ‘researcher storyteller’, having chosen these words earlier while thinking about how I bring, show *Marie’s* ‘voice’ to the page after she had been silenced that day at the GP surgery. Frank (2013, 21) states, “Storytellers are healers, caring for others and creating empathic bonds between themselves and their listeners. Diagnosed individuals are wounded not just in body but in voice”. Consequently, with the permission of what Arthur Frank (2013) terms “communicative bodies” in illness or diagnosis, I communicate via *Marie*.

## **In response to the opening vignette: Researcher Storyteller - Navigating Voice**

I return to the terms 'researcher' and 'storyteller' as I reflect on the loss of voice and its significance in this research concerning unexplained (in)fertility (UI). I also wonder about voices (Jackson and Mazzei 2009), if I/*Marie* also reject the overly simplistic notions of voice; instead, seeking an approach to voice that interlinks power within relationships, which in turn creates or silences voices, just as it did in both different ways that day for the three of them in the GP's room. As *Marie* described, there were two educated white men, both tall and broad in stature, confident, smartly dressed, and possessing voices that were stronger, deeper, and louder than *Marie*'s. The GP's approach to delivering the UI diagnosis that day left *Marie* feeling silenced; her inner voice, trapped inside her, was screaming to be heard. However, in those moments, she could not release it. I reflect on Mazzei, Coleman and Ringrose's (2013, 97) proposal that silences can be "purposeful and meaningful". I now represent *Marie* in the way they (2009, 97) describe concerning the "already absent present" (*Marie*'s silence) as I contemplate the "unthought voices in the form of silence, which have much to contribute as data worthy of hearing in research, silent yet full of meaning".

Moreover, what can a voice achieve or be prevented from doing if silenced, and how might the longing for that voice to be heard later emerge? I invite *Marie*'s 'communicative body' (Frank 2013) to emerge, along with her voice, after her experience of existing in a state of what Frank (2013) describes as 'patient-hood,' which began during that transitional moment in the GP's surgery, when the medical voice held all authority. Troubling voice in this way introduces a power element in the

giving, taking, and silencing of voice. This makes me think of 'Desire' and 'silencing' as Mazzei, Coleman and Ringrose (2013) theorise in reference to Deleuze's writings on silences and his approach to the 'image' in cinema, notably silent cinema and speech-act, and how voice or indeed silences can be communicated in qualitative research in this 'cinematic sense', i.e., through inter-titles, actions and so forth. This takes me further into Deleuze's concept of thinking (Mazzei, Coleman and Ringrose 2013, 99) with image: reading what you see makes something visible in 'viewing' voice or silence, "allowing a re-imagining" of voice and silence.

I wonder, then, if one of the two men—either *Marie's* husband or the doctor in the GP's room with *Marie* had shifted from their conversation and loud laughter to notice *Marie*, as if watching her in a silent film, powerless and speechless in a "cinematic sense" (Mazzei, Coleman and Ringrose 2013, 99). Might they have 'viewed' *Marie's* silence differently? Perhaps they could have 'read' the image of *Marie's* silence from a multi-dimensional perspective, realising her voice had been taken from her in those moments. Furthermore, having reflected on this from a different perspective with Mazzei, Coleman and Ringrose 2013 (109), as they articulated Deleuze's theory, I appreciate that thinking with this 'image' is also like watching a silent film featuring my clients. As a therapist, I not only listen to my clients' voices differently, but I also 'read' their silences from another perspective, similar to my imagined GP appointment for *Marie*, a 'desire' for the two men in the GP's room to do just that: 'read' *Marie's* silence (Mazzei, Coleman and Ringrose 2013).

In that moment in the GP's surgery, *Marie* felt powerless and speechless. In my 'fantasy' for *Marie* of that ten-minute appointment, my 'desired lifeline for *Marie*' would have meant *Marie* being heard that day; she would have grabbed that lifeline had it been given to her and spoken, and *Marie* would equally have had a voice. This reminds me of Foucault (1975), who argued that power is deeply rooted in all social relations, practices, and norms, influencing both the dominant and the subordinate as it operates through various positions, shaping institutions and authority figures in many ways. I see this as challenging the idea of power being a fixed force. Therefore, this complex web of relationships means everyone is closely connected. Thus, the two men in the GP's room that day were the 'dominant' individuals, while *Marie* became the 'dominated', the 'subordinate' who needed a lifeline thrown by the two 'dominant' actors in the GP's room.

"Doctors discourage our stories", writes Anatole Broyard (1993, 124), author and literary critic known for his insightful essays and reflections on life, illness, and the human experience. As I navigate the loss of *Marie*'s voice, I reflect on what silenced *Marie* in the GP's room that day, immersing myself in the time and place of this unexplained (in)fertility (UI) diagnosis. I keep in mind the power of the institution of medicine over our social norms and beliefs, alongside the power of medical diagnosis and interventions over our social constructions and identity, i.e., reproductive identity (Athan 2020). As I think of *Marie*—the high-performing, successful individual entering the doctor's office—and how that experience appears from the perspective of a 'researcher storyteller' getting up close yet distanced by time and space, I explore *Marie* from back then through this autoethnographic lens. I recognise that her silence stemmed from being *given* the diagnosis, the way the

doctor delivered it, and how both men in the room behaved afterwards. I consider how this affected her thought process in that moment as she unexpectedly transitioned into an ill patient by being given the UI diagnosis and placed on an IVF waiting list without consultation.

This overwhelmed *Marie*, as she perhaps instantly felt stigmatised as well as very confused in that moment, leading to a shift in her identity into an abnormal status as an ill patient and a sense of failure in her culture and society from not being able to conceive naturally, all while struggling to absorb that she/they had just been given what she calls an “anti-diagnosis” following all test results showing no medical issues. *Marie* could not fathom how the medical model turned this ‘not known thing’ into ‘a known not known thing’: the unexplained (in)fertility diagnosis. It seems a contradiction in terms: a linguistic trick, a confidence trick, an epistemological vacuum.

Thus, upon further consideration of the UI diagnosis, a medical diagnosis (UI) is given despite no medical issues being found for the couple. Since no medical problems are identified, should this condition, as Arthur Greil and Julia McQuillan (2010), sociologists who have undertaken numerous studies on the emotional impact of infertility suggest, not be viewed as ‘a sociological issue’ rather than a medical diagnosis? For *Marie*, being ‘labelled’ with the UI diagnosis was a paradox; the lack of an explanation means there is no certainty and no medical problem to resolve. As I reflect on this, I appreciate *Marie*’s naivety in not expecting any medical diagnosis unless it pertains to something objective that can be rectified. *Marie* did not realise that such a UI diagnosis even existed; to this day, it still does not make sense: a ‘no-

thing' with a name, a diagnosis. Labelling this 'no-thing' as 'unexplained (in)fertility' (UI) labels a couple/individuals as ill patients with nothing medically to resolve. In *Marie's* situation, it took her power, her agency in that moment in the GP's room, as well as her voice. Had this situation remained within the realms of a sociocultural existence (Greil and McQuillan 2010), where she might have navigated this 'situation' of fertility impairment (with the option of medical intervention open, should she so desire), perhaps it would have been less debilitating to her, subsequently allowing *Marie* the freedom for further exploration without the burden of this label/diagnosis/illness.

On top of that, her culture and society would have *Marie* believe that a diagnosis means not only being stigmatised as an ill patient but also feeling and being perceived as abnormal in relation to the most important aspiration of her life: to reproduce, to have a baby; something she believed would be the most straightforward and natural thing she would do in her life as a woman. *Marie's* husband, on the other hand, seemed to focus on how excellent his sperm count and motility were and thus appeared not to absorb or accept the diagnosis for himself, even though the UI diagnosis is typically given to the heterosexual *couple*. Perhaps her husband 'heard' that all was well for him and that *he was not an ill patient*. He also 'heard' and accepted the solution was *for Marie* to partake in the IVF process, affirming *his normality* by continuing to chat and joke about it with the doctor, as he stood firmly on the side of power held by the doctor and the medical institution. I note *Marie's* silence here and the voice screaming "FAILURE" in her head as she desperately needed one of these two men to "throw her a lifeline". I even feel a

sense of violence present in these moments as *Marie's* voice is taken and replaced by these two loud men.

*Marie* lost her agency and power in those short moments, and all at the same time, she was unaware of the many prolonged losses she would face now that she had transitioned into a UI patient. Foucault (1989, 93) states, "Power is everywhere; not because it embraces everything, but because it comes from everywhere". The sense of 'violence' is present in *Marie's* silencing, which signifies the unfolding power dynamic. The shutting down, the immediate inscription of the 'failed woman' placed upon *Marie*, already there; perhaps it was waiting. Discursive violence and discursive power viscerally manifesting. As Foucault (1989) explains, while exploring the violent aspects of power in relation to societal control and punishment, violence is not a straightforward act; it can represent a complex set of relations, as it did in the GP's room that day.

Therefore, the power dynamics in this situation would mean *Marie* would undergo all the medical treatments, including In Vitro Fertilisation (IVF), relating to this *couple's* diagnosis. Perhaps when it comes to Assisted Reproductive Treatments and Medicine (even when there *is* a direct issue with sperm), it is the woman (the woman's body) who endures the invasive medical treatments, such as In Vitro Fertilisation (IVF). There exists a configuration of power dynamics where *Marie's* husband seemed to align with the authority of the medical professional, thereby diminishing *Marie's* autonomy and agency (Burfoot and Gungor 2021). From this perspective, Foucault (1975) further explains that power transcends any singular

authority and is not confined to political structures, class, domination, or the reproduction of production relations.

I have introduced my vignettes in Chapters One and Two, and now turn to Chapter Three, the first of my three core chapters, where I share and respond to the remaining re-remembered and re-written memories of *Marie* as vignettes.

## Chapter Three

### Medicology: The Silenced Patient

“My silence had not protected me. Your silence will not protect you”.  
(Audre Lorde 2018, 420)

**2003**

**My biggest failure: the story I should not tell; ‘it’s actually a good thing!’**

*‘They’—I don’t know who ‘they’ are; their faces are hidden beneath green surgical masks. Yet, I still see serious expressions in their eyes. I can smell the scrubbed cleanliness of medical staff in their faded, green, washed-out scrubs. The sterile, empty white walls stretching through these seemingly endless hospital corridors are overwhelming. Everything looks the same, corridor after corridor illuminated by bright lighting all around me. I hear the beeping sounds from monitors. Voices rise and fall as I struggle to keep up. What’s happening? I need to know, but no one addresses me directly. I’m frightened. My thoughts are muddled. Something is amiss. The intense pain the doctor previously described as ‘discomfort’ in my abdomen is subsiding. I feel a tingling sensation now; I’m so still, yet there’s a sense of bustling activity all around me. Am I dying? Surely not, but it feels that way. In what seems like slow motion, I cannot prevent my eyes from closing. I am now adrift. It’s getting dark, so dark.*

*Ah, it’s alright. It’s more than alright. I’m back in my favourite place. It’s no longer dark; it’s the opposite. I adore being here; it’s my paradise, so warm and bright. I am now strolling through a beautiful park, partly draped in a blanket of colourful pink blossoms and impressive trees. The paths are lined with stunning pink*

*cherry blossom petals, the trees towering on either side, creating a breathtaking walkway. I glance down to one side through the summer sun; I can smell the flowers, sheer summer. A little boy, faceless, wears a cool blue baseball cap, red chinos, and a cute yellow t-shirt with some detail that appears blurred. He must be around five years old, vibrant and lively in his appearance and body language. I feel so good in his presence; this is very special. The trees shield us like armour from the bright sunshine. We are safe here on this beautiful, pink-paved path.*

*The adorable little boy extends his arm towards me and places his silky, tiny hand in mine. He smiles and calls me 'Mummy'. I use my other hand to stroke his knuckles, trying not to squash his delicate little fingers. I feel joy, pure euphoria. We chat and laugh together, playfully... about what, I do not know. It's the sensation of untouchable bliss that makes me wish this moment will never end. This is exactly where I want to be; my lifelong purpose of motherhood is realised right here. This moment cannot end. My life depends on it.*

*Those bleeping sounds are coming back; it's all blurry, getting louder. The stark lights are almost blinding. It's bright, so bright. I can't fully open my eyes. My eyelids are heavy. No, oh no... I need to get back to my recurring dream. I know this dream so well, and I desperately need to get back to it... especially this time. I see through my blurred vision, green scrubs and masked faces all around me again. The lower half of my body is numb, and I can't feel my legs.*

*I am told my baby has gone...*

*Miscarriage.*

*I feel physically numb from the waist down...*

*My thoughts are racing uncontrollably.*

*The one nurse left behind, still bustling about the bed I'm lying in, says quite cheerfully as she tidies the sheets, "It's actually a good thing, you know, miscarriage. Your body now understands pregnancy and what to do, so you'll see, you'll be pregnant again in no time".*

*I have no words. Paradise. Lost.*

*What have I done? What did my body do?*

*After the miscarriage and back home again, I desperately try to make some sense of it. This pain doesn't make any sense. It's not "great news" that nothing was found wrong in our medical tests, as the GP said that day. And it's not "a good thing" that I had a miscarriage. How can they say these things? Do I - does miscarriage not deserve understanding and empathy? I can't seem to find the words for how I feel. Alone... perhaps...*

*...I have carried you for longer than 'they' know*

*In my imagination, and now in my womb for eleven weeks*

*You are now a part of me, always... like...*

*my heart*

*my soul*

*my breath...*

**“Can a mother forget her infant, be without tenderness for the child of her womb? I will never forget you”**

**(Combs, 2008; Isaiah 49-50)**

What comes to mind when you hear the word “diagnosis”, and how would you interpret a medical diagnosis preceded by the term “unexplained”? Here, I reintroduce a historical term: “medicology” (Richardson 1905). This term was first introduced by Joseph Gibbons Richardson in 1905, a scholar renowned for his contributions to the fields of medical history and philosophy, to describe the encyclopaedia of health. His work examined the intersections of medicine, culture, and society. Therefore, he coined the term “medicology” to create a comprehensive understanding of health that encompasses not just medical knowledge but also the cultural and societal contexts in which health and illness are situated.

So, why do I need the term “medicology”? Although it is not a term we recognise in our post-modern times, I bring it back to provide a foundation for exploring the philosophical influence of a particular medical diagnosis of unexplained (in)fertility (UI); the medicalisation of a couple not being able to conceive, the medical intervention, and what that means in our culture, society, and social norms regarding the complex and confusing impact that UI can have on individuals and couples. I originally arrived at this term by combining *medic* derived from the Latin *Medicus*, meaning physician or healer, which typically leads to a medical diagnosis and medicine as a solution or even a cure, with “ology,” from the Greek *logia*, meaning study or discourse. My inspiration for this term stems from the word “theology,” the study of God and religious beliefs, prompting me to consider how medical discourse shapes our understanding of health, well-being, and identity change from an

individual to a patient status in connection with ‘unexplained (in)fertility’ (UI) in terms of one’s “reproductive identity” (Athán 2020, 445).

Speaking of the new concept of “reproductive identity”, Aurélie M. Athán (2020), a professor and psychologist specialising in reproductive health and related identity development theories, defined it. Athán (2020, 445) states, “Like gender and sexuality, reproduction is a healthy aspect of human expression to be openly explored, destigmatized, and self-authored”. I think of “reproductive identity” often as an invisible aspect of a person’s life—something that is frequently assumed and judged by others, yet seldom addressed in our societal discourse or cultural conversations. However, as Athán (2020, 447) fundamentally points out, “every person has a reproductive identity”. Therefore, I wonder why we are not discussing it more openly and how that might influence the stigmatisation of UI and infertility if we did.

Returning to the term ‘medicology,’ it resonates with me as a way to explore the controversial diagnosis of UI and its impact on individuals’ experiences, here in this study for *Marie* and some of my clients. In making this point and considering the scope of this chapter and project, I refrain from further general philosophical discussions of diagnoses and medicine here, except to acknowledge the ongoing influence that the UI diagnosis and medical treatments have in shaping our cultural and societal beliefs, as they hold the power to assess and subsequently offer solutions. For example, *Marie* grew up in a society where doctors and medicine were influenced by a philosophy that shaped her understanding of the world and herself, linking medical diagnoses to the certainty that something was wrong and positioning

medical professionals and medicine as the solution. Therefore, this chapter explores these dynamics and their implications by critically inquiring into *Marie's* experiences of living with unexplained (in)fertility (UI).

To deepen our understanding of this complex dynamic, I think of Michel Foucault (1973), who explored the relationship between diagnosis, illness, and The Medical Gaze, emphasising how diagnosis and medicine cultivate a sense of certainty about health as he explains the development of the new subject, the object of the gaze, and the illness as the new object, manifested through a framework, a set of indications readily available to that gaze. In it, he discusses the role of diagnosis and illness, how society is led to believe that medicine serves as a solution, and the perception of certainty in medical practice began in the eighteenth century. Foucault (1973) did not discuss fertility issues directly. However, he addressed the medicalised and medicalising family and how it started with children 'cared for' by parents, where the politics of children's health began with breastfeeding, hygiene, and disease. Foucault (1973, 32) states, "The first consequence of the medical politics that emerged throughout Europe in the eighteenth century was the organisation of the family, or rather the family-child complex, as a first and immediate instance of the medicalisation of individuals". He argues that the paradox of modern medicine stems from its rejection of medieval superstitions. The medical gaze represents a unique perspective that empowers practitioners to see beyond mere appearances, uncovering hidden truths about the body and enabling a deeper investigation. Foucault (1973) believed that the medical gaze was a mode of seeing that was not simply a matter of observation but a way of knowing that established a relationship between power and knowledge. I concur with Foucault's (1973)

argument as I think of medicalising bodies as unexplained (in)fertility or infertility, how they/we as individuals become objects and how power is exercised within certain institutions and by individuals acting as conductors of power, such as medical professionals in reproductive hospitals and clinics.

I appreciate how *The Medical Gaze* (Foucault 1973) and a diagnosis establish a framework through which society perceives health and well-being, reinforcing the belief that medicine provides definitive solutions. Foucault (1973) discusses how numerous human issues and concerns increasingly came under the scrutiny of the medical gaze, fundamentally reshaping our understanding of the human body, making the most hidden aspects of the body apparent to the medical eye, while transforming medicine into a tool for enforcing self-discipline and social control. In this context, when an individual becomes a patient, the medical professional typically holds significant power, as Foucault (1973) believed, power that has been consolidated through extensive observation in contemporary society, where individuals gradually become more examined and exposed to the surveillance of the medical gaze. Consequently, the patient immediately loses their power and often their voice under the watchful eye of the medical gaze. As Foucault (1973, 89) put it, “it was no longer the gaze of an observer, but a doctor. Supported and justified by an institution, the gaze belonged to a doctor endowed with the power of decision and intervention”.

Furthermore, a stigma is associated with becoming a patient, as the medical gaze identifies individuals through their illness, transforming them from normal to abnormal. Foucault (1973) suggested that the medical gaze is a way of seeing that

separates the patient from the illness, thereby creating a stigma around those deemed 'abnormal'. Thomas O'Brien (2010, 47), a scholar known for his work on stigma, speaks to the implications of identity and social interaction and being "othered," describing stigma as "a complex social phenomenon that not only marks individuals as different but also shapes their experiences, identities, and interactions with others". In *Marie's* situation, the "human condition" is being "othered" and branded by society as a failure in her quest for motherhood. Erving Goffman (1963), one of the most influential social theorists of the 20th century, explored how individuals with stigmatised identities navigate social interactions and manage their self-presentation in the face of societal prejudice. He (1963, 117) continues, "stigma is a process by which the reaction of others spoils normal identity." This explains how the normal aspect of *Marie's* "reproductive identity" (Athán 2020) is being demolished, torn down, and "spoiled" (Goffman 1963, 117).

### **Medical Intervention, Miscarriage and Disenfranchised Grief**

Before *Marie* could fully grasp her situation concerning the implications of entering the unknown world of Assisted Reproductive Technologies (ARTs), without counselling or awareness of the extent of the physically invasive and mentally challenging medical treatments, she found herself haemorrhaging a miscarriage. Additionally, there was no discussion between *Marie* and the medical team regarding the high risk of miscarriage; as a result, she was unprepared for it. Immediately after her miscarriage, while feeling overwhelmed by her experience and having just lost her lifelong dream of pregnancy and her baby, *Marie* was in desperate need of

validation and support for her loss. She found herself in a dark place, longing for comfort, understanding and support.

Instead, she encounters the nurse's dismissive attitude, albeit undoubtedly unintentionally. Nonetheless, the nurse's words instantly shut down and invalidated *Marie's* feelings of loss and, worse still, tells her that her miscarriage was "a good thing" at a time when she desperately needed validation of her loss, as well as understanding and empathy for how she was grappling with the unexpected loss of her baby at eleven weeks and the dream of motherhood. This left *Marie* feeling unheard, invisible, and burdened by an injustice, adding to the stigma she does not know how to process. *Marie* is unaware that, in addition to being in shock about the miscarriage happening, she is also experiencing disenfranchised grief. Doka (2002) explains that the concept of "disenfranchised grief" indicates there is no clear societal ritual or process to recognise or mourn losses such as (in)fertility or even miscarriage; consequently, those affected may feel stigmatised or judged and pressured to remain silent or to "move on." This rendered *Marie's* grief disenfranchised, complex, prolonged, and invisible (Doka 2002). *Marie's* experience and loss have gone unrecognised. As soon as she is physically able to move, she is sent home with no follow-up whatsoever from the hospital.

Furthermore, *Marie* believes she must not share this experience, which she thought would never happen to her, with anyone. It all begins with the invalidation of the nurse's thoughtless comments, which burdened her with the pressure to, as Doka (2002) explains, "move on" without counsel or processing of this experience of chronic sorrow (Harris 2017) and implied that this miscarriage was not worthy of a

grieving process. Or I wonder, did it all begin as a nine-year-old girl who was told by her mum, “Don’t have children, *Marie*, it’ll ruin your life”?

Brene Brown (2021, 766) states, “Disenfranchised grief (the least studied form of grief) is a highly complex grief that is not publicly acknowledged or supported through mourning practices or rituals because the experience is not valued or counted by others as a loss. Or it is invisible or hard for others to see. Examples include the loss of an unborn child and infertility”. Thanks to Doka (2002) for validating this type of loss, I rarely discuss UI or miscarriage without mentioning disenfranchised grief. These elements serve as a common denominator throughout the entire unexplained (in)fertility (UI) experience involving medical intervention. They are inextricably linked to the complex nature of disenfranchised grief, which unfortunately often accompanies miscarriage, as noted by Tristan D. McBain and Patricia Reeves (2019), scholars who conducted a phenomenological study on disenfranchised grief associated with UI. They concluded in their research involving eight women experiencing UI that disenfranchised grief was unavoidable and had the most significant impact on each of these women (McBain and Reeves 2019). McBain and Reeves (2019) assert that the repercussions of ARTs, including IVF, inevitably lead to loss and disenfranchised grief.

McBain and Reeves (2019) examined the complex loss experienced by UI participants who “cannot be socially supported” as Doka (1989, 4) described. They (2019) found that when grief becomes disenfranchised, it extends the negative impact on the grieving process and further complicates emotions. For *Marie*, after experiencing her miscarriage, disenfranchised grief weighed heavily, leading her to a

very challenging and confusing point in her life (Doka, 2002). Fujisawa et al. (2010) describe it as an ongoing, intense grief that disrupts daily functioning. Medical intervention, along with its further ramifications of low success rates, poses serious emotional implications for UI patients (McBain and Reeves, 2019). I appreciate Michelle Obama (2018, 85) utilising her platform to encourage people to discuss miscarriage, sharing her own experience: “I didn’t know how common miscarriages were because we don’t talk about them. We sit in our own pain, thinking that somehow, we’re broken. I think it is important to talk about the fact that miscarriages happen”.

Miscarriages do happen: Approximately 10% to 20% of known pregnancies end in miscarriage, with some estimates suggesting the actual number may be significantly higher when considering early pregnancies that are not clinically recognised, as stated by the American College of Obstetricians and Gynaecologists (ACOG) in 2020. The European Society of Human Reproduction and Embryology (ESHRE), a guideline group focused on reproductive medicine, conducted a study on recurrent pregnancy loss (RPL) in 2023. Further updates indicated that pregnancies ending in miscarriage may well exceed 20% due to many being unrecorded. Also, a study conducted by researchers of miscarriage, Lee and Slade (1996), demonstrated that this traumatic experience leads to serious emotional consequences. They aimed to identify predictors of improvement; however, the results have been inconclusive. Despite the grief and distress identified post-miscarriage in this study, along with an awareness of the emotional impact, criticisms were raised regarding the lack of professional psychological care and dissatisfaction with the absence of standard follow-ups, as highlighted by Lee and Slade (1996).

Moreover, *Marie* and others who have experienced miscarriage may have been experiencing what Winnicott (2012, 1) describes as “primary maternal preoccupation”, a heightened sensitivity related to a mother’s love for a longed-for child, which is “something far more profound than her later affection for a growing child” (Winnicott 2012, 59). This state can arise during early pregnancy and as noted by Winnicott (2012, 60), can be considered “almost as an illness” if the baby does not survive, necessitating that the mother “recover from it.” Winnicott (2012, 60) further observes, “I would go further and say that the memory mothers have of this state tends to become repressed.” For example, during her eleven weeks of pregnancy, *Marie* may have felt the powerful longing intensify weekly for her developing baby “in the nature of a completely satisfying love-relation, which fulfils not only every mental wish but also every physical need” (Winnicott 2012, 1).

This could partially explain the depth of *Marie*’s grief following her miscarriage, as well as her intense reactions to hearing about pregnancies, seeing mothers with their babies, and her efforts to avoid contact with pregnant women or discussions about babies after her loss. Following her miscarriage, *Marie* embarked on another IVF cycle without addressing the complex grief that the miscarriage engendered, nor did she prepare for yet another invasive, unpredictable medical procedure (another IVF cycle), as no preparation is offered to patients undergoing ARTs in hospitals or private reproductive medicine clinics. Thus, *Marie* was left vulnerable to further loss.

I now guide you to a vignette interlaced with related medical descriptions from reproductive biology papers to demonstrate its purpose: to give voice, emotional

connection, and meaning to this medical diagnosis and experience. Hence, I present an illustration of living with unexplained (in)fertility: *Marie's* 'emotional rollercoaster'; this term, described by Watkins and Baldo (2004), refers to the emotional scale of adverse effects that UI has on a person's day-to-day life, often moment to moment, making it challenging to prepare for. I direct you to the next re-remembered memory from *Marie's* journals.

**2004**

**"I bear witness. I memorialize. When I write"  
(Giorgio, 2016, 406)**

### **I Remember**

"Biochemical pregnancies (implantation and pregnancy occurs but results in miscarriage after 2-3 weeks) and chemical pregnancies (a pregnancy that is confirmed both by high HCG hormone levels and detection of a heartbeat from ultrasound or handheld fetoscope vaginal probe, that ends in miscarriage). The biochemical pregnancy rate and the clinical pregnancy rate increased by 11.41 % ( $p = 0.0068$ ) and 9.04 % ( $p = 0.0279$ ), respectively. The miscarriage rate did not differ significantly in comparison" (Máté and Török 2020, 512).

*...I remember... another IVF cycle begins, mustering up hope; I desperately need hope. From the many failures of trying to conceive, I try to pull myself out of a lonely, dark place, neither here nor there, the in-between. I've existed in this place for many years, unable to find a way forward and no way back to where I started. I live a double life: on the outside, I put on a façade of normality, doing my job even more efficiently than ever, my only escape from my ever-increasing damaging thoughts, my protection from the effects of fully living in the world. Work is all I have that moves forward. Everything else but me moves forward. I feel stuck in time while everything and everyone around me moves forward.*

“The success of an IVF cycle depends upon several factors: (i) properly performed controlled ovarian hyperstimulation, (ii) technique of oocyte fertilization, (iii) composition of culture media. A side effect of this surgical extraction of oocytes is that menopausal effects are highly likely to occur, consisting of hot flushes, anxiety, nausea, panic attacks, irregular heartbeat, depression, memory lapses, sleep problems and night sweats” (Muharram et al. 2021, 36).

*...I remember... thinking I an unwanted label, 'a tag', reminding me of Sophie Tamas (2011, 140) saying, "she finds fault in herself rather than the adequacy of the label" when "the labels don't quite fit but at least we have something to wear". My identity has merged into an unexplained (in)fertility patient as I spend so much of my time in reproductive medical clinics. I am lying in a bed in a ward with a number strapped to my wrist indicating the number of eggs collected from my ovaries. Do they really need to do this? I feel less and less like a human being each time I'm in here; it should perhaps be named 'The dehumanisation clinic'.*

“Drawbacks do still exist in these procedures in trying to induce multiple dominant follicles (eggs), causing issues with ovulation induction, even though drugs such as gonadotropins have been improved and are closely controlled in this crucial factor of IVF” (Abbara et al. 2018, 927).

*...I remember... subtly covering the number '20' written on my tag under my bed sheet as my hazy gaze is drawn to the woman quietly sobbing in disbelief in the hospital bed next to mine (there is always one woman sobbing). Like a small herd of cattle waiting... Eight women lay quietly in the stark, white-walled hospital ward, where the paint peeled like forgotten memories from the weary ceilings. Harsh, flickering strip lights cast a cold glow over the room, creating an uninviting atmosphere that felt heavy with unspoken stories and silent struggles. The egg (oocyte) retrieval seems to be going to plan for me. At least I have made it to this recovery ward, the other end of the operating theatre, where I can only hope my*

*eggs will be 'good enough' quality to hopefully form 'good enough' embryos. All of us [in this ward] are wearily recovering from this invasive procedure in silence. The woman quietly sobbing in the next bed has a '0' written on her 'tagged' wrist, meaning no eggs were retrieved; the invasive surgery has been in vain for her. I long for the energy to say something useful to her, but the anaesthetic is potent, although that heavy fog lingers, making moving feel like a distant dream; it is wearing off. I wish I could reach out to her somehow and comfort her. I know the drill here: the nurses will be doing their rounds as soon as we all start waking up, with tea and toast; the only good part of all of this. Plain old tea and toast never tasted so good after a procedure under anaesthesia.*

*...I remember... not being 'asked' how I felt or having a discussion about how I, or any of those other women in that hospital recovery ward with numbers strapped to their wrists, might be feeling.*

“Less than 4% of IVF patients will be affected by ovarian hyperstimulation syndrome (OHSS) during an IVF procedure” (Fauser et al. 2003, 238).

*...I remember... not being the woman with a '0' strapped to my wrist; I never was. However, I am one who was rushed to the accident and emergency (A&E) in the middle of the night, only a few days after my egg retrieval with 'ovarian hyperstimulation syndrome' (OHSS). I remember reading about the possibility of OHSS occurring following this surgical procedure and thinking, Well, that's not going to happen to me; the research I did stated OHSS only happens to 4% of women.*

“Ovarian hyperstimulation syndrome (OHSS), is a serious iatrogenic condition, predominantly related to the hormone used to induce oocyte maturation (multiple eggs) during IVF treatment and in most cases develops unexpectedly” (Fauser et al. 2003, 239).

*I remember... peacefully sleeping in my cosy bed at home, waking up gasping for breath and seeing... my tummy suddenly expanding to the size of a pregnant belly, as if ready to give birth to twins. Then there was chaos: the flashing blue lights and the ambulance siren's screaming. I was abruptly put in a chair while the other paramedic got an oxygen mask on me immediately... the breathing apparatus was pushed into my face. I'm claustrophobic, but it's chaotic, so I don't tell them. I sense the seriousness of it, and I just let them as I am still struggling for breath. What is happening? I am rushed into the hospital and urgently connected to larger machinery. I am now in the hospital being treated for something serious. I am informed that I will be here for a minimum of three days to be closely monitored and to reduce my swollen belly, caused by my extremely swollen hyperstimulated ovaries that pushed up all my other organs, causing the extreme breathlessness.*

“OHSS can cause considerable patient discomfort and other side effects (e.g., weight gain, headache, mood swings, breast tenderness, abdominal pain, nausea) and requires regular visits by the patient to the clinic for ovarian response, monitoring of complications” (Fauser et al. 2003, 238).

*...I remember... the ink lines drawn directly onto my tummy with an ink marker. I'm exhausted, but I can't sleep. During the night, the medical staff switch on the lights every hour, rushing in and out, drawing lines on my belly and checking my breathing. How busy they must be. I lie here feeling completely helpless, mentally*

*paralysed, yet grateful for this care I so desperately needed. I've spent so much time in hospitals and clinics these past few years that I have learned to engage and 'play' my part, ensuring I am as compliant as I can be.*

“OHSS is a serious complication of assisted reproductive technology, with potential for critical morbidity and death” (Whelan et al. 2000, 887).

*...I remember... three days later, showering at home, still shaken and saying out loud, “did that happen to me?” It was frighteningly surreal. Leaning exhaustedly against the shower wall, water pouring over my face and body, I glance down at the ink-pen marks on my belly, confirming it had actually happened. Everything stands still. I use all my strength just to keep standing up, listening to the flow of the water for a moment or two longer. It's Saturday afternoon, so I have time to recover before work on Monday, when I will pretend none of this even happened. This is going to hit me... hard... I haven't processed it yet; OHSS happens. It's real!*

“The use of these hormone drugs is not without danger” (430). When OHSS occurs, usually in the rare instance when 19 or more oocytes are retrieved in one IVF cycle it has a very serious impact on the patient's health” and “may cause severe morbidity, even mortality” (Abbara et al. 2018, 430).

*...I remember... that traumatic night, struggling for breath: I was suffering from a hyperreaction due to hormonal over-stimulation of my ovaries, which swelled to the size of two large watermelons. I am told that 'in my case', after receiving hormone drugs, my organs had been pushed dangerously close together, a result of producing an unusually high number of eggs for my age (20) as opposed to the expected average of 6 - 9 eggs, given my age. I am told my blood pressure was critically low, fluid was getting into my lungs and chest: this could have stopped my*

*breathing and possibly killed me. However, they confirm that ‘the good news’ is that there is no sign of thrombosis (blood clots) in my legs or lungs, another possible symptom of the severe OHSS I experienced. I pray this will not have happened in vain, and there will surely be a pregnancy at the other end following an embryo transfer with ‘good enough’ embryos.*

“The failure of up to 90% of apparently normal embryos to implant in the uterus following embryo transfer, is the problem to which IVF researchers must now address themselves if success rates are to be radically improved” (Fauser et al. 2003, 239).

*...I remember... the medical team being pleasantly surprised by my extremely high egg retrieval and later at my embryo transfer; they told me it was looking optimistic. I hang onto their every word: Once again, I’m filled with hope.*

“Potential reasons for implantation failure in the human are difficult to assess, primarily for ethical reasons” (Rogers et al. 1986, 98).

*...I remember... being ‘told’ two weeks after the embryo transfer “it’s a ‘failed’ cycle”. “No pregnancy”. “Take some time to recover and just try again, but we would advise not to leave it too long,” they said. I know they were yet again referring to my age. Another IVF cycle. Another £10,000 down the drain. All the damage caused. How did I end up here in this hell? Fail... Fail... Fail. I am a failure.*

“While it is probable that ‘failure to implant’ is due to a combination of embryonic and uterine factors, the relative contributions of these two variables have not been previously studied” (Rogers et al. 1986, 97).

*...I remember... I awaken every day feeling a lack of purpose. Emptiness. Less of a woman. Another day with no prospect of the child I yearn for. I cry into my pillow every night in despair, hiding it from my husband to prevent that conversation that starts with him telling me he's worried about me, another reminder that something is wrong... with me...*

*...I remember... failure after failure, no pregnancy, no validation of my loss, and no follow-up from the hospital, feeling more and more invisible.*

*Another piece of me broken*

*Gone*

*All in vain...*

**Ovarian hyperstimulation syndrome (OHSS): “No one dies of infertility. You just wish you could” (Feske, Participant quote, 2012, 31)**

Firstly, and tragically, people have died from infertility treatment, as confirmed by Tianqi Wang et al. (2021), who reported for The American Journal of Forensic Medicine and Pathology (2021). I refer to Ovarian hyperstimulation syndrome (OHSS), which is the rare but serious condition linked to assisted reproductive technology (ART) that *Marie* experienced, with severe cases leading to complications like pleural effusion and death, occurring in 0.008% to 10% of cases.

One example reported by Tianqi Wang (2021) and others was a 29-year-old woman who underwent assisted reproduction (IVF) with leuprorelin acetate and follicle-stimulating hormone. Three days after egg retrieval, she experienced

abdominal pain and distension, leading to her unexpected death. The autopsy revealed pleural and peritoneal effusions, enlarged ovaries, and dusky organ surfaces. Microscopic findings included haemorrhage in ovarian follicles. The toxicology screening was negative, and her death was attributed to severe OHSS (Wang et al. 2021).

Side effects from IVF and other ART procedures are typically menopausal effects and are highly likely to occur, according to *Marie's* experiences as well as those of my clients. These side effects include hot flushes, anxiety, nausea, panic attacks, irregular heartbeat, depression, memory lapses, sleep problems, and night sweats (Muharam et al. 2021), to name just a few, as described by the Medical Research Council (MRC), Wellcome Trust, and National Institute for Health Research (NIHR). They usually develop unexpectedly (Fauser et al. 2003). *Marie* experienced most of these during her ARTs. However, OHSS is known as an extremely dangerous side effect; it is the one that can be fatal, the one each patient desperately believes won't happen to them, as *Marie* believed, since the percentage is very low.

In 2002, statistics indicated that when *Marie* experienced Ovarian Hyperstimulation Syndrome (OHSS), fewer than 4% of IVF patients encountered OHSS during a procedure (Fauser et al. 2003). Sadly, *Marie* was among those affected. Since her experience, there have been updated reviews and ongoing research into OHSS. For example, Abbara et al. (2018) reported that issues persist in these procedures when attempting to induce multiple dominant follicles (eggs), resulting in challenges in ovulation induction despite improvements in drugs like

gonadotropins, which are carefully regulated throughout the embryo transfer process—an essential stage in IVF. Abbara et al. (2018, 430) state, “the use of these drugs is still not without danger.” They (2018, 430) explain that “OHSS has a very serious impact on the patient’s health” and “may even cause severe morbidity and potentially mortality.” Fauser et al. (2003, 238) recently described OHSS as involving “considerable patient discomfort and milder side effects (e.g., weight gain, headache, mood swings, breast tenderness, abdominal pain, nausea).” They (2003, 240) also emphasise the importance of regular clinic visits for “ovarian response monitoring and monitoring of complications, especially Whelan et al. (2000, 887) add that “OHSS is a serious complication of assisted reproductive technology, with potential for critical morbidity and death”. *Marie* received no follow-up from the hospital and did not seek help after her experiences. She also did not access counselling. I believe that counselling with an experienced infertility counsellor would have greatly supported her after this severe OHSS episode, not only in processing her losses but also in making more informed decisions about her future attempts to conceive. Instead, she was left unsupported and under pressure to proceed with further ARTs.

### **Should Unexplained (In)fertility (UI) exist? - A subject of ongoing debate**

This leads me to question the effectiveness of the term ‘unexplained (in)fertility’ (UI), as it is highly sensitive to the quality, number, and nature of tests involved, particularly given the overwhelming reliance on these invasive and costly medical evaluations (Kamath et al. 2012). Furthermore, I wonder whether the diagnosis imposes an unhelpful label, thereby exacerbating the situation for the diagnosed couple and the woman undergoing medical treatment.

I agree with Gleicher (2006) and Kamath (2012) that the rationale behind the UI diagnosis is contentious, triggering animosity as articulated by those diagnosed with UI in previous studies, due to the inability to follow the diagnosis with a specific treatment tailored to a woman's body. Furthermore, I maintain that the term 'unexplained (in)fertility' (UI) ought to be entirely discarded because of its reliance on the fragile and often inconclusive diagnostic tests performed, which render them ineffective (Gleicher et al. 2006; Kamath et al. 2012). Thus, I am not convinced that 'unexplained diagnoses' qualify as a diagnosis in the strict sense. Furthermore, whether enhanced diagnostic accuracy and reliability would improve the forthcoming prognosis remains uncertain. Gleicher et al. (2006, 195) state, "Even the best and most accurate diagnostic approach will leave some patients without a specific diagnosis. We would argue that such patients should be considered 'undiagnosed' rather than have a formal diagnosis attached to them. After all, they do not have a diagnosis".

The likelihood of achieving a successful pregnancy without IVF and other Assisted Reproductive Technologies (ARTs) for couples with UI is lower than that of normally fertile couples. It is only slightly above zero (Fertility Network UK, 2018). Studies of couples with UI observed without medical treatment reported pregnancy rates widely ranging from thirty to eighty per cent over a three-year monitoring period (Templeton et al. 1982). Given that pregnancy rates are higher without medical intervention, I would question: could UI be better addressed in a sociological context, without a diagnosis, but still retaining the option of assisted reproductive technologies (ARTs)? And now to the next re-remembered memory for *Marie*.

**April 2006**  
**Life is Great**

*I've been married for six years and am a member of a lovely Catholic Church and community. My career is going from strength to strength. I own my first hotel on the east coast of Scotland, and I plan to give up my corporate job at the agency soon. My husband is living his dream: a professional golfer in The Home of Golf. I'm busy workwise, as my hobby in property development has become part of my growing business. We just bought the perfect family home, ideal for raising children, with a fantastic garden overlooking the sea. I am grateful, but nothing I achieve seems to fill this gaping hole of longing, sadness, emptiness, harbouring of my dark secret of 'unexplained (in)fertility' and all that comes with it.*

*I have just scheduled the first of the three intrauterine inseminations (IUI). This medical procedure is recommended for unexplained (in)fertility to enhance the chances of pregnancy by placing specially prepared sperm directly into the uterus, a slightly less invasive approach than the other medical cycles I have endured, they tell me, allowing the egg and sperm to meet naturally, which they recommend I try following the OHSS ordeal. I do my best at building up hope again that I will need for a pregnancy to occur, remain, and develop to term. I am becoming accustomed to hearing and seeing the words 'failure', 'unsuccessful', and 'negative' all around me, since I hear them and see them written more frequently on my file at the medical reproductive clinic; all reminders that unexplained (in)fertility is an ongoing conundrum with no end in sight: there is no tangible medical problem to fix-all my reproductive organs are working perfectly but this perfectly working reproductive system of mine cannot seem to perform the very natural function it was created for.*

*Ever since I began wearing this label of 'unexplained (in)fertility', which even the medical professionals don't understand or are willing to investigate further, I have been left feeling I have lost my self somewhere along this journey; my agency, my power, my voice, my confidence, my dignity; my body no longer belongs to me; it is more often than not under the scrutiny of medical intervention in ARTs. Nevertheless, I must remain engaged and compliant with the medical team at the clinic since they hold the authority, and I must be seen to participate. Otherwise, it will be detrimental to me.*

*My first IUI is horrible. I enter the room, remove my clothes and underwear behind the provided curtain, as I do often at the clinic. However, I usually only take off the lower half of my clothing and underwear for the ultrasounds to check the follicles and egg stimulation, which doesn't feel quite as vulnerable. I put on the gown provided. As I do this, between the small opening of the curtain, I catch a glimpse of the examination table and the array of medical instruments lined up like tools of a medieval torture chamber. The metal stirrups loom ominously around the table, with large adjustable lights also positioned around it in the centre of this cold, sterile room; everything is metal and looks cold to the touch. I wince at the sight of the speculum; its clamping mechanism is designed to widen or reduce in size inside a vagina; why? I quickly look away, wishing I hadn't seen it.*

*The room was already extremely bright due to the extra-large, bright ceiling lights. The clamps on the metal stirrups will lock my legs in place, keep them wide apart, and hold them up for this twenty-minute procedure. The nurse explains that once the speculum is in place, a catheter will be inserted to transfer the freshly*

*prepared sperm into my uterus. I can't believe I'll be awake for this. No anaesthesia? I feel a wave of panic. I have done this before for embryo transfers, and it never gets any easier. I need to work hard at calming myself. Are all of those horrendously looking instruments going inside me through the most private, intimate area of my body, and without anaesthesia? I try to distract myself, but I'm struggling to do it today. The nurse confirms there is no anaesthesia for this procedure, and she assures me she'll be there to hold my hand if I need. She reiterates that it's essential to relax during this time. Relax... during... this?*

*As the consultant enters the room, the medical team stands to attention, immediately following his commands. He doesn't acknowledge or address me; interesting, from feeling incredibly vulnerable to being dehumanised, like an object just lying helplessly on a table, like an animal caught in a trap, unable to run with my legs strapped into stirrups. I fix my gaze on the ceiling, repeating to myself, "I can do this. I can do this." I must relax, as the consultant needs to proceed with the procedure and requires me to be calm; otherwise, it will make it difficult for him to perform the transfer or even impossible, I tell myself. I understand, but why does it feel barbaric, like a torturous procedure for something I have done wrong. Why does it feel like I'm being punished. Okay... relax... impossible... ridiculous. No, come on Marie... relax... you can do this. We mustn't upset the consultant. I've seen that look of annoyance and disappointment on his face before when I've questioned things or tried to give my opinion. Nope, there is no mercy or empathy in these operating rooms; 'you know this by now Marie... be quiet, clench your fists and do not take your eyes off a fixed spot on the ceiling, you know the drill; you can do this,' I tell myself... over and over. But when the nurse locks my legs into the cold metal*

*stirrups, I feel helpless, trapped in this torture chamber; they've got me. My instincts scream to escape.*

*"Stop! I need to move my legs," I blurt out, sensing the cold clamping me open speculum being prepared for insertion. No, something like that does not belong in the most intimate part of my body. I shouldn't feel cold metal in there. I look at the consultant as if my head had been held in a clamp; I was so rigid. The consultant is visibly annoyed, he looks at the nurse and quietly signals to her to 'deal with me', the object on the table of torture, complaining, causing a fuss... how dare I. The consultant walks out of the room. The nurse obediently talks to me and explains again that I must relax if I am to go through with this. "Will you release my legs, please"? I respond. I now feel a mix of anger, regret, guilt and shame for causing this procedure to stall. But I don't think I can go through with it, this time... I'm so scared... perhaps I've had enough... is this it for me? No, I'm not a quitter...*

*Okay, I ask the nurse to promise she won't let go of my hand and that she'll pray for me during the procedure. She agrees. She is sweet, gentle and calm, and allows me to squeeze her hand tightly while she gently and consistently reassures me it will be over soon. She helped bring a human element to all of this. She showed me compassion during this 'procedure'. I appreciated it. The sperm transfer is completed, painfully and unnaturally. Once the speculum is out, I remain in the stirrups for another ten to fifteen minutes, which is compulsory after the sperm transfer in the hope that the sperm finds my eggs while my body remains in that position (the only natural part of this procedure). I apologise to the consultant for*

*interrupting the procedure. He merely offers a curt smile and nods before leaving the room again, no further words exchanged.*

*(They now offer general anaesthesia in most reproductive medicine clinics (RMC) for IUI transfers. However, it wasn't an option for me back then).*

## **May 2006**

*Only a few family members and very close friends know that we're undergoing more medical treatments this time. It's purely because the comments like "just relax, or go on holiday," and "just have a glass of wine", and especially "great that you're doing IVF; that's wonderful" are becoming too much to bear. IVF is the furthest from great or wonderful that one could imagine; it's horrible, unbearable in my opinion. Also, explaining everything to others is utterly exhausting, only to subsequently hear 'well-meaning' suggestions of what I should try to become pregnant and have a baby. With so many unexpected twists and turns in the ART rollercoaster, it's difficult enough to grasp it myself half the time. I'm reading extensively about fertility and UI; it's a minefield and very confusing, so I'm trying to understand it all first in order to get ahead of it. I'm also conducting my own investigations, as there must be a reason for not conceiving or holding onto a pregnancy to term, and I'm trying everything I can to uncover it. However, each new piece of information sends me off on another wild goose chase, but I'm certain I will find something if I keep searching. I have an appointment at the hospital later.*

*I walk up the stairway at the medical school clinic for reproductive technologies, past the sea of baby pictures covering every wall. This again! It certainly doesn't get any easier, trying to avoid looking at them and feeling that rush*

*of sadness and failure; what a powerful combination. Then I remind myself, as the sadness, sense of alienation from womanhood and stigma wash over me like a wave, that I must work harder at building up that hope again; I must find a way! I am about to embark on my second IUI. Fourteen days after the first one, the cramping and signs appeared, followed by my period. I am not pregnant from the first attempt at IUI. This simple walk up a stairway for me is so challenging, and that's just getting to the clinic reception.*

*Nevertheless, during each ART cycle, I need to grit my teeth, try to avert my gaze away from the baby photos and 'walk this walk' every other day again for two weeks of this month. It always makes me feel like a desperate, hopeless failure, getting it all wrong, with my mixed emotions going into overdrive. Is there a back door into this clinic I could use?*

*When I reach reception, I am handed a ticket with a number on it, as if I've just arrived at Ikea to make a return. They call your number when they are ready for you. I understand it's to protect our identities by not calling our names. We sit in silence, anxious, like cattle waiting for the slaughterhouse, not speaking, just sitting, trying to avoid eye contact with anyone else. If you happen to make eye contact, you offer a knowing, awkward half-smile. We are all here for the same thing—some form of ART—and yet nobody talks to each other or about it. There will be scanning, checking follicles, closely observing the medical professionals' expressions as they measure each follicle, and desperately awaiting their words, typically beginning with either "good news..." or "unfortunately...": follicles growing or not, everything going to plan... or not... It's always such a fine line between it going great or disastrously.*

*Then, we either ecstatically or hopelessly take prescriptions for the next batch of drugs, depending on what we are told in that fateful scan room. Something feels off about being given a 'ticket' on arrival. You'd think I'd be accustomed to it by now; I've been here so many times.*

*Sitting with the consultant for the first time following my first IUI, he opens my file, and there it is in bold: **UNEXPLAINED INFERTILITY**. It generates anger in me to see it; it disturbs me, this excuse for a diagnosis. He confirms that my IUI 'failed', marked in my file as 'unsuccessful'. He can barely make eye contact with me; it's very unsettling. I ask him why he thinks it 'failed'. I almost expected him to say it might be because of all the fuss I caused during the procedure, but he doesn't mention that. Neither do I; the big pink elephant in the room. He said the first round of IUI often fails, which is why they recommend giving it at least three rounds before moving back to IVF. But why does it often 'fail' in the first go? Ah, yes, they don't know. That's the answer, they don't know. Does this guy hate me or is he just naturally socially awkward? It feels strange sitting across his desk from him. The only reason I stay with him is because his success rates are higher than those of every other consultant in my location. Perhaps he is an introvert who gets the job done. No talking or questions; got it. I will make an effort to be more silent around him and comply; be a good patient.*

*I consider for a moment mentioning the language used and written in my file, such as 'failed' and 'unsuccessful', even to joke light-heartedly about it being the first time these words have been used against my name, letting him know I have not been a failure or unsuccessful in my life... until now. However, I think better of it and*

save it for my journal. He would only give me one of those looks that would make me feel like a non-compliant patient; his expression, if it could speak, saying, "Really, that's your concern when there is so much else you ought to be worried about instead?" I would then awkwardly apologise and start backtracking, and as soon as those words might have left my mouth, I would have felt regret and realised how silly they must have sounded. I inwardly congratulate myself for keeping these thoughts to myself. I have been diagnosed with **UNEXPLAINED INFERTILITY**; it's a cop out; what does this mean? I remind myself yet again that I must be seen to be engaging with all this.

In these thoughts, I realise that I have started to think of this consultant as a 'God-like-God-fearing' creature, and I mustn't upset him; He has so much power over my fate, my dream of carrying a pregnancy to term. My future lies in his hands. It's unnerving how little he communicates with me/us as a couple (when my husband is there). Some nurses have indicated that it's just how he is, that he is like this with all his patients, and that he likes to get on and get the job done; so he doesn't just hate me. I feel awkward sitting in consultation with him; even more so than when his head is between my thighs, shining a massive spotlight up 'there' in my most intimate space during medical procedures. I believe he should communicate better with his patients, or just communicate, and show some compassion. He makes me feel like a deviant who is getting it all wrong, or is that more my inner dialogue that he triggers?

On the journey back to work, I practice my once-natural smile that will give absolutely nothing away to my colleagues about where I have just been, and that I have been putting all my energy into believing I was pregnant from the first IUI, only

*to find out I'm not... again. I am drowning in emptiness and hopelessness... adding it to the list of failures my life now seems to be. I start a new cycle of talking myself into building up that hope again that I desperately need for this next cycle to work. I've worked hard at masking my feelings and disguising the emptiness within, which grows stronger each day. I feel angry, like there is an injustice in all of this... It's taking so much from me...*

*I'm struggling, but I need to box all of that up and put my feelings and emotions to one side for now, as I need to focus on the here and now: this upcoming IUI. This consumes me; it takes all my time and energy. This string of 'negative pregnancy test results gets longer and amounts to 'no baby', all medical tests showing no reason for not conceiving amounts to 'no baby', following a good diet and exercise programme, no sugar, no alcohol amounts to 'no baby', producing 'good quality and plentiful eggs and sperm' and implanting 'highly graded' embryos = 'no baby'. Now, IUI amounts to 'no baby'. My life as a UI patient leaves a trail of negative test results in its wake. Being a UI patient is laden with failure. UI is a biomedical way of claiming 'we can't find anything', but instead of staying with 'not knowing' and investigating further, the medical model has packaged this 'not knowing' as a 'knowing'; we 'know' what this is, it is 'unexplained infertility' (UI) – 'so that's our diagnosis'. It's all just smoke and mirrors - a magic trick - a way of turning uncertain into something certain, the unknown into the known; just like that, ta-da!*

## **The Interplay of Identity, Emotion, and Medical Discourse**

*Marie* desperately needed her consultant to listen to her, talk to her, and understand her, show her empathy; instead, she felt dehumanised, invisible, and ignored. It seems *Marie* was treated like an object, a subject under the consultant's medical gaze. She rightly expected and hoped from the beginning of her medical treatments for communication, compassion, and understanding from consultants and medical professionals in reproductive medicine centres. However, other than a few kind nurses, this did not happen, and she gradually became the silent, compliant patient. Jyotsna Agnihotri Gupta and Annemiek Richters (2008), scholars in bioethics and gender studies, discuss the fragmented body and the commodified body in relation to ARTs, and the integral relation between these two aspects of the body in Western medicine. Gupta and Richters (2008) explain that due to their professional responsibilities, doctors who specialise in infertility often struggle to empathise with their patients, failing to fully grasp the emotional pain and suffering they endure. Consequently, the potential of women's reproductive capabilities becomes a "coveted area for scientists, an uncharted territory that they can meticulously map and explore, seeking to manage and control it scientifically" (Gupta and Richters 2008, 245). In this context, Sarah Franklin (2010) furthers that ART is frequently likened to a hybrid technology that envisions conception as an in vitro replication of 'natural existing biology,' heralding a new era of 'artificially created' bodies that are simultaneously real and not representing improved and redesigned versions of biological existence. Janice Raymond (1995), a feminist scholar specialising in women's health, argues that women are subjected to excessive reproductive technologies, often leaving them devastated by treatments such as hormone drugs and IVF. She (1994, 14) even states that "reproductive technology is itself the

disease,” contributing to the ongoing medicalisation of women and creating problems that can be worse than the original infertility.

I wish I could have reassured *Marie* that non-judgmental support was available in counselling to assist her in navigating the myriad of emotions associated with the effects of her UI diagnosis and ARTs experiences alongside this lack, even an absence, of empathy and understanding of the physical and emotional turmoil *Marie* was experiencing during the dictatorial approach of the consultant and medics surrounding her during the IUI and other ARTs, such as her IVF and Intracytoplasmic Sperm Injection (ICSI) (A single sperm is injected directly into an egg) to achieve fertilisation cycles. These experiences gradually stripped her of her agency, her voice, and her sense of womanhood-previous reproductive identity (Athan 2020).

Moreover, I would like to have explored with *Marie* at that time the varied emotions arising in her as she struggled to comprehend these lacks that she thought would be available to her in medical environments, which also represent stages of disenfranchised grief, starting with the troubling diagnosis of UI and its ongoing effects. These invisible losses are unacknowledged by her society (Doka 2002). In the medical environments where she has spent so much of her time, they did not provide the much-needed attention to the emotional impacts of becoming a UI patient and undergoing these very challenging invasive medical treatments, offering no preparation at all. Of course, recognising that these emotions form part of the grieving process would not eliminate her pain. However, counselling through these experiences would have helped to name and validate her feelings while providing her with the tools to acknowledge that those losses occurred, they were real,

allowing better preparation for these invasive medical procedures, in a safe and trusting environment with a counsellor who specialises in infertility and UI, coaching her through the medical procedures, guiding her, establishing goals and limits on medical treatments.

I come back to the potential benefits of naming feelings. This brings me to Brene Brown's (2006) research, which suggests that moving forward from a difficult place and healing is deeply connected to recognising, naming, and understanding emotions as a part of lived experiences. Consequently, identifying these emotions might have helped *Marie* connect with them more effectively. However, while Brown's (2006) approach to naming emotions is practical, some individuals may find a medical label reassuring, which I understand. I wish I could extend the same sentiment to naming the UI diagnosis. To be labelled with the UI diagnosis has caused *Marie* to experience profound anguish, along with stigma, and a rupture in her identity; her reproductive identity (Athán 2020), a transformation into a patient identity, and sheer hopelessness. I believe the purpose of a diagnosis is to provide certainty. The 'unexplained' aspect became *Marie's* enigma; the term unexplained means no solution. Even in cases of infertility where a medical problem is identified, such as a blockage in the fallopian tubes, a solution is available, which may involve a minor medical procedure to unblock the tubes or, in more severe cases, remove them, thus allowing the individual to proceed to the next stage. *Marie* would have preferred to remain undiagnosed (Gleicher et al. 2006) if it meant retaining some hope by avoiding immediate patient status.

Like Foucault (1973), Conrad and Schneider (1980) used the term 'medicalisation' to show how certain behaviours become linked with discussions about health and illness, influenced by the authority of medical institutions. Conrad and Schneider (1980) argue that a condition increasingly recognised as a medical problem is 'unexplained' (in)fertility; this refers to a couple unable to conceive after twenty-four months of regular unprotected sex without any medical symptoms being identified, as described in the biomedical framework (1980). While I acknowledge that most issues addressed within the medical model are likely to lead to medicalisation, I agree with Arthur Greil (2010) that 'unexplained' (in)fertility (UI) should be seen as a socially constructed 'process' rather than an illness. Sufferers, professionals, and others could negotiate this process within a sociocultural context, especially since no medical problems have been found. As Greil et al. (2010, 140) explain: "sufferers are seen by others and how they come to see themselves are both products of processes of social definition". Foucault (1973, 123) describes diagnosis and illness as perceived through the medical gaze as "a system of relations and reciprocal actions, a functioning or a dysfunctioning". I interpret the 'unexplained' diagnosis/illness of infertility as Foucault (1973) describes, exploring the relationships between the components of a known illness and then between a known illness (infertility) and an illness yet to be understood.

Furthermore, experiencing UI and ARTs "can lead to feelings such as shock, fear, unfairness, anger, a sense of being marginalised or stigmatised, a complex grieving process, the perception of becoming a victim in this experience or the 'cause' of longing, along with cultural factors" (Conway and Valentine 1988, 43). I wish *Marie* had known that counselling could have assisted with these issues. Grief

related to infertility and UI can be perceived as a process that may “require ongoing mastery of coping strategies and support” (Hart 2002, 32). Harris and Daniluk (2010) suggest, for instance, that UI patients found certain coping rituals beneficial, such as naming and discussing their unborn child following a miscarriage, as this validated their grief and made their loss feel more real. Ultimately, there lies the overwhelming loss of *Marie*’s ‘assumptive world’ to explore and derive meaning from (Burns and Covington 2000, 25), which could have aided her in finding acceptance in her grief and enabled her to move forward.

### **September 2006 My Gruelling Regime**

*My ongoing holistic routine in my efforts to improve my fertility has become all-consuming; it’s all quite miserable. For years now, with only short breaks from this at times, but mainly when I’m going through a medical cycle, when I’m not busy preparing my concoctions of Chinese herbs, I focus on my strict sugar-free diet, practise meditation/pray, consult with a nutritionist, and use some homoeopathic remedies to try to keep my hormone levels balanced. I have researched both Eastern and Western methods for fertility issues, and I have my own carefully designed combination of these practices, which include acupuncture and fertility-focused reflexology, all financially costing a small fortune.*

*I provide each practitioner with a comprehensive list of everything I am doing and consuming, including the supplements and herbal tinctures I take alongside others, ensuring there are no conflicts. Additionally, I receive regular chiropractic adjustments to alleviate the stress in my nervous system, which I learned through my*

*research; this does help to relax and release tension from my reproductive organs, especially my womb. I incorporate all these strategies leading up to and during each Assisted Reproductive Technology (ART) cycle, particularly IVF and ICSI, to maximise my chances based on everything I have learned. I seek out and explore every book or journal on fertility impairment that I can find. Consequently, while I have become physically healthier, I have not managed to conceive again and carry a pregnancy to full term. When I started on this road, I believed as I was advised by the medical professionals, that UI meant having to engage in ARTs, which would lead to pregnancy and a baby; the solution to my problem. I have always been solution-focused, and it had always paid off. Problem: find the solution, execute it, do the work, and it will be resolved. My hard work would mean the result I desired. Not this time, UI has got me; ART is offered as the solution, but it turns out it's more of a gamble—a roll of the dice, a spin of the roulette wheel. And I have never been much of a gambler...*

*You might tick all the boxes, for example in my last IVF cycle, a perfect number of eggs is collected-around fifteen, all great quality-check, sperm dropped in by visiting husband, high quality and motile, great job husband, your work is done here-check, lab work carefully executed by embryologist who has chosen the best looking eggs and sperm to meet, flirt and impregnate in a petri dish-check, three grade A embryos form beautifully in the dish and continue doubling in size to blastocyst at which point they are text book perfect for pregnancy. They are transferred into my uterus at which point I also have a perfect endometrium lining thickness, which has been checked every other day, and thanks to the hormone drugs, by ultrasound to ensure it is thick enough for those precious embryos to grab*

*onto and continue growing. The HCG test is arranged for two weeks later when a blood test is arranged at the clinic to see whether you are pregnant or not-check. If you are pregnant, the HCG levels will be tested every week by blood test for the first six weeks at the clinic to ensure that they are doubling in numbers, and if they are not doubling, there is a high risk of miscarriage, and you are highly aware of it. Women who have become pregnant naturally know nothing of all of this. They miss their period, do a pregnancy test, and have already passed this stage, oblivious to all that is going on in their bodies, how delicate it all is. How wonderful not knowing would be.*

*Having become a pro at the 2-week-wait, I do all I need to do, meditate, pray, gentle walks in nature, spend time alone away from all the business and stresses of life-check. Yip, this is the one, even all the medics think so, the embryologist seemed sure, and the nurses seem excited about this one, joking with me about having twins or triplets; my dream, getting more than one baby, all in one pregnancy! I keep that thought firmly in my mind for the whole 2-week-wait-check. Two weeks later, I visit the clinic, undergo the blood test, and leave. I eventually get the call from the consultant three hours later, having kept my phone firmly in front of my face the whole time, ensuring I do not miss that fateful call, praying this is the one; my turn.*

*Negative-no pregnancy. "Why? Everything was perfect, wasn't it?". "Yes, it was", says the consultant. He used the same explanation as before: even with top-grade embryos, as they appear on the outside, they cannot see what's underneath, and if they were chromosomally defective, they would not continue to grow. He also said we could implant a grade B or C embryo and get a perfectly healthy pregnancy.*

*Wait! So, to add to my concerns, I now need to worry about whether the right embryos are being implanted. Perhaps a mix of grades next time? This really is just potluck, then? He finished the call by advising me to get some rest and call after my next period to take things from there. Right, okay, thank you? My body deceived me once again. Was it my fault? Was it because I secretly did a pregnancy test at home the night before? They say not to, as it can be misleading, but I did. I couldn't stop myself. It was negative, but I thought that was because the HCG levels (pregnancy hormone levels) in my body would not have been high enough yet. Each call I have received from the clinic like this devastates me. It's the death of my dreams. I carried these embryos safely in my womb and my heart.*

*It feels hopeless. Am I losing this battle? What will it be next time, red or black? I'm a low-risk, all-in, do-the-work-and-get-results, dead-cert kind of person. Perhaps I am just a failure. But I have never been a failure.*

**December 2006**  
**Another wedding invitation**

*I now have a phobia of all social events that I once enjoyed, particularly weddings. There are always babies at weddings; people asking me/us when we'll start a family is the worst. Oh, how I dread weddings now. I can't believe it; I have been put beside a heavily pregnant woman at dinner. What are the chances? What can I expect when the couple getting married (one of them is my friend and colleague) doesn't know anything about my UI? There's nothing I can do now except grit my teeth, smile and hope she doesn't want to talk about her pregnancy. Nope, no such luck; her pregnancy was pretty much all she talked about. Just when I thought it couldn't*

get any worse, **she** poured herself a glass of red wine, “I just have the one, and just add plenty of water”, she said, smiling as she continued talking me through her whole pregnancy story with not a worry in sight. **I'm** the one drinking sparkling water, in my giving up of alcohol, to give myself a better chance of conceiving. Am I just getting this all wrong?

*I wanted to tell her how damaging that ‘watered down’ red wine was for her baby, even at this late stage in her pregnancy, as I had read so much research about alcohol and pregnancy and the risks, one of which was even the smallest drop of alcohol might cause blindness in the unborn child or severe sight defects, for example. I wanted to tell her how dangerous it was to be drinking alcohol during her pregnancy and explain all I had learned in my years of research about how delicate a pregnancy is, even right up to the delivery of the baby. Instead, I smiled and tried to change the subject, concealing my anger.*

### **The Assisted Reproductive Technology (ART) Factory**

*In these ongoing experiences in and out of reproductive medicine clinics, I feel less and less like a woman and more of an object with no identity, left wondering about my possible future identity: Mother or Other? What will I be if my reproductive organs continue to fail me? I know my heart can't handle not being a mother. I think of my lost dignity as I leave it at the door of the clinic every other day as part of my routine for two weeks of every month during treatments, before I undress and bear what was once my most private self to strangers: radiologists, sonographers, nurses, doctors, and consultants. They witness my shame for failing at the very core of being*

*a woman, first-hand. I have left my dignity on that doorstep so often now that I might have eventually forgotten to pick it up again on my way out.*

*Along with the other women at the clinic, we are probed, examined, scanned, injected, our struggles to get pregnant medicalised, and physically invaded in the most private areas of our bodies, our vaginas. Each time something metal, cold, and very unnatural is inserted into me, another part of my dignity fades into the horizon. Husbands and partners visit the clinic occasionally to drop their sperm samples or wait, hang out there looking at their phones or laptops, as even when the infertility is a sperm issue in a heterosexual couple, it is the woman who will endure all the medical treatments, her body.*

*I leave my agency, my power, my voice behind as I walk through those doors and up the stairs of the reproductive medicine clinic. My body and I have become an object, another cog in the factory wheel of reproductive medicine. I never imagined it would be like this: being dehumanised, objectified, and silenced by UI and the medical world of ARTs, starting with that first appointment with the GP those years ago, where he so chirpily and light-heartedly informed me that we (I) would go onto the IVF waiting list without discussion, question, or preparation. If only I had known what that world entailed and what it would have done to me. "Great news" he said. I now liken the reproductive consultants and doctors to Adam and Eve in Genesis: God gives them the power to name all things and thereby gives them dominion over all things. They claim the power to name in order to give themselves dominion over everything related to the human body.*

*I find myself caught in a relentless and cruel wave of hope, loss, sadness, anger, anguish, shame and stigmatisation, with no way forward and no way back. I feel trapped in the medical world of ART. I'm not sure how I got here. As I withdraw into the secrecy of it all, along with social isolation, this world of reproductive medicine seems to be all I have left, other than my work. How do I shield my heart from further pain? Despite my efforts to cultivate hope, I feel it slipping through my fingers, leaving me increasingly despondent.*

*...The heartache feels overwhelming.*

*The loss-and-hope roller coaster is becoming unbearable*

*I have never felt so alone...*

### **Caught in a Trap: The Medical Gaze and the Quest for Motherhood**

*Marie's* gruelling regime demonstrates how thoroughly she has done everything she can to contribute to trying to conceive. It feels like the only aspect she *could* control in her UI journey, while medical intervention took control of the rest of it. Moreover, I would like to acknowledge that *Marie* felt increasingly isolated and lonely. She felt she could not talk to anyone. I can understand her anger at seeing the heavily pregnant woman sitting beside her at the wedding dinner drinking red wine, albeit mixed with water. *Marie* has made it her mission to discover and implement all that she can do to support and care for her health while undergoing ARTs such as IUI, IVF, and ICSI. It is no surprise to me that her anger intensified upon witnessing a pregnant woman drinking wine. She had invested a great deal in her efforts to conceive. *Marie* also explains that she feels objectified and like a cog in the machine

of the ART factory. She had no idea what she was walking into, and without preparation, guidance or even a discussion on whether she or her husband would want to go down the road of medical intervention in the first instance. It felt like her agency was claimed by the reproductive medicine world there and then, as she walked unknowingly and ill-prepared into the completely unknown world of ARTs.

Feminist medical researchers and writers, Barbara Ehrenreich and Deirdre English (2011, 3), argue that “medical science has been one of the most powerful sources of sexist ideology in our culture”. They characterise the medical profession as a patriarchal institution that discriminates against women “by taking control over areas of women’s lives, such as pregnancy and childbirth, which were previously the domain of female lay practitioners and midwives (Ehrenreich and English 2011, 4). Deborah Steinberg (1990), a researcher known for her work in the field of reproductive medicine and ethics, discusses how procedures like IVF can lead to the depersonalisation of women. She emphasises that “the history of medical science, particularly in obstetrics and gynaecology, has been the history of abuse and injury for women” (Steinberg 1990, 76). This certainly feels like it fits *Marie’s* narratives from her journals.

Arthur Greil (2002, 109) notes that “entering the medical system puts these women in a contradictory position” as “the process of undergoing infertility treatment is marked by feelings of frustration, loss of control, and humiliation”. He addresses the significant depersonalisation that comes with infertility treatment, suggesting that women perceive it “as an intrusion on their personal integrity” and are “highly critical of their doctors for neglecting the human aspect of care” (Greil 2002, 113). I hear in

*Marie's* vignettes her wondering how she got there, trapped in ART, the world of medical intervention, and we might wonder, how does one find themselves trapped there, and how do they know when to stop? As *Marie* initiates, it begins an innocent journey in which she is ready to 'fix a problem' by utilising a solution; the solution she was led to believe was ARTs.

However, it transpires that IUI, IVF, and ICSI are more of a gamble, and therefore, *Marie* was compelled to 'keep trying' despite the hardships and risks involved physically, emotionally and mentally. Greil (2002) speaks to the risks linked to medical advancements, especially in reproductive health. He (2002, 113) adds that women often feel "compelled to utilize new reproductive technologies," which can lead to the conclusion that they are "more exploited by these technologies than benefiting from them". Greil (2002, 101) also argues in the context of reproductive medicine and infertility that women inevitably face "medicalisation of infertility, a *fait accompli*" leading to their bodies being often subjected to the medical gaze... as flawed machines requiring expert intervention, being viewed through a clinical lens. Putowski (2004, 2) states that following their critical study of the medicalisation of infertile bodies, they learned terms such as "living laboratories", "hope technology", "mother machine" and "baby machine," and examined how these terms impacted people experiencing UI, seeing them as cogs in the wheel of reproductive medicine and ART; they state, "biotechnology perpetuates the eighteenth-century biomedical metaphor of the body as a machine with replaceable parts allowing for the replacement of perceived 'flawed' body parts, further objectifying them".

This brings me back to Foucault's (1973) concept of the 'medical gaze' and the medicalisation of something 'normal'. Shaw (2012, 112) draws from this "surveillance of the body is not only a question of controlling women's reproduction, but also a fundamental component in understanding modern femininity as it is experienced by women". Menstruation, menopause, pregnancy, childbirth, and nursing are just a few of the essential and natural female reproductive processes that have been medicalised and associated with "illness" or "disease". Shaw (2012) further argues that whether in the context of scientific research or the increasing medicalisation, medical science has emerged as the language of the body, lacking any human influence.

Moreover, Steinberg (1990) discusses the effects of IVF treatments on women, involving the alteration, removal, and reconfiguration of body parts, as well as the overall impact on women's bodies. In contrast, within the context of IVF, erasure refers to processes that complicate or exclude women from recognition. Consequently, she (1990, 77) states, "within the context of IVF, erasure and recombination operate to depersonalise, that is to fragment, alienate and injure, women". In other words, the "imposed visibility" of women's bodies during IVF procedures results in a "literal and conceptual transfer of women's private domain (their bodies) into public commodities, the disembodied property of medical science" (Steinberg 1990, 86).

On the other hand, Sarah Franklin (1997) argues that, despite the high rates of failure, physical difficulties, and the significant financial, emotional, and psychological burdens, women persist in pursuing treatment because IVF offers an enabling

aspect that sustains the hope of conception. However, given the ongoing debates surrounding infertility and the declining conception rates, it appears that Artificial Reproductive Technology remains the only practical option for prospective parents. Franklin (1997, 165) states that IVF is conducted as a “way of life” with competence and expertise, a recognition that must be weighed against valid concerns regarding IVF as an approach to treating infertility. However, Franklin (1997) does add that people initially feel hopeful and confident when starting ART, only to face ongoing challenges as they go through the stages of treatment, and confirms this can lead to confusion and unhappiness as they often struggle to navigate the processes of ART.

I agree with Kashyap and Tripathi (2025), as they argue that, firstly, infertility is mainly seen as a women’s issue, which sustains societal stigmas. Secondly, although women may have the option to pursue Assisted Reproductive Technology (ART), financial constraints often limit their access to these treatments, reinforcing the notion of ART as an elitist technology. I also concur with their conclusion that the disparity between how technology is portrayed, and the actual experiences of individuals is a significant issue, particularly in the realm of Assisted Reproductive Technologies (ARTs). There remains a persistent gap between women’s real experiences with these technologies and the idealised images of them as a ‘hope technology’ or a societal source of ‘happiness’. Infertility/UI, despite being one of the most common pregnancy-related health issues, is frequently overlooked in personal stories and popular culture. The teleological narratives surrounding reproduction and the utopian ideals of motherhood contribute to the invisibility of infertility and UI in mainstream discussions, complicating conversations around the topic and causing considerable emotional distress for those affected. In this ‘technological’ context, I

think of ideas or stories, like *Marie's*, that aim at a specific goal of having a baby. In reproduction, this suggests that society and reproductive medicine clinics expect this to lead to the ideal of motherhood. These ideals can create a framework where only successful pregnancies and motherhood are valued, rendering infertility and unexplained (in)fertility (UI) less visible or even ignored in mainstream debates. This invisibility can make it difficult for those suffering from infertility and UI to find support and understanding, resulting in greater emotional distress and, as *Marie* experienced, becoming a silenced patient.

Finally, considering *Marie's* tumultuous journey through loss and hope in reproductive medicine, where she lost her agency, control, and power, it is understandable why Florencia Herrera (2020, 385), a scholar studying reproductive issues from a sociological and Catholic religious perspective in Chile, explains that “to define their boundaries, prospective parents turn to both God and nature, viewing them as part of a transcendent realm that exists beyond human control”. Therefore, as I now turn to Chapter Four, I wonder, with *Marie's* loss of faith in reproductive medicine, will God intervene?

## Chapter Four

### Fertility & Faith: Loss

“If God is quick to bless, then why does He withhold joy? To rationalize His promise, the barren woman thinks either she is currently living in sin or she has displeased God”.

(Feske, 2012, 5)

#### **August 2004**

#### **The pregnancy chair:**

*I have been relocated to a different location in the agency where I work as a recruitment consultant. A lovely bunch of people I will be sharing an office with. I'm settling in well. I can tell the Director is impressed with me. I have exceeded my targets and already made good, solid placements. I overheard her telling our Regional Director how this agency is now 'cooking with gas' since Marie came on board. Yes, I like Kim's upbeat attitude, the director here. We get on well and laugh a lot together; she's intelligent and bubbly. I particularly like that Kim doesn't have kids, so I feel safe knowing I won't get stabbed in the heart during general conversations, no talk of kids and babies! Kim is single. We are both childless and around the same age: 36.*

*On my first day, when Kim showed me around the office, she warned me light heartedly as she pointed to an empty swivel office chair behind a desk: “Don't sit on that chair, though. The last three people who sat on that chair got pregnant and left. So don't you dare sit there, we don't want to lose you to maternity leave anytime soon”. As my eyes fixate on that ordinary-looking chair that looks the same as any*

*other office chair, we both throw our heads back in laughter, and I swiftly pull my eyes away from the chair and respond, "You won't catch me sitting there then". I hope she didn't notice my fixation on the chair.*

*So, what do they know about me here at this agency? I have a strong, proven, and successful background in sales and marketing. Their clients will be in capable hands with me. I will earn the commissions. I am committed and trustworthy. What they don't know about me is that I carry a dark, shameful secret everywhere I go: the heavy burden of the ball and chain that is my unexplained (in)fertility (UI) and the medical treatments I endure; the lies I tell my colleagues about where I'm going when I'm actually heading off to the reproduction clinic for IVF appointments every other day... the façade; the double life I lead that creates so much shame to arise in me.*

*They also don't know that after everyone leaves the office late that afternoon, when I stay behind to organise my desk and workspace, I can't help but fixate on that chair again and think, "What if that **is** all I need to do, just go over and sit on that chair? What if I had stepped into some magical fairy-tale-like place where "chairs" can create pregnancy by simply sitting on them? What if God had guided me here to sit on that chair, destined to be the answer to all this suffering? I've tried everything: reflexology, acupuncture, giving up sugar and alcohol, working out/training, extremely restricted diets, meditation, walking in forests, walking on beaches, practically giving up my social life to preserve my energy, working on manifesting my body to look after, protect and nurture any small chance there might be a tiny embryo in my womb, giving this possible beginning of life a fighting chance to cling on to the*

*lining of my healthy womb, an inviting pollution free space of warmth, to grow. I even gave up cold drinks, only warm drinks for my uterus and womb, especially when I was in the '2 week wait' period after embryo transfers of IVF cycles, of which I would be starting another soon, and that I would keep secret from my lovely Director and colleagues here; the guilt and shame growing even stronger just thinking about it. I will lie to them when I go to my appointments at the clinic, telling them it's somewhere else I'll be at those times; keeping it all secret makes me feel deviant; they don't deserve this; I already feel bad about lying to them.*

*So, what if all these invasive medical procedures and holistic practices I follow are not the answer? What if this was God's way of offering me an opportunity to take all my longing, suffering, guilt and shame away by simply providing me with 'the pregnancy chair' as a gift so that I would stop my devious ways of meddling with medical interventions, offering me a way back to my Catholic practices without the guilt, shame, and stigma? I try to put it out of my mind that IVF and all ARTs are forbidden; they are wrong, but the shame and guilt always win. Perhaps God is saying, "Okay, enough suffering. I will send you a chair. Go sit on it, and you will get pregnant"? That's it; God always finds a way for me. The promise of a magical trinity, the promise of a miracle. This must be my destiny, divinely orchestrated by my Almighty God. If sitting on that chair and embracing the possibility of pregnancy is part of that plan, then who am I to argue? Okay, stop, I say out loud – I laugh out loud in a slightly crazy way and tell myself this is just a ridiculous and desperate thought and to forget about that silly chair; it is just a chair, no different to any other. Of course, that chair had nothing to do with those other women getting pregnant – I say out loud again.*

*Before I can stop myself, I walk over to that chair, sit firmly on it, and swing around like a child on a roundabout in a playground. Before I know it, I am crying out all that is aching in my heart. As I swing around on that chair, I pray for this unexplained (in)fertility (UI) to be taken from me as my gentle tears turn to sobbing.*

*I sob, in anguish, exhausted from the facade I must uphold, feeling compelled to wear a mask to get through each day. I sob because my life feels like a lie, a hollow existence that betrays my true self. I sob, weighed down by shame for what I have become, struggling with a grief that hangs like a dark cloud, ever-present and suffocating. I sob in private, knowing I cannot share this pain with anyone. I sob because the chaos of my emotions defies understanding, and I feel utterly alone in my struggle. I sob because I feel robbed of my lifelong dream and plan to have a baby and my own family. Day by day, it slips away, a little further.*

*I pray to return to my life as it was before UI, for the relentless pain in my heart to disappear... nothing feels real or certain anymore... each day begins with a cloud of doubt, cloaked in the unknown. I beg you, God, to grant me just a glimpse of purpose and joy once more—even a tiny flicker. I need a reminder of what I have not felt in so long.*

*My mobile phone rings and cuts across my thoughts and sobbing. It's my husband. I can't remember ever crying like this before. I quickly wipe my face and try to put on my best 'I haven't been crying' voice. He sounds cheerful. I manage to pull it off... he hasn't noticed. Having pulled my mask back on, I seem to sound okay,*

*report on my successful day, ask about his, then tell him I'm just leaving the office. I no longer share what is truly in my heart. Even if I did, it would only remind us of where we are with this: him wanting me to stop and leave it all in God's hands. Me, left feeling unheard, unseen, and once again not validated; so, what's the point? Anyway, I don't want to impose my dark cloud on anyone; it feels too heavy. We discuss dinner plans. After dinner, I share Kim's comments about the 'pregnancy chair' with him. He asks me jokingly, "Did you sit down on it?" to which I reply, "Of course not, how sad would that be?"*

*In my prayers later, I ask, is my belief system, which I've relied on since childhood, now inadequate? Am I naïve to continue to rely on my right to create the 'sanctity of life' I thought I had earned, deserved, and was entitled to purely by having the identity of a woman, a Catholic woman? Is a baby not to emerge from my married Catholic lifestyle? And, what if I fail? God knows, having children has always been my wish. God, please forgive me for whatever I have done to displease you.*

In this chapter, I explore the intricate and recurrently painful pilgrimage of navigating unexplained (in)fertility (UI) from the pillars of religious observance and faith. I contemplate these pillars through Catholicism's influence on social norms from my understanding and experiences of the Catholic family and the Catholic world around *Marie* in her struggle to hold onto hope through the sufferance of unexplained (in)fertility (UI). As I continue to draw on *Marie's* experiences from her journal entries – re-remembered memories, I provide a nuanced understanding of this emotional landscape by walking through *Marie's* shame and disenfranchised grief that set her

adrift in the uncertain waters of UI that led to a loss of orientation and ruptured identity as a Catholic woman and the life she had built around that.

Additionally, during *Marie's* twelve years on the inside of medical intervention that also stands shoulder to shoulder with UI, and exasperated by the principles of Catholic dogma, i.e., the Roman Catholic 'ban' on IVF, partly affected *Marie's* reasoning for why she kept her UI hidden in shame, resulting ultimately in the anguish she lived through that led to virtual self-isolation. The Roman Catholic tradition gives absolute value to the 'sanctity of life'. However, it strongly prohibits any medical intervention, stating that procreation is "considered absolute from the moment of fertilisation, forbidding Assisted Reproductive Technology (ART)" (Serour et al. 2017, 26), thus why *Marie* kept her medical treatments a shameful secret for all those years.

Now, I explore *Marie's* personal experiences with UI, including medical interventions and their impact on her religious way of life as a Catholic married woman, daughter, sister, friend, and colleague, as well as her role in society. I focus on my autoethnographic methodology and methods, critically analysing *Marie's* experiences of her religious practices and faith, and how the personal reflects the culture through them, evocatively bringing this to the page rather than through a broader theological discussion. Hence, "showing and telling" (Adams 2015) the effects of *Marie's* Roman Catholic observance and beliefs on some of her closest relationships through her experiences with UI.

Also, a note on identity. When addressing ‘identity’ here, I approach it primarily through the rupture in *Marie’s* religious observance as a Catholic woman struggling to procreate, which in turn disrupts the role she held in society and how she saw herself personally, leading to the disorientation she finds herself in. Thus, I draw on the framework provided by Michael J. Carter and Jen Marony (2021), who conducted a study on identity, gathering data using an online survey with 854 participants over six months to explore the distinctions between role, and social and personal identities, as well as how each identity type aligns with specific self-related findings. This study utilised a cross-sectional research project to review how individuals perceive changes in their identities as a role player, group member, and a person. They aimed to understand how these perceived changes are associated with various self-related findings. This approach fits my research as it categorises identity into three dimensions:

1. Role Identity: This refers to how individuals perceive themselves within their social roles.
2. Social Identity: This involves the identification of a particular social group.
3. Personal Identity: This encompasses the unique and individual traits that define one’s personality.

Carter and Marony’s (2021) work on identity helps me to show how these dimensions intersect with the rupture of *Marie’s* Catholic religious observance through her experiences of UI. This significantly impacts her “role” and “social” position within her church and her family as a Catholic woman. Thus, the intercommunication of otherness, stigma, shame, and disenfranchised grief

contributes to her sense of being marginalised through her UI experiences, leading to feelings of isolation stemming from the loss of her “personal” identity as a woman whose body is unable to procreate (Carter and Marony 2021). I also consider her “reproductive identity” (Athán 2020) in relation to her experiences with assisted reproductive technology (ART), as discussed in Chapter 3. Hence, I do not explore the broader implications of ‘identity’; instead, I focus on this specific approach to identity as it relates to *Marie*’s experiences with UI, the “role” she held in “society” that led to the rupture in her perception of her “personal identity” (Carter and Marony 2021). In this process, *Marie* experiences shame, a central theme of this chapter.

Shame and Catholicism tend to stand shoulder to shoulder, particularly in teachings of chastity, celibacy, and ‘appropriate’ sexual behaviour, such as matters related to marriage, fertility, and reproductive ‘choices’. They are part of the same walls: the Catholic doctrine bricks cemented with the mortar of shame that hold in place the solid structure of who *Marie* is and how she understands and faces society, her world, and her life. One of many examples in the bible (John 8:7, NIV) of a public act of shaming is of the woman caught in adultery and brought before Jesus by the Pharisees, who intended to stone her to death as the law of Moses commanded; the crowd enforcing their perfect moral standards (John 8:7, NIV). Catholicism also employs shame as a pathway to redemption, to feel deep shame, but to “go and sin no more” (John 8:7, NIV) as Jesus said when he asked the crowd of Pharisees, “Let the one among you who is without sin to be the first to cast a stone at her” (John 8:7, 8-11). Her accusers then leave one by one, *in shame* for *their* sins. Jesus offers the woman and the crowd an opportunity for transformation through a starting point of shame (John 8:7, NIV). I link examples like these from the bible, of which there are

many, to *Marie's* Catholic learned deep-rooted shame in being diagnosed with unexplained (in)fertility (UI) and failing to meet God's order for motherhood (John 8:7, NIV). This shame led to her internalised belief that she was, therefore, also failing to meet societal expectations. The theologian Millicent Feske (2012) conducted a study of over thirty narrative interviews of Christian women who were members of church congregations experiencing infertility. Feske (2012) found that with such substantial, significant value placed on fertility and motherhood, there is a strong sense of shame created for people struggling with infertility. Brene Brown (2015, 68), a researcher of shame and human emotions, states that shame is ultimately a "fear of disconnection". Brown (2015, 74) affirms, "Shame is the intensely painful feeling or experience of believing that we are flawed and therefore unworthy of love".

Furthermore, *Marie* was unaware that part of what she was experiencing or rather suffering from, was a grief she did not know existed: disenfranchised grief (Doka 2002), as I introduced in Chapter One and continue to discuss throughout this thesis. For infertility and UI, one's grief is generally not socially acknowledged or openly supported in the loss of a hoped-for child, the ability to conceive or a miscarriage (Doka 2002). This leaves one feeling their grief is overlooked or minimised not only by family, community, and society but by their faith or religion; the Catholic church in *Marie's* situation (Doka 2002; Feske 2012), therefore, intensifies feelings of shame and isolation. The absence of acknowledgement of mourning infertility and UI as a legitimate loss by others only compounds a person's grief (Feske 2012). Brown (2021) confirms that of all the types of grief she has researched

over twenty years, 'disenfranchised grief' is the least researched, the one we still know little about.

Reflecting on *Marie's* journals and recalling the rocky waters she navigated reveals not only a struggle with disenfranchised grief but also a sense of shame that led to a religious faith-related rupture in her identity after having been a practising Catholic all her life. Her sense of comfort, sanctity, and peace lay in tatters after a tumultuous storm of unexpressed confusion, anger, fear, disconnection, and despair. This upheaval in *Marie's* internal world left her in anguish from living with UI for twelve years following a miscarriage in her first pregnancy. Consequently, her belief system, as she understood it, which had always been her guidance, strength, and hope, was taken from her and replaced with a sense of loss for the future she had envisioned and hopelessness at the injustice of it all.

This not only led to a pivotal point of disorientation in *Marie's* identity but also to the hopelessness that drove her into dark thoughts about how a childless future was just too overwhelming. Particularly when it is accompanied by emotional pain, Brown (2021, 86) affirms, "hopelessness is a reliable predictor for suicidal thoughts, suicide attempts and completed suicides". *Marie* experienced a loss of orientation regarding where she once belonged; she no longer felt accepted within the identity she had always known: a married Catholic, white, Scottish, educated woman who had always excelled in everything she endeavoured in her life. This was the identity she held in her family, workplace, society and culture. This was how she was perceived and believed *herself* to be until UI disrupted her identity and took it away from her.

As Allison (1996, 39) described, “Behind the story I tell is the one I don’t”. Now, I unleash *Marie’s* voice further, telling the story *Marie* once kept guarded as a secret for many years that she wished she could have (Allison, 1996). Instead, she kept it hidden through socially constructed (mis)understandings of her perpetual cultural teachings: procreation, pregnancy, proud catholic married heterosexual parents; all expectations feeding her shame that led to her living a double life, forcing a smile and ‘getting on with it’. From *Marie’s* then-buried stories that were not being told, I now embark on a search for worthiness, love, belonging, and connectedness to others, making meaning of the shame, disenfranchised grief, and loss of *Marie’s* identity in the search for hope.

Through these vignettes, I demonstrate the complexities of these experiences, highlighting Catholicism’s entanglement with *Marie’s* formidable rollercoaster of loss and hope by confessing to her shame, plea for repentance, and contrition. Through the lens of *Marie’s* confession and contrition, I speak to Catholic religious observance and guilt, which influence societal discourses that shape *Marie’s* understanding of infertility and UI, and how these factors impact her faith and identity. Again, I critically explore these recorded memories as a constructive part of exploring *Marie* as she was then (disoriented, disillusioned, lost in religious observance through UI) and of responding in the present as a researcher of UI and an infertility counsellor. Through this, I make meaning and create a deeper understanding of the underappreciated and under-researched emotional effects of infertility and UI. By showing the insider experiences and responding to them, I hope to improve this experience for others.

### **In Response to The Pregnancy Chair: 'To grieve that which is not'**

*Marie's* everyday life has become, as Raphael-Leff (2012, 208) describes, a "split between the ongoing activity of professional and social life" in which she makes choices, and "the permanent grief and secret yearning for the realisation of a potential life now held "frozen in cold storage that is beyond her control and cannot be lived" until pregnancy occurs. *Marie* is tired of wearing a fake smile and trying to get on with life without feeling joy. She no longer confides in her husband, feeling too exhausted to revisit the unresolved issues that continue to strain their marriage. *Marie's* husband sees her as a strong, confident woman who is always in control.

*Marie* appears to use work as a means to distract herself from her grief in the ordered, structured world (the walls of bricks and mortar, Catholicism and the accompanying shame that stand side by side) that she has constructed within her Catholic lifestyle. In contrast, there is now perpetual disorder, chaos, and disruption in her life. Raphael-Leff (2012, 207) asserts, "Being branded infertile constitutes an existential shattering of naïve trust in the natural universal order, unquestioned since infancy." As time passes, *Marie* feels "marginal and peripheral – belonging neither to work nor to people with children" (Raphael-Leff 2012, 212).

To cope with her grief and longing, *Marie* has turned to work, struggling to manage her internal conflicts about her religious beliefs and faith within the structured world she has built. However, this sharply contrasts with the chaos and disruption now permeating her life. *Marie* fears that if she speaks about the impossible situation she finds herself in, she would be instantly stigmatised in the workplace. She is already struggling with feelings of being stigmatised in her

Catholic society and church, which is overwhelming. This turmoil reflects her ongoing identity fractures, primarily linked to what has always been the most significant and reliable force in her life: her Catholic faith and religion.

*Marie's* Catholic rituals embody her 'natural universal order' which has never been questioned until living with UI. Consequently, her position in society as Catholic is now 'shattering', leaving *Marie* feeling disconnected and isolated, amplifying her sense of shame, and indeed calling her identity as a Catholic woman into question. Sara Ahmed (2014) writes extensively about shame. I wonder, alongside Ahmed, whether *Marie's* perceived failure to live up to her unattainable 'ideal self' of motherhood reinforces her shame. Ahmed (2014, 106) explains, "the view that I have taken on in relation to myself; I see myself as if I were this other. My failure before this other, hence, is profoundly a failure of myself to myself. In shame, I expose to myself that I am a failure through the gaze of an ideal other".

Moreover, through *Marie's* shame, disenfranchised grief, and hopelessness are all fragments of the complex, prolonged feelings of loss she carries with her daily, stemming from the rupture of her identity (loss of orientation and belonging) as a Catholic woman. Through this process, her failure to conceive naturally and her reliance on ARTs come to the surface. However, she also must conceal her grief and longing for something that never was: a full-term pregnancy, a birth, a child. She feels ashamed, believing that not disclosing her UI clinic appointments makes her dishonest with her colleagues. This internal conflict stems from her pride in being honest with her colleagues prior to her experience with UI. More seriously for *Marie*,

she regularly confesses and repents in prayer for ‘sinning’, displeasing God, living in secrecy, while instead forcing a smile.

Feske (2012, 3) addresses this profound loss from a religious perspective and asks, “What does it mean to grieve that which is not?” She (2012, 4) states, “Due to the silence and shame surrounding the experience of infertility, those affected by it—along with their priests, pastors, and church congregations—are often ill-equipped to address such questions compassionately through the usual channels of religious ritual, community care, and theological reflection.” Feske’s (2012, 4) study revealed the strain between those labelled infertile and their relationship with the church, as well as their religious rituals, which have been damaged and, at times, irreparably harmed—confirming that shame and stigma are the most significant issues faced by their congregations, stemming from a lack of understanding of the “deep emotional scars, fears, and death of dreams that accompany it”. This reminds me of Luna Dolezal’s (2022) work, a healthcare expert who explored the relationship between shame and stigma in the context of women’s health, which I discuss further in Chapter Seven. For now, this may explain why *Marie* feels deviant, ashamed, and guilty about her inability to conceive naturally and her turning to medical intervention, which the Vatican and Catholicism prohibit.

The Catholic Church's position on reproductive technologies, such as IVF, and its implications for the sanctity of marital union and procreation have become points of contention. Joseph Schenker (1992; 2021), Professor of Obstetrics and Gynecology at Hebrew University, has conducted extensive research on the problems and solutions related to assisted reproductive technologies (ART) in the

context of religions. Schenker (1992) notes that the Catholic Church's perspective regarding fertility impairment, for instance, underscores its concerns about the dehumanisation and commodification of the reproductive process within medical intervention. Even the most contemporary approaches to procreation and fertility issues in Catholicism view IVF as vulgarising the essence of sexuality and procreation by generating life in a laboratory, which deprives the act of a physical, personal, spiritual, loving, and existential union between two individuals. In the eyes of Catholicism, *Marie* would be considered guilty of failing to maintain her dignity during the IVF process by detaching her relational and physical self, thereby denying her sexuality, which allows for the "disconnection between the unitive and the procreative aspect of sexuality" (Schenker 1992, 5). Schenker (2021, 6) further elucidates:

"The woman is anaesthetized to extract eggs, while the man masturbates to produce sperm alone with pornography. When third parties are involved, they are reduced to producers of healthy gametes or hired uteruses. The technology fixates on the concerns of health, efficiency, and cost to create the ideal product of a healthy newborn. Marriage and pregnancy are tangential to this technocentric mentality".

Schenker asserts that Roman Catholics derive their principles from the Bible and the Church's traditions, rooted in declarations from church councils and popes in the form of doctrines (Schenker, 2021). The Roman Catholic Church is a Christian institution with an episcopal hierarchy led by the pope, maintaining its belief in the authority of tradition and its sacraments (Schenker, 2021). The main principles within Catholic doctrine include marriage and procreation. The first of these key principles involves the protection of human life from the moment of natural conception. The

formal stance of the Roman Catholic Church explicitly states that “abortion, under any circumstances, including to save the life of the mother, is prohibited” (Schenker 2021, 11). The second principle highlights the close connection of procreation to the physical sexual union of parents, emphasising that offspring must be conceived within the sanctity of marriage (Schenker, 2021). This principle underscores the importance of commitment, regardless of circumstances, between a heterosexual married couple in the conception of new life. The third principle emphasises the significance of human dignity and decency in all medical decisions, particularly concerning reproductive medicine.

The Vatican has maintained a strong stance against assisted reproduction of any kind since 1956, when Pope Pius XII denounced artificial fertilisation as sinful and illegal due to its impact on lives (Schenker, 2021). The Vatican's directive regarding respect for human life, issued in 1987 by the Congregation for the Doctrine of the Faith and approved by Pope John Paul II, emphasised the Church's opposition to assisted reproductive technologies (ARTs), including embryo freezing, IVF, and surrogacy. Furthermore, the Catholic Church has traditionally opposed contraception, viewing all sexual conduct as both unitive and procreative. “Pope Paul VI's *Humanae Vitae* in 1968 condemned artificial contraception as intrinsically evil while permitting the use of natural family planning methods that align with the natural process of conception” (Schenker 2021, 12). Nevertheless, with Catholic doctrine strongly emphasising parenthood and the growth of (heterosexual) parent families, I am somewhat perplexed by the intensity of its rejection of medical intervention to aid in producing more children within the Catholic community.

Some bodies within Catholic communities honour medical intervention despite the strict stance taken by the Vatican. “*Donum Vitae*”, meaning “Instruction on Respect for Human Life in Its Origin and on the Dignity of Procreation” (Martucci et al. 2022, 552), was the notorious statement issued by the Vatican’s Congregation for the Doctrine of the Faith in response to the New York Times on 18 March 1987, which reported a front-page headline concerning Catholic hospitals ‘defying’ the Vatican in their treatment of infertility through IVF (Martucci et al. 2022). “Catholic hospitals in Lille, France, Leuven, Belgium, and Nijmegen, Netherlands defied the Vatican’s unwelcome intrusion into the clinic, asserting that Rome’s position caused “grave moral problems” for them as they believed they had developed a work ethic aligning with their Catholic understandings and that they were supporting married couples grappling with infertility and UI. Martucci et al. (2022, 553) explain their endeavours to make sense of the different approaches Catholic hospitals take towards IVF. The Vatican “flatly denied” in the publication of “*Donum Vitae*” that a Catholic should not take part in IVF or any other reproductive medicine or procedures, even calling upon national governments to insist they ‘ban’ all assisted reproductive technologies (ARTs) (Martucci et al. 2022).

Some European Catholic hospitals continued to resist pressure from the Vatican. Conversely, however, Catholic hospitals in the USA agreed to this prohibition on IVF and all assisted reproductive medical procedures due to the strictly regulated religious and bioethical practices of Catholic Bishops, in accordance with the instructions of the “Ethical and Religious Directives for Catholic Health Care (ERD’s)” (553). Even as of 2022, when the paper was published, Catholic patients experiencing (in)fertility and unexplained (in)fertility (UI) continue to

be denied medical interventions such as IVF in major American hospital sectors, as reported by Martucci et al. (2022).

This study highlights that, even within Catholic communities, the nuanced nature of the Vatican's moral guidelines in medicine is subject to debate and interpretation. These researchers discovered that in the United States, the practice of Catholicism in reproductive healthcare has traditionally emphasised observance to the Church hierarchy, with bishops holding power over decision-making on ethical issues (Martucci et al. 2022). In contrast, Europe (Belgium in particular) has appointed a more liberal approach, integrating Catholicism with forward-thinking developments in reproductive healthcare and progressive technology. This has opened the door for the institution where Catholic theology and ethics can be discussed, debated, and implemented contextually. Therefore, this study has shown that these two contrasting Catholic healthcare systems have emerged (Martucci et al., 2022).

Catholicism has instilled in *Marie* a deep-rooted belief system; she is branded as wrong and deviant not only by the act of being diagnosed as an unexplained (in)fertile patient but also by choosing to participate in the “evil” IVF and all assisted reproductive technologies (ARTs) (Schenker 2021). Society tells us one thing: to aim high and realise all your dreams. In contrast, Catholicism imparts a different message: *Marie* is sinning by failing to be a natural and virtuous Catholic mother and by resorting to medical intervention in an attempt to fulfil her dreams of motherhood. The shame and tears stemming from sitting on ‘the pregnancy chair’ are undoubtedly driven by *Marie’s* desperate plea to rid herself of this shame by asking God to allow

her to sit on that chair and miraculously become pregnant, thus stopping her from sinning and enabling her to be a natural mother, no longer requiring Assisted Reproductive Technologies (ARTs). For instance, some theologians today are still delving into the concepts of infertility, tracing back to St Augustine of Hippo's original theory (Augustine, 1996, vol 1). Hence, arguably the most distinguished theologian that the Christian church has ever known, Augustine was the first academic to inform the fundamentals of Christian doctrines on original sin, sexuality, and "the transmission of original sin, with the aim of clarifying the implications for assisted reproductive technologies (ARTs)," as stated by Cristina Richie (1984, 79).

In a separate study, Richie (1984) investigates marriage and procreation, emphasising how strongly most theologians often revert to the historical Augustinian teachings that marriage is solely a means of procreation and view non-procreative sex as sinful (Richie 1984). This has had enduring consequences on Catholic theology and ethics, leading many Catholics to believe that the only goal of marriage is to produce children and that every marriage must result in offspring. To this day, the Catholic sacramental marriage and children arising from that marriage exemplify both the literal (procreative - physical act) and the figurative (reflecting the union of love) aspects of marriage. Moreover, sex for the sake of pleasure, especially when contraception is involved, is deemed sinful according to Augustine (Richie 1984). Consequently, the Augustinian belief that sex is only for procreation has created social pressure to marry and reproduce, regardless of ecological concerns such as overpopulation and resource depletion (Richie 1984).

Nonetheless, *Marie* felt she had no choice but to keep her UI and medical treatment very much a secret due to her shame and fear of being stigmatised as “Barren” (1 Sam. 1:5-6), viewed as less of a woman in the eyes of the Catholic Church, and cast out from the congregation and her Catholic-influenced society. Consequently, she went on to experience what it was to feel othered and isolated, weighed down by the burdens of Catholic shame and guilt as she carried this secret everywhere with her. *Marie* felt, as Brown states, “Shame is the intensely painful feeling or experience of believing that we are flawed and therefore unworthy of love and belonging.” (Brown 2015, 69). *Marie* believed she was flawed for living a double life and, therefore, felt she did not belong wherever she found herself. Thus, her defiance in ‘lying’ as she perceives it, to her colleagues, peers, and friends only deepens her sense of shame for not adhering to God’s commandment, “Thou shalt not lie” (Exod. 20:16).

### **September 2006**

#### **“That’s me in the corner. That’s me in the spotlight” (R.E.M. 1991):**

*I’m driving back from the clinic of reproductive medicine when my phone rings. It’s my younger brother. He invites my husband and me, along with the rest of the family to lunch the following Sunday. I force myself to accept, despite my usual concerns about social gatherings, protecting my heart from pregnancies and babies in these situations. It’s family, a safe space.*

*Just as we are about to tuck into lunch, my brother stands up, clinks a spoon against his glass and begins to make an announcement. He and his wife are pregnant, their second baby. His mouth continues to move, but I stop hearing the*

*words. Everything falls into slow motion for me as everyone around the oblong table cheers and clinks their filled wine glasses together, while my nieces and nephews play happily, huddled together in one part of the large table. I try my best to stay composed. It takes all my strength to lift my sparkling mineral water (I am midway into an IVF cycle and can't drink alcohol), force a smile, and mouth congratulations to them, too. Another stab at the wound of the emptiness and longing I carry in my womb, but this time it hurts more deeply; the knife doesn't just stab at that wound; it deepens and twists in a way that it hasn't before during the many other pregnancy announcements I have been around. It's doing something different, something I already know will never leave me. This is not the usual 'person' or 'couple' who didn't know my situation. This is my wee brother, and he does know. I feel humiliated. He also knows I am in the throes of another IVF cycle. Why didn't he give me a pre-warning, even a quick text beforehand? It would have prepared me. Oh, how I would have appreciated that. All the difference it would have made...*

*It feels punishing. I have witnessed all my siblings delivering babies effortlessly. I feel my sister's eyes fixed on me. Sitting beside me, my older brother instantly grabs and squeezes my hand beneath the tabletop as if with words attached: 'I'm shocked, too; I've got you.' He then says gently, without moving his head, "Nobody knew, I would have told you". I feel an act of love, perhaps even forgiveness, for what, I do not know, in his actions and words, but I appreciate it. I look over at my dad and watch him raise his glass obviously towards the happy couple; he doesn't look over at me at all. My wee brother's newly pregnant wife looks at me and then quickly avoids my eye contact as I look towards her in my best congratulations impersonation, as if she couldn't bear to see the pain in my eyes. My*

eyes then meet wee Mummy's across the table. She doesn't do or make any gestures. I feel let down.

*I desperately hold back my tears; mummy's voice from the past echoes in my head, "Don't ever have children, Marie; it'll ruin your life". As always, I pull myself together, "I can do this"; I can get through this". I remind myself, but I don't believe it or feel it anymore. I feel I've also lost my agency, my power in all of this. I used to believe it when I would say "I can do this", but this announcement has cut deep into my wound; I feel it already. I feel I have no fight left in me. My husband isn't with me today; he is playing in a golf tournament. I am flying solo, as I seem to be a lot these days. Subtly and gracefully, as later confirmed by my sister, I pick my moment and leave the table.*

*I make it to the bathroom before the tears start. My sister follows me quietly, gently knocks on the door, and I let her in. She also wonders why my younger brother didn't give me prior notice of the big announcement—a quick text, even? I feel forgiven again, perhaps for letting everyone down by not being able to produce children. I also feel temporarily validated again, lifting a little of the shame in this moment. It feels like an injustice, but no doubt, one that most would not understand. I have stopped trying to explain it because of the sheer exhaustion of not being heard and the fear of being pitied — even worse. I feel I am drifting away from my identity as a part of this Catholic family and as a woman. The loneliness and isolation wrap a little tighter around me like an uncomfortable dark cloak. I feel weighed down by a sense of not belonging, as the spaces, places, and people that once felt like home are now filled with uncertainty and are no longer safe.*

*My sister would later ask my younger brother about not giving me the heads up in advance, and his response was, "Why should I? It was our good news, and 'everyone' should be happy for us in our special moment, including Marie... it's all in the hands of God for Marie; God's Will". This feels like an even deeper punishment. Even though I was subtle in my response to my younger brother's announcement, it feels like I'm getting something wrong. On top of punishing, it feels stigmatising; otherhood, not motherhood for me; their blessing, my pain; a confusing sense of grief washing over me again; increasingly a regular experience for me: 'God's Will'? It seems my husband is not the only one 'of my loved ones' growing weary of my needs during this season of my life. Note to self, 'I will do better next time, not to disrupt anyone else's good news'.*

*Where is your beautiful smile, mummy? I need it so badly right now. I hang my head in shame again for trying to have it all, for not listening to my Mummy and Nanna when they warned me to choose the career path, not to do as my ancestors did before me: getting married and having children means giving up your dreams; struggle and sacrifice, a 'cross to bear' as you once said, Mummy, for the rest of your life.*

*You told me that day, Mummy, "Don't have children, Marie, it'll ruin your life".*

*"I can't have children, Mummy, and it's ruining my life".*

*Why can't I have it all?*

*Please don't cast me out like a leper from my family's dinner table.*

*Please forgive me for wanting to die if life is without Motherhood for me.*

*Please do not let me live in shame and be pitied. I would rather die than be pitied.*

*Please help me find hope again.*

*I am desperate to find hope again... To find 'me' again.*

*“God created man in His own image, in the image of God He created him; male and female He created them. God blessed them; and God said to them, ‘Be fruitful and multiply, and fill the earth, and subdue it; and rule over the fish of the seas and over the birds of the sky and over every living thing that moves on the earth’ (Gen. 1:27-28a, 2)*

*Marie’s* shame and its potency, which intertwines with her stigma, arises primarily from her perceived failure to achieve the singular purpose deeply ingrained in her core belief system - shaped by her Catholic teachings: that a woman’s ‘role’ in life is to procreate (Carter and Marony 2021). Furthermore, if she does not fulfil this expectation, she is deemed shamefully lesser and stigmatised as a deviant. “The Creator of all things has the authority to proclaim the purpose for His design, which includes procreation” (Genesis 1:28). *Marie* is desperate to understand why she has not embodied the one predominant and most natural role she has witnessed in her family time and time again, instilled in her belief system from early childhood in her Catholic Church and society—that of procreation. Despite the verbal accounts of the suffering and sacrifices of her female grandparents and parents, they all, nonetheless, reproduced. *Marie* has failed to do what all her female relatives before her accomplished: reproduce; the message is stark and constantly evident in her daily life; families and children surrounding her serve as reminders of her perceived shortcomings, leaving her with no escape. She believes that fulfilling this expectation is her priority and her purpose in life, to accomplish what God has ordained, as expected by her ancestors, siblings, the church, and society.

The secondary aspect of her shame and stigma arises from turning to what Catholicism regards as the “vulgarised” medical intervention in her desperation to fulfil her primary purpose in life. Thus, *Marie* experiences not only suffering and struggle with her internal pain and emptiness from longing for children of her own, but she also feels a desperate need to provide her parents with grandchildren, her siblings with nieces and nephews, her nieces and nephews with cousins, and her close friend’s children with ‘cousins from their chosen families’, as she and her close friends had envisioned and discussed over the years.

More broadly, in her community and church, it is expected of *Marie* to marry and have children, a social norm within the Catholic tradition. As a result, she feels she has disappointed everyone—herself, her family, society, and most importantly, God. This reminds me of the moments when her older brother held her hand and her sister accompanied her to the bathroom that day, each doing a kind act to ease the pain of her younger brother’s announcement. These actions made *Marie* feel somewhat accepted and grateful, yet perhaps also “forgiven” for something. However, she remains unsure about what exactly. It is clear she believed her situation was somehow a punishment from God. Her siblings, all of whom have children, perhaps felt pity for her, which was the most painful aspect for *Marie*. She would rather die than endure this lingering pity, cast out like a leper. *Marie* had worked to succeed in her life and within her family, but now she felt like an outsider, being fed at her family’s table like a disease, a leper, on the periphery, yet they still chose to include her. For reasons unknown, her younger brother chose to hurt and humiliate her that day, knowing she was in the middle of an IVF cycle, a cruel act, akin to being named and shamed at the family dinner table: the one who cannot

produce children; her primary function; her primary shame; a disgrace to the family, as *Marie* perceived it and indeed as it would seem quite intentional by her younger brother.

### **A confession: An act of contrition**

*“My God, I am sorry for my sins with all my heart. In choosing to do wrong and failing to do good, I have sinned against you, whom I should love above all things. I firmly intend, with your help, to do penance, to sin no more, and to avoid whatever leads me to sin.  
Amen”.*

(The Act of Contrition prayer, Flannery, *Vatican Council II: 1996*, 2)

This potent double-barrelled shame of not being able to create a child naturally, coupled with turning to assisted reproductive technologies (ARTs), perhaps explains why *Marie* admits to harbouring darker thoughts about not wanting to continue with an involuntarily childless life. *Marie* would sooner die than reveal her shame over involuntary childlessness or relinquish her identity to the broader society. Brown (2021, 93) asserts, “Shame hates being spoken”. She continues, “Shame thrives on secrecy, silence and judgement” (Brown 2021, 94). If placed in a Petri dish with judgment, secrecy, and silence, shame will grow aggressively into every part of our lives, explains Brown (2021). Might this explain *Marie*’s act of contrition: “please forgive me for wanting to die if life is without Motherhood for me”? Wanting to die is yet another mortal sin in Catholicism for which *Marie* was prepared to be punished in order to alleviate the crushing weight of her shame (Motry 1920, 15).

*Marie* has always relied on and placed her complete trust in her Catholic faith and religious beliefs above all else, hoping it would resolve this for her, as her belief system has consistently done in the past; core beliefs linger. *Marie* feels there is no

way out; every option presents a problem in UI. The confusion and her solid determination to hold onto her Catholic identity persist, even though it causes her significant pain to be intertwined with that identity, which is gradually diminishing her agency and power, placing her in a seemingly hopeless position. However, the forces opposing *Marie's* feelings of hopelessness and powerlessness are indeed formidable: the Catholic doctrine and the institutions that uphold it. Foucault (1977) helps me eloquently elaborate on how *Marie* is essentially woven into her Catholic identity through the forceful communication of the Catholic society, as if unknowingly in a prison that she has always been surrounded by. He (1977, 217) states,

“Our society is one not of spectacle, but of surveillance; under the surface of images, one invests bodies in depth; behind the great abstraction of exchange, there continues the meticulous, concrete training of useful forces; the circuits of communication are the supports of an accumulation and a centralization of knowledge; the play of signs defines the anchorages of power; it is not that the beautiful totality of the individual is amputated, repressed, altered by our social order, it is rather that the individual is carefully fabricated in it, according to a whole technique of forces and bodies”.

*Marie* grew up hearing comments from her mum and grandparents suggesting that she must choose between having a career or having children; she was taught that she could not have both. Furthermore, there is chronic sorrow (Harris 2017) in the act of contrition for *Marie*, who wishes to pursue a career alongside the sanctity of family and new life. *Marie's* ancestors, including her parents, were raised in a culture where this was the norm. Women would give up their jobs as soon as they married and automatically became homemakers, bearing children and raising them while their husbands provided for the family. Historically, these women suffered and

struggled with large families, having too many children to care for and making significant sacrifices.

Consequently, *Marie* often heard remarks about choosing which path to take, as it was deemed socially unacceptable, particularly in the Catholic community, for a woman—especially a married woman—to have a job, let alone a career. Perhaps *Marie*'s internal narrative was shaped by the powerful language she encountered in her culture, some of the “anchorages of power” and the “centralisation of knowledge” (Foucault 1977, 217) conveyed by her female elders, particularly her mother. This was exemplified by the extent to which her mother angrily admonished her one day, as if deciding for her: “*Don't have children, Marie; it'll ruin your life,*” implying that this ‘choice’ would lead to a life of (imprisoned) suffering and sacrifice.

This brings to mind Leslie Leyland Fields (2008), a writer who addresses the complexities of motherhood in relation to God within the framework of Christianity, somewhat resonating with *Marie*'s mum. Fields (2008) characterises motherhood as self-sacrifice, a challenging and unglamorous role akin to Jesus's sacrifice on the cross. Fields (2008, 39) further asserts,

“I tell younger women the truth: If you aspire to be a mother, you aspire to a job without pay that is harder than any job you'll be paid for. It's a job with no time off, only time away. I tell them they should not have children to derive anything from them - not love or joy or fun or a legacy. It is possible that any of all of these may come, but there will be long stretches when little fulfilment is in sight”.

This reminds me of *Marie's* mum, who referred to children as “a cross to bear.” *Marie* felt a confusing mix of guilt and shame for “wanting to have it all,” as if it had to be a choice between one or the other: a career/a job, or marriage and children. She was only listening to her elders, her culture, her Catholic faith, and all that the church taught her. Her grandmother urged her to “do better” than the women in her family before her, who did not have the option to pursue a job or career after marriage, especially after having children. Her elders, perhaps with the best intentions, sought to offer *Marie* a better life free from the suffering and sacrifices they claimed they had endured by marrying and raising children. I wonder whether her elders were striving for a different kind of life for *Marie*—the good life—and if *Marie* was attempting to meet her societal expectations. I think of Lauren Berlant (2011, 2) as she discussed “Fantasies of The Good Life” associated with a cruel optimism that can be “an obstacle to your flourishing”. As she addresses the “fantasy” of “a certain way of life”, Berlant (2011, 96) briefly touches on the complex desire for motherhood and the challenges of infertility, framing infertility as “a significant life challenge that intersects with broader cultural narratives”, in *Marie's* situation, Catholic doctrine. Berlant (2011, 98) speaks of the “hopes and dreams associated with motherhood and how this can become a source of disappointment and pain when faced with the realities of infertility”. She argues that these desires are often linked to societal expectations, leading to a profound sense of loss when those expectations are unmet.

Thus, *Marie's* unmet expectations, along with the shame and stigmatisation intertwined with her pain and complex losses (disenfranchised grief) due to a combination of miscarriage, difficulties in conceiving again, and her Catholic rituals,

led her to question her identity. This is evident through her confessions, her feelings of sorrow, and her pleas for God's forgiveness for straying from His teachings, as she hopes that her act of contrition will lighten these burdens. I wonder, has *Marie's* dream and plan of having children shifted from an "expectation" to a mere "fantasy"? As Berlant (2011, 99) poses, "What happens when fantasies start to fray?" She answers, "depression, dissociation, pragmatism, cynicism, threat, optimism, activism, or an incoherent mash". This aligns with the confusion in *Marie's* emotions, all spurred by the harsh intersection of her experience with miscarriage and her ongoing struggles with UI, all 'mashed' with her Catholic beliefs.

Beyond *Marie's* expectation that having children might become a vague 'fantasy' over time (Berlant 2011), could others—including family, friends, her surrounding culture, and her Catholic Church community—also view her lack of pregnancy as a form of punishment, seen as "*God's Will*," as her younger brother suggested? The Catholic community, perhaps acting as *Marie's* "concrete training of useful forces; the circuits of communication; the supports of an accumulation and centralisation of knowledge" (Foucault 1977, 217), would likely influence *Marie* to accept "*God's Will*," as her younger brother said, her fate of unexplained (in)fertility (UI), and refrain from taking matters into her own hands, instead turning to what Catholicism perceives as 'evil' medical intervention in her desperate desire for a child. "This ancient Hebrew narrative of the desperation of infertility resides in the consciousness of many modern Christian men and women who are grappling with infertility, even in the 21st century," states Mary Elizabeth Caler (2012), a scholar of Christianity, *God's Will*, and Family Building, who conducted interviews with Christian women and couples experiencing infertility. *Marie* had been successful in all her

endeavours, both in her work and in her personal life, yet now feels her support systems crumbling around her. She is in anguish, struggling with the shame of being unable to reproduce, while also feeling guilty for pursuing her career as well as 'evil' reproductive medical intervention.

Of the very few who knew about *Marie's* UI, some did believe it to be "God's Will" that she was diagnosed with this, which is often viewed within the Catholic Church and communities as a "*punishment*" for, in *Marie's* situation, "*trying to have it all*" or "*sinning*" in some other way. *Marie* confesses and repents. She prays, offering her contrition and beseeching God to "*show*" her what she has done wrong so that she can correct it, be forgiven and be blessed with children. She lives like a prisoner of her own soul and feels pressure from her deep-rooted Catholic beliefs to accept her "*punishment*", her fate (UI) determined by God (God's Will). This brings to mind Foucault's (1977) theory on 'punishment' regarding the 'soul being a prison of the body', likened to the notion that "civilised punishment" is a physical act of being sent to an actual prison (1977) to be punished. Perhaps when *Marie* describes her younger brother's behaviour towards her fertility issues as "*punishing*", it serves as a reminder of her perceived failing body, and thus feels deeply "*punishing*" to her, highlighting her 'failing body' and perhaps explaining how that led to the 'imprisonment of her soul'. These words might also contribute to a form of control and shaping of her behaviour and identity within society (Foucault 1977). Therefore, it is understandable that she finds her younger brother's behaviour not only "*punishing*" but also "*humiliating*".

*Marie* perhaps felt she was expected to accept things as they were without question and to live in this prolonged state of shame, stigma, otherness, and disenfranchised grief. Her suffering continued within this excruciating identity of Catholic religious observance, as she kept her medical treatments a “vulgar” secret and her lifelong aspiration of having children unvoiced, resembling Foucault’s (1977) “imprisonment” of the “soul” in not feeling she was ‘allowed’ to be open about her dreams and actions. She increasingly felt the pressure to conceal her needs, hearing it from her husband’s comments and pleas to stop pursuing ARTs, or to ‘leave it all in God’s hands,’ and now from her younger brother to accept “*God’s Will*” and to “*move on.*” All the while, she is expected to partake in the celebrations and the joyful news of seeing others blessed with pregnancies and babies that she desperately longs for, suppressing her disenfranchised grief and ambiguous losses (Doka 2002; Harris 2017).

All at the same time, an involuntary childless life is becoming increasingly burdensome for *Marie*. Consequently, she feels deeply hurt and let down by these so-called ‘loved ones’: her husband and her younger brother; two significant people in her life from whom she particularly needed support and understanding during this season of her life. At the same time, she feels confused, torn, and guilty regarding the deeply ingrained shame she harbours for not being able to fulfil her lifelong dream and plan to have children, not to mention resorting to medical intervention, turning away from “*God’s Will,*” and rejecting her “punishment” for “wanting to have it all.” Ultimately, she feels torn because she cares deeply about her family’s opinions and she fears losing her place within it, which has been central to everything she has known and trusts. This only leads her into further disconnection and isolation.

## **Redefining Family: UI through the Lens of Faith and Social Ideology**

Speaking of family, James Dobson (2012), the founder of the Christian ministry 'Focus on the Family' and Clinical Professor of Paediatrics, holds a dogmatic belief from a strictly Christian perspective that society is solidly built upon the institution of the family, which serves as the foundation of our entire culture. He (2012) insists that if this foundation is ruptured, everything we value collapses with it. In Dobson's (2012, 17) work, 'The Cause of the Family', within the Christian community, he asserts, "We should never tamper with it frivolously or undermine its rationale for existence, as it is still an institution that explicitly links God and family". This strong assertion by Dobson, echoing sentiments *Marie* may have encountered in church, from her family, and within her society, may explain why *Marie* was so strongly impacted by her younger brother's behaviour and comments, intensifying the heavy burden of stigma and shame she already bore. Consequently, she feels the weight of responsibility for disrupting or unsettling her family, as she forgets, "To cooperate with the Holy Spirit in sharing the Gospel of Jesus Christ with as many people as possible by nurturing and defending the God-ordained institution of the family and promoting biblical truths worldwide." (Dobson 2012, 23). Due to such strong dogmatic statements, *Marie* wondered how she would now fit within this institution from a Catholic perspective, which enforces even stricter rules than the broader Christian view, with the "Gospel of Jesus Christ directly linked to the institution of the nuclear family" (Dobson 2012, 25).

Dobson (2012, 33) continues, "The family was divinely instituted and sanctioned at the beginning when God created one man and one woman, brought them together, and commanded them to 'be fruitful and multiply'." The nuclear family

is regarded as the centre of Christian and, consequently, Catholic culture, making it particularly difficult for those who struggle to have children. This situation leaves *Marie*, along with other marginalised groups such as the LGBTQ+ community, singles, childfree couples by choice, and indeed any groups living outside of the Church's ideal of a nuclear family, feeling excluded, confused, and cast out (like lepers) from both the Church, society, and sometimes even their own family's dinner table. Some may dispute Dobson's (2012) view, as reality demonstrates that we exist in a multitude of family constellations in our postmodern times, including babies born out of wedlock, single parents, same-sex couples, and heterosexual or gay couples employing surrogates, among others. Nevertheless, George Murdock (1950, 196), the anthropologist who coined the term "nuclear family" in 1949, asserted that it is "the type of family recognised to the exclusion of all others".

Therefore, since the 'nuclear family' has traditionally been perceived as a heterosexual married couple with two biological children, those living outside of this configuration have often been marginalised. However, it is clear that society now demonstrates that the typical heterosexual married couple is not always the path to parenthood. For instance, Rachel Lehmann-Haupt (2023), an expert in reproductive science and technology, a researcher and writer on the future of family structures, recently reported that the 'traditional nuclear family' now represents less than half of the families in the USA. She (2023) states that more than forty per cent of babies are born to unmarried mothers in various circumstances, typically by choice. Lehmann-Haupt (2023, xxvi) further asserts, "Never-married single motherhood, which has long carried a social stigma, has been redefined as an empowered feminist choice for an increasing number of women who are opting to have children independently

with sperm donors and new forms of community support”. Additionally, members of the LGBTQ+ community are increasingly becoming parents through assisted reproductive technologies (ARTs), utilising resources such as sperm donors, egg donors, and gestational carriers outside of the traditional ‘nuclear family’.

Additionally, Friedrich Engels (2004) championed socialism as a remedy for the problems arising from capitalism. He is best known for his partnership with Karl Marx in co-authoring several pivotal works that articulate their revolutionary concepts and advocate for the overthrow of capitalist societies. Consequently, many contend that the so-called ‘nuclear family’ is a construct of capitalism and the Industrial Revolution. It is possible that dogmatic religious texts, such as those by Dobson (2012) from a purely religious standpoint, also play a role in Foucault’s (1977, 217) depiction of the “meticulous, concrete training of useful forces; the circuits of communication; the supports of an accumulation and a centralisation of knowledge”, including ‘Catholic doctrine’, which was part of the entrapment *Marie* found deeply troubling in her experiences.

The word from Genesis states in the Bible that family is essential to God’s image for human society. *Marie* understood that God proclaimed Himself to us using the language of family and thus believed she was adopted as a child of God (Jay 1986; Rom 8:0-90). She understood that marriage was a lifetime commitment in the relationship between a man and a woman and that it would predominantly symbolise God’s relationship with His children (Haskel 1999, 54:5). Therefore, *Marie* entered her marriage with serious consideration of these beliefs. She married with the understanding of her Catholic church’s pro-family culture, as intended by God, to live

in a two-parent family with a central focus on this way of life, emphasising the importance of having children. *Marie's* belief and approach to serving God included a vision of having children of her own, and she believed herself worthy of this gift from God. However, dogmatic idealistic Christian writings and teachings, such as Dobson's (2012), only exacerbated *Marie's* feelings of disconnection, intensifying her hopelessness and the rupture of her identity (disorientation and the sense of not belonging), while adding to her sense of failure, as if she were being punished for something she must have gotten wrong in her life. Alongside Feske (2023, 3-5) and her participants in a narrative study, *Marie* also felt the injustice within Catholicism that, while men honour God through a broader range of approaches, such as work, ministry, or family, a "woman's spiritual aptitude was measured primarily by her ability to procreate". This only exacerbated the hopelessness she experienced while battling UI.

Nonetheless, *Marie* values having children as the most important priority in her life. She never *chose* her career; she wanted both. As she struggled to conceive, gradually over the years, everything else felt entirely pointless to her. As she had been living with UI and the prolonged uncertainty that accompanies it, *Marie* wondered what her purpose was. She was confused and fearful about this shift in her lifelong purpose, which was always to be a mother. Therefore, I wonder, alongside Maura Ryan (2005, 72), a researcher of religious studies and reproductive technologies, for a woman whose priority and life's purpose is to have children, "What will be the purpose of life if there is no one to influence nor a legacy to produce? Furthermore, "If motherhood was a sacred calling to follow, then why are godly women not allowed to answer the call?"

There was ongoing confusion in *Marie's* life, caught between her Catholic teachings and practices and her place in her family and society. She not only desires to have children and to be a great mother but also feels strongly about contributing something good, valuable, and helpful to future generations as a parent. John Abbott (1995, 6), an American historian and pastor from the Religious Tract Society, states, "Mothers have as powerful an influence over the welfare of future generations as all other earthly causes combined".

Thus, her younger brother's deliberate decision to announce the pregnancy in the manner he chose that day evokes a more complex and profound mix of emotions within *Marie*, to say the least, intertwined with her deep-seated shame and feelings of failure regarding her fundamental purpose in life. She struggles with guilt over the sadness and pain it stirs within her while simultaneously feeling genuinely happy for her younger brother and his family, who are expecting another new baby. She finds it difficult to reconcile this with the complex disenfranchised grief that washes over her (Doka 2002). Moreover, *Marie* felt humiliated at the pregnancy announcement. Brown (2021) asserts that with shame, we feel we are unworthy of love and connection and that we *are* flawed. The humiliation *Marie* experienced on top of that, Brown (2021, 98) explains perfectly how *Marie* felt: "I have been belittled and put down by someone, and my identity has been devalued. This has made me feel unworthy of love and connection, and I feel disgusted with myself, but I believe this was unfair and I didn't deserve this".

*Marie* has experienced many pregnancy announcements, some unexpected and others surprising, and has accepted that they are unavoidable. The people in

her close circle were very thoughtful in the different ways they chose to tell her, which she greatly appreciated. However, the humiliation she felt about this particular pregnancy announcement explains why *Marie* experienced a deep sense of injustice during those moments. This brings to mind another concept of Foucault's (1977), as he discusses the complexities of power embedded in certain things, which remains highly relevant in contemporary research. Foucault (1977) argued that 'shame' was inherent in the practice of open punishment and that 'shaming' diminished within the realm of 'civilised' imprisonment, which, conversely, facilitated control and discipline. Perhaps *Marie*'s feelings of humiliation, shame, and guilt, along with this punishing injustice she articulates—feeling belittled, dismissed, and having her identity devalued (Brown 2021)—created a sense of 'imprisonment' for her within her religious observance and the oppressive structures of Roman Catholic doctrine. Therefore, her younger brother's announcement and the complete disregard displayed towards *Marie* in this situation possibly evoked Foucault's (1977) concept of 'control and discipline' over her, manifesting as humiliation, which may also explain why it felt like a "*punishing*" injustice to her. This may have led to a deeper sense of isolation stemming from her feelings of unworthiness regarding love and connection (Brown 2021). Furthermore, she struggled even deeper into isolation, felt lost in the turbulent waters of UI and loss, and is no longer certain about "*God's Will*" for her.

Furthermore, *Marie* was left wondering where she now belonged — not only within her family but also regarding her religious observance, Catholic practices, faith, and societal position, her entire identity. She questioned whether there was any place for her at all, with her womanhood now in doubt. According to Catholic

doctrine, *Marie's* decision to reject her shameful UI and seek medical intervention would be seen as defiance. As a result, *Marie* would be regarded as deviant. Gradually, she felt shamefully stigmatised and excluded, similar to divorcees, the voluntarily childless/free, and the LGBTQ+ community. *Marie* would become one of the “unexplained (in)fertile” individuals who choose to pursue the path of “vulgarised” and “evil” medical intervention in a bid to procreate, slowly becoming a sinful outsider, not only within the church but possibly within her family, workplace, and community. If she revealed this, she would indeed be marginalised; the shame and stigma she internally struggled with would become publicly known. This was *Marie's* greatest fear: not belonging, being cast out, rejected. Brown (2021, 36) asserts that among all areas of research into fear, the most powerful is “the fear of social rejection”. In the vignette, *Marie* said, “*Please forgive me for wishing to die if life is without Motherhood for me,*” and this demonstrates how deeply her complex shame issues led to stigmatisation. This only worsened the prolonged, multiple, and persistent socially unrecognised fragments of her disenfranchised grief (Doka 2002) that caused the rupture in her identity.

### **December 2006**

**“He gives the barren woman a home, making her the joyous mother of children. Praise the Lord!” (Psalm 113:9).**

#### *My Contrition:*

*My Lord, My God, I often think of Hannah from my bible studies, how she prayed and pleaded desperately, begging you for a child as she stopped eating and cried at the temple every day. The priest condemns her one day for her intoxication in her prayers. Hannah replied: “Not so, my Lord, I am a woman who is deeply*

*troubled” (Bezzel, 2019, 147). You eventually blessed Hannah with her son Samuel after many years—my Lord, my God. I beg you to bless me as you did, Hannah. I beg you for the same mercy for my own, and others cast out like me in these prolonged years of bareness and sorrow. I do not know what I have done to be punished, left drifting in these rocky waters of uncertainty and shame, left stigmatised as Barren for all these years now. Only you know the outcome. Please show me Your mercy, forgive me, and offer me a better plan for my future. I feel guilty for not being the grateful person I used to be.*

*My Lord, my God, please take away my shame and give me hope again.*

***“For surely I know the plans I have for you, says the Lord, plans for your welfare and not for your harm, to give you a future with hope”.***  
**Jeremiah, 29:11**

*Marie* recalls from her Bible studies that after nineteen years of infertility, Hannah’s prayers were answered following much suffering. This miracle granted Hannah the honour of joining the respected women of the community as a mother. It was bargained by Hannah to “remove her shame” and thus the stigma of barrenness at a cost: that she would “give up” her son for temple service. *Marie* pleads for the same after all these years of suffering from the effects of UI connected to her Catholic faith, seeking God’s mercy. She likens herself to Hannah from the Bible and wonders whether she has not prayed enough or offered enough of a sacrifice; in her prayers, she often offered years to be cut from her own life in exchange to have a child.

*Marie* felt a deep connection to Hannah's suffering, reaching her breaking point when provoked by the shame and stigma she could no longer endure, leading her to seek medical intervention in an attempt to conceal her shame of not being able to carry a pregnancy to term and become a mother (1 Samuel 1:6-7). Like Hannah, *Marie* hoped for many years that she would have children who would begin their lives under her careful guidance, eventually maturing into catalysts for good in society. *Marie* believed her children would be souls existing for eternity; thus, her impact as a mother would not be confined by time (Cameron, 2001). She relied on her obedience to her "sacred calling" of marriage and motherhood to demonstrate her trust in "God's kind authority" (Genesis 1:28). *Marie* accepted and trusted in her Almighty Father-God, proclaiming this design, which encompassed procreation, as a blessing for her obedience that would be bestowed upon her. Matthew 7:11 (Psalm 127:3-5) states, "He is a good Father who wishes to give the best to His spiritual children, and one of the greatest gifts He can grant is physical children".

*Marie* could not understand why, as a Catholic woman practising her faith's rituals, she was not being granted what she had considered an expected next step in her life, which had so far been a good one. I think of Berlant's (2011) fantasy, once *Marie*'s dream and plan: a pregnancy to term and the birth of her own child. Berlant (2011, 4), who discusses social norms and "the good life," asks, "What happens to fantasies of the good life when the ordinary becomes a landfill for an overwhelming and impending crisis of life building and expectation, whose sheer volume threatens to undermine what it has meant to have a good life"? She further explores this in various ways. Yet, for *Marie*, Berlant's (2011) concept of an 'impending crisis' arising from the 'mash' of infertility and her Catholic faith causes her trust and faith in nearly

all aspects of her life to wane, leading to multiple unacknowledged losses- disenfranchised grief for her (Doka 2002); affecting her family, society, the social norms she was raised with, the church, relationships, God, and, more destructively, her sense of self- her identity and who she was. Berlant (2011, 99) describes such situations as “soul-killing”.

After suffering like this inside the UI experience for many years, *Marie* was taken to a dark place; she no longer knew or understood who she was or what her purpose was to be. The simplicity of *Marie*'s upbringing fostered a firm trust in God. She believed that He would grant her everything she asked for in prayer, as He always had until this point. She thought this to be because of her Catholic faith, the only faith she knew. This trust in God and her Catholic faith seems to be shattering before her, contributing to the identity loss into which she has been railroaded, leaving her unsure of how to cope. Based on her understanding of Catholic teachings, *Marie* blamed herself and believed she had caused this situation, feeling that she has done something wrong and was being punished. Although she was well practised in keeping it all hidden from view, internally, she was growing weary of this relentless prolonged cycle of shame, guilt and punishment.

## **October 2007**

### **Longing and Leaving: The plea for contrition changes**

*Elkanah, Hannah's husband, says, "Why is your heart sad? Am I not more to you than ten sons?" (1 Samuel 1:8). Although he meant to encourage her, this response broke her heart more.*

*My husband and I arrive at my colleague's 40<sup>th</sup> birthday party. Great venue.*

*We start mingling and gradually separate into different groups. One of my single*

*associates is distracted by someone who catches her eye. She touches my arm, her eyes fixed on him, and says, "Who is that? Someone, please introduce me". I look over; it's my husband she's talking about. I respond casually and joke, "Well, that's something I can help with. He's my husband". She is mortified, I make light of it, and we both laugh uncomfortably. I'm used to situations like this, as he is charismatic and strikingly handsome. He always attracts attention wherever we go. We sometimes laugh about how we've been stopped at golfing events or just on the street by people asking for his autograph; to this day, we don't know who people think he is. We laugh together about how he asks them who they think he is and signs the name they give.*

*The same weekend, we have another discussion followed by an argument about our different opinions on having more ARTs or adopting a baby. This same weekend, I tell him I'm leaving.*

*Strangely, although I have committed yet another cardinal Catholic sin, ending my marriage and pursuing divorce, I feel hugely relieved. I feel relieved because, for our different reasons, we both want this 'rollercoaster' of UI and assisted reproductive technologies (ARTs) and arguments about this and adoption to stop. I wanted UI to end in a successful pregnancy and a healthy baby, and he wanted 'me' to give up what he called 'my' obsession that had taken over 'my' life and to accept the possibility of a 'childfree' life with him. I was troubled by how he called it 'child-free' and not 'child-less. That last IVF procedure did feel quite robotic, and I knew somehow it would be our last, as our relationship couldn't take another.*

*I was also feeling increasingly resentful towards my husband that he didn't seem to experience any grief after the miscarriage. 'I', on the other hand, was devastated by. He was quite impatient about my grieving; that cut deep; I knew then I would never forgive him. I told myself I would deal with our other relationship issues later, as I had the urgent matter of my racing biological clock to deal with first; my ageing eggs and ovaries would not wait. Infertility and UI wait for nothing and nobody; it's relentless; it shows no mercy. I have been feeling more restless than ever. We had to face this. This was something I had been harbouring, and only my heart knew it was true: My marriage was over. I'm done! What does this say about me? Could it get any worse?*

*I am tired of asking for forgiveness.*

*I am tired of being punished.*

*I am tired of being judged and made to feel I am getting it all wrong.*

*I am tired of being persecuted by my husband, my younger brother or anyone else who wants to cast the next stone.*

*I do not need forgiveness.*

*I no longer repent.*

*I have done nothing wrong.*

*I am done!*

*Oh God, who am I now?*

**December 2007**

**Loss of Marriage – “That’s me in the spotlight, Losing my religion”  
(R.E.M. 1991)**

*I feel I am losing my place in what was once a massive part of my identity: I identified as a married Catholic woman, thriving in all areas of my life until this, until UI. Who am I now? I feel scared. I am scared of disconnection from all that I know and feel I belong to... a marriage, my church, my family, my community, and all that was once familiar to me. All until now... this. Do I no longer belong to any of it, my Catholic faith that I always turned to, no matter what? Without it, will I get completely lost? Somewhere deep in my lostness, shame and guilt for all that I keep getting wrong, committing sin after sin, feeling loss after damn loss, somewhere deep inside, I believe ending my marriage was the right thing to do. Even though it goes against everything I have been taught and had faith in, it feels fitting somehow, perhaps that it sets two people free from living in this pain... I am tired of feeling alone, othered, and punished. How can I remain faithful in all that I have always believed in when it now feels wrong; wrong to be in a marriage and feel so alone? Yes, I would rather actually be alone.*

*The end of this marriage is more loss to endure, I know, but at least this loss will not be prolonged, like living the unpredictable UI roller coaster of that turbulent ongoing loss and hope, which is utterly exhausting. There will be gossip: Catholic girl who always played it by the book, divorcing and childless... but I feel I am past caring about this... I’m too tired to care about this. I care more about doing something to end the pain of UI, not just for me but for both of us in this marriage. Strangely, I feel I have done something useful, something worthwhile... and I haven’t felt like that in a very long time. I have done something in the hope of releasing the*

*agony of living in shame, guilt, anguish, and misery. My truth is I can no longer tolerate this marriage, the behaviour of family members, the church society or anyone else who feels they have the right to “other” me.*

*But who am I going to be if not a wife and a mother?*

**Torn apart: “Truths that won’t keep still.”  
(Pelias 2004, 171)**

For the first time, *Marie* considered who she would be if not a mother? Being a mother has always been her primary goal, main priority, and the most significant part of her identity. Years spent navigating the rollercoaster of UI have created a loss of orientation and a sense of belonging as a Catholic wife, woman, daughter, sister, dependable colleague, and a loss of identity from trying (and failing, as she was often reminded) to become a mother. She feels she no longer belongs in Catholicism, the one constant that has always guided her. Consequently, she feels adrift and without a map (her faith in her Catholic religion) to steer her. Brown (2021) discusses the concept of a map to address naming, making sense of, and connecting to emotions.

*Marie’s* emotions are understandably complex and profound, as anguish and distress overwhelm her while adrift in the turbulent waters of UI, without the ‘map’ of faith she has always relied on to guide her to where she needs to be or to a safe place to go next. She feels she has broken all the rules of Catholicism by participating in the forbidden ARTs and keeping this shameful secret in many aspects of her life. Now, with divorce on the horizon, she feels unable to continue in her Catholic faith. She feels lost. Her marriage, family, church, and society are all moving

away from *Marie* at a pace she cannot keep up with, which is how Brown (2021) describes ‘overwhelm.’ *Marie* is swimming behind them in these unstable waters of UI and loss, shouting, “*Wait for me! Where am I to go?*”

Despite being married for eleven years, one might expect *Marie* to have shared her burdens with her husband. And she did for a while. However, in recent years, she increasingly felt isolated even in her marriage because she did not receive the support and understanding she hoped for from her husband. In both her Catholic faith and her marriage, *Marie* felt cast out and alone. Consequently, she believed she must now navigate this journey entirely on her own, overwhelmed by shame, prolonged sadness, loneliness, and isolation. *Marie* is tired of maintaining a façade of happiness within her marriage and of attempting to continue with her life in Catholicism, struggling with its rules and rituals. She stopped confiding in her husband because she felt she was burdening him with her feelings. She felt pressure to move on from this and leave it behind her. He had seemingly ‘moved on’ from their struggles with UI and often encouraged her to do the same.

It seems *Marie* could no longer ignore what her heart was telling her. As Pelias (2004, 171) describes, “The heart learns that stories are the truths that won’t keep still”. She reached the point when she was ready to listen to her heart, even though it frightened her and led her further into the unknown, away from her Catholic faith. *Marie* knew that both hearts involved in this marriage were being torn apart by the effects of UI and ARTs, albeit for different reasons. Her husband desired to live a life free from *Marie*’s UI and ARTs, having also said he would be happy to have a child if it happened naturally. I recall Elkanah’s question to Hannah: “Am I not more to you

than ten sons?" (Bezzel 2019, 147). Equally, *Marie's* husband believed his devotion and love should have been enough for her. Elkanah's plea to Hannah, thinking he was the solution to her problem, reflects *Marie's* situation with her husband, which remains unresolved. Instead, Hannah's and *Marie's* suffering, similar to that of many women experiencing fertility impairments, serves as the internal and 'shameful dilemma' that others, including husbands, fail to understand (Baldwin 2023).

Studies conducted by Lorraine Culley (2009), a sociological researcher of health and illness, investigated infertility and endometriosis. For example, Culley (2009) used qualitative interviews and thematic analysis in a study that revealed infertility can be a deeply isolating experience for women, often worsened by the fact that their partners may not fully understand the emotional and psychological burdens they bear (Culley 2009). Greil (2001), synthesised findings from existing literature regarding social and emotional support (or lack thereof) for women facing fertility challenges, and also found that men often struggle to comprehend the profound sense of isolation women experience during infertility and ARTs, as they may not fully appreciate the emotional and physical toll it takes on their partners, leading to a gap in empathy and support (Greil 2001). Culley (2009 89) states, "Women often feel that their partners do not understand the emotional turmoil they are experiencing, leading to feelings of isolation and loneliness". Greil (2001, 523) adds, "Men may not fully appreciate the emotional and psychological burdens that infertility places on their partners, which can lead to a lack of empathy and support."

Therefore, *Marie* increasingly felt more alone in her separate mission to proactively conceive, striving to alleviate her shame and the stigma she faced in the

culture and society she thought she belonged to. It seemed she was willing to pursue motherhood at any cost; life without it was unbearable for her, and ending her marriage proved to be excruciatingly difficult, as it was another action viewed as forbidden in Catholicism. Conversely, it also highlighted the strength of her need to continue her journey towards motherhood, to escape “otherhood” (Knight 2017, 230), regardless of what that journey might entail, even if it meant moving further away from her Catholic faith and church community, which she struggled to maintain in this increasingly challenging situation.

*Marie* also recognised that this whole process had uncovered a truth she could no longer ignore: she was unhappy in her marriage. Although she eventually accepted that her husband was not meeting her emotional needs nor interested in expanding their family beyond natural conception, he insisted that he was devoted to *Marie* and their marriage and could happily live together without becoming parents. He frequently stated that he could not and would not adopt, as *Marie* wished, but there were additional layers to this. The strain that medical intervention (ART) placed on their relationship also brought other complexities to light. Some couples grow stronger and closer through UI or infertility treatments involving ART. Sadly, others do not survive it, possibly due to unresolved issues within their relationship; I believe this was the case in *Marie’s* marriage.

Brian Peterson (2006, 5), a psychologist and researcher renowned for his work in reproductive psychology, including its impact on marital satisfaction and individual mental health, states, “Infertility can be a profound stressor for couples, often leading to feelings of isolation, frustration, and despair, which can strain the

relationship and, in some cases, lead to its breakdown,” as it has here. The scrutiny of the dyadic relationship in assisted reproduction and fertility impairment forces issues that previously lurked beneath the surface to emerge, where they can no longer remain unresolved. *Marie* is satisfied that she made an effort to save the marriage. She frequently discussed ART, adoption, and other pathways to parenting (as well as seeking to resolve the other issues within their relationship), although this did not lessen her guilt. Her husband consistently made it clear that he was unwilling to pursue these options and preferred to carry on as they were, childless, and “see *what happens naturally*.” He maintained that there was nothing further to address.

*Marie* feels both shame and guilt, blaming herself for ending the marriage, and her husband openly blamed her as well. These emotions were excruciating burdens for her to bear. Interestingly, *Marie* accepted all the blame for the breakdown of the marriage to ease her husband’s feelings, likely stemming from her Catholic upbringing, which probably encouraged her to assume punishment for all the sins she believed she had committed: her sense of contrition. Brown’s (2015, 19) grounded research revealed that shame is expressed as: “I am bad for doing this,” while guilt is articulated as: “I did something bad”. *Marie* carried both burdens heavily. Compounding her Catholic guilt and shame, she felt conflicted about breaking her religion’s rules by choosing to end her marriage. However, she also sensed that she had done something useful in making this decision. She felt internally that she had acted rightly, despite years of Catholic dogma and the sentiments of some in her close circle suggesting that her punishment was ‘God’s will’ and that she deserved all this suffering. Perhaps this profound sense of doing something right, something worthwhile, emerged instinctively from a more profound

belief that resonates with her inner feminist. As she heeds her feminist convictions, perhaps she gradually questioned and ultimately distanced herself from Catholic observance and societal views that deem actions like ending a marriage as wrong or sinful because she knew instinctively it was the right thing to do.

*Marie* concludes that she and her husband were not aligned in their marriage for the same purpose. Consequently, they struggled to support or empathise with each other, as their hearts craved different things in life. He missed *Marie* as she once was and longed to return to that life. Meanwhile, *Marie* desperately persevered in her desire to conceive the baby she yearned for and to live the family life she had always envisioned, filled with children. They had been travelling down two disconnected paths for some time. Perhaps what *Marie's* husband perceived was, as Tamas (2011, 51) describes, “those who remain traumatised as somehow wallowing, refusing to feel better”. I wonder if this troubled him because he believed her grieving (wallowing), particularly over the miscarriage, obstructed her healing, and he was eager for her to return to how she was before. He was not used to seeing her struggle and suffer, and perhaps did not know how to address it.

Nevertheless, her husband could not understand or engage with *Marie's* grief, even though she initially tried to share it with him. He was confident their relationship would somehow revert to how it was before—trouble-free and happy in his view. Sadly, *Marie* and her husband did not take the necessary space to work through this complex grieving process before feeling ready to look towards the future again. Perhaps *Marie* felt pressure to simply ‘move on’ from her disenfranchised grief, as Doka (2002) describes, before she felt ready after her experience of miscarriage. It

appears there are two irreconcilable perspectives: her husband believes they are doing well as they are, while *Marie* feels unfulfilled and incomplete without her lifelong dream of having children. They were unable to have a child naturally, and he would not consider adoption. It feels unbridgeable.

*Marie* is aware that she will commit yet another sin within the Roman Catholic culture: divorce. She feels increasingly othered, stigmatised, deviant, sinful, and shameful as each significant event in her life unfolds through UI, while the Catholic Church prohibits all that instinctively feels the only way forward, such as ART and divorce. This renders it impossible for *Marie* to endure this agonising position, trapped in the Catholic identity she had always known but now suffering because of UI and Catholic doctrine; she felt like a prisoner, being punished. Her everyday existence as a Catholic woman living in her culture and society had become highly challenging.

However, *Marie* found some relief in freeing both herself and her husband from the torment of living with UI and undergoing reproductive medical treatments. The only sense of agency she had felt for many years was believing she was doing something 'helpful' for both of them, even though she was breaking yet more Catholic rules, a particularly significant one: divorce. The burdens felt heavy, yet *Marie* feels more hopeful in recognising that not all the power belongs to them, the Catholic institution, medical professionals, her husband, and others in her family and culture. Foucault (1976, 92) states, "Power is not an institution and not a structure; neither is it a certain strength we are endowed with; it is the name that one attributes to a complex strategic situation in a particular society". *Marie* appears to be claiming

some of that power for herself in a “complex strategic situation” (Foucault 1976, 92). She has begun to assert this power by leaving Catholic doctrine and her husband behind. *Marie* choose no longer to live under the oppression of this institution of Roman Catholic observance, grappling with how she manages UI in her daily life, handing over her power to this institution. She may be losing her religion and her Catholic faith; however, she *has* a choice.

Speaking of ‘choice’, this reminds me of the various feminist perspectives on procreation and reproduction. *Marie* has made several significant life decisions after exhausting every other avenue and making new choices following the loss of her Catholic identity, along with many other losses that ultimately led to her departure from Catholic observance. Where do these choices originate? Perhaps she is now contemplating that it *is* acceptable for her to assert her agency and, consequently, construct a new identity in which *she* holds the power to choose divorce and medical intervention, which are not ‘forbidden’ in the broader society outside the ‘prison’ of oppression she has endured over the past decade.

Therefore, *Marie* is leaving Catholic doctrine and her husband, ‘moving forward’ in reclaiming her life and power of choice rather than ‘moving on’ without confronting her unacknowledged losses, as Doka (2002) discusses regarding societal pressure to move on from an invisible loss such as UI. It appears that *Marie* is discovering and tapping into her inner feminist, which she is now embracing and allowing to guide her, her newfound faith. This embodied response feels significantly more important than herself, just as Catholicism was larger than her: two entirely opposing guides in faith.

Furthermore, there are echoes of the seeds her mother and grandmother planted from parts of *their* inner feminist, urging *Marie* to ‘do better.’ *Marie’s* newfound faith has introduced her to a markedly different more authentic relationship with herself, unleashing her innermost feminist, which no longer connects with her external world. Consequently, in discovering her ‘real’ faith and experiencing personal authenticity—now considered more significant than Catholic doctrine and church guidance—*Marie* finds herself unable to tolerate the existence she has been living. Mervin, Hartwig, and Morgan (2012, 81) describe faith and spirituality beautifully in this approach,

“Beyond a theistic interpretation, here, spiritual literacy is rooted in ‘an embodied relationship with external reality’ spirituality is ‘the developing relationship in thought, feeling, speech and action, of the individual, within community and tradition, to that which is – or is perceived to be – ultimately real”.

Furthermore, might feminism’s spiritual guidance be where *Marie’s* inner strength came from to ‘move forward’ in leaving the Catholic Church and her marriage? Catholicism has always been *Marie’s* spiritual map (faith) until this point, and *it* failed *her*; *she* did not fail *it*. It would seem this has been replaced by her feminist map (faith) offering her choice rather than Catholicism telling her what she ought to be and what she ought to do and that she is wrong, deviant, shameful, stigmatised, stuck in ‘otherhood’ no matter which way she turns in her life decisions relating to UI in Catholicism (Knight 2017, 230). However, perhaps over time, *Marie* will as Mervin, Hartwig and Morgan (2012, 81) describe, “develop her relationship” with her feminist guide, her newfound faith further with her “real thoughts, feelings, speech and action” in helping her to ‘move forward’ (Doka 2002) rather than stay

restricted in all that she decides in UI but without the guilt and shame, and within her new developing identity.

### **Identity Beyond Religious Observance: A Feminist Awakening Amidst UI**

Maura Ryan (1995), a graduate in religious studies who researches reproductive liberty from a contemporary feminist perspective, is just one example that offers a different approach to *Marie's* UI predicaments. Ryan can help us understand how this presents an opportunity for *Marie* to step outside the rigid Catholic rules that have confined her. Ryan explains that there is freedom in deciding whether to have children and in which situations, as this is the core issue in the women's liberation movement. Ryan (1995, 223) states, "As religious persons whose self-identity and social role have been historically defined by their procreative capacities, women have a great deal at stake in questions of reproductive freedom".

Ryan (1995) further explains how early feminists dedicated considerable effort to securing access to contraceptive methods and advocating for legal abortion, as well as gaining recognition of their rights as consumers of gynaecological and obstetric care. She confirms that while it is accurate to assert that feminism has championed procreative liberty for women, it is essential to note that contemporary feminists do not universally embrace recent advancements in reproductive technology without reservations. There is perhaps a tension here between *Marie's* acceptance of her desire to pursue her dream and her acceptance of 'God's will' in taking what she has been given.

However, unlike Catholic dogma, which is entirely opposed to ART, at least this wave of feminists has come to accept medical interventions to some extent, partly because some feminists themselves choose to utilise ART to achieve their own dreams of motherhood (Inhorn & Patrizio, 2015). This wave of feminism seems to be something *Marie* has embraced, focusing on feeling valued rather than enduring the punishing persecution she faced within Catholic doctrine. This grants her the ‘freedom’ of ‘flying solo’ in a new way: to pursue her dreams of motherhood outside the confining walls of Catholic shame and guilt, where she has been a ‘prisoner of her own soul’. The feminist perspective offers *Marie* autonomy and human relationality, particularly emphasising personal choice within her social environment (Ryan 1995).

Nevertheless, a shift is evident—a clear message from *Marie* in her decision to end her marriage. “*I am done*,” she states, and there is a sense of freedom in this. *Marie* acknowledges that she can no longer be a good Catholic wife. She is exhausted from “*bearing*” her “*cross*”—shame, guilt, ambiguous loss (Harris 2017), disenfranchised grief (2002); “*sacrifice*” and “*contrition*”—while concealing her guilty secret of UI. “*She is done*,”. It feels as though she is at the end of her tether with struggling and suffering within the suffocating confines of her Catholic rituals and the society to which she once felt she belonged. She is leaving behind her battle against hopelessness and despair, feeling ‘imprisoned’ by the Roman Catholic rituals and the UI ‘mash’ (Berlant 2011).

Perhaps the cost of leaving her husband and her exhaustion from trying (and failing, according to the rituals of Catholicism) to ‘maintain’ the Catholic aspect of her

identity far outweigh the benefits of moving further into the unknown. *Marie* has long felt a deep longing to have children, partly driven by her culture, society, and Catholic upbringing, and perhaps also despite them. Nonetheless, she has carried this heavy burden of Catholic shame and guilt, alongside her disenfranchised grief, through more than a decade of experiences. She is now freeing herself from both her marriage and the oppression of the Catholic faith, breaking free from the 'soul-killing' sacrifices, as Berlant (2011) describes them, in which she had been miserably living.

*Marie* longed to be part of something, to belong, but not at the expense of her freedom, authenticity, or power. She is moving towards a space in search of a deeper sense of belonging. This belonging is more profoundly and spiritually connected to vast humanity, allowing her to explore her newfound faith, which serves as her feminist guide, while still believing in God and that He loves her, without the constraints of Catholic dogma. Through this process, *Marie* is now ready to practise hope again as a cognitive process within her feminist faith. Thus, enabling her to voice her shame and listen to the guidance of her feminist mentors without fear of social rejection, which she previously experienced in the impossible blend of UI and Catholicism. *Marie* finally feels that she belongs where she has found herself, in a hopeful place where she can finally 'be' who she perhaps was all along—the inner feminist that has always existed within her and has now been unleashed. "Belonging does not require us to *change* who we are; it requires us to *be* who we are," as Brown (2021, 102) aptly puts it.

## Chapter Five

### Fertility & Faith: Hope

Dare I Hope Again?

“And indeed, there will be time  
To wonder, “Do I dare?” and, “Do I dare?”  
Do I dare  
Disturb the universe?  
In a minute there is time  
For decisions and revisions which a minute will reverse.”

(Eliot, 2021, 132)

**January 2011**

**Counting my losses: Loss of time – Limbo; a Liminal Space:**

*I just had my fortieth birthday. My close friend from London is visiting me. We've just been on a wild, windy walk on the beach where I live in Fife. I light the fire. My friend gets the drinks. We sit quietly for a moment (unusually for us), both of us staring into the fire, watching the flames grow, their edges curling and twisting like ribbons. With each burning wood pop and crack, the fire breathes life and takes centre stage in the room, creating a mesmerising display of light and movement. I feel a sense of peace within and around me, especially from my beautiful, thoughtful friend sitting beside me on my sofa.*

*It's a relief to be taking a break from my strict health regime. Instead, I'm sipping a glass of red wine, something I have missed in all these years I gave up alcohol and all things sugar. I'm snuggling up beside one of my closest friends (one*

*of the very few people I have confided in throughout all my experiences of UI) in front of my lovely fire. I take a sip of my Malbec and say to her, “All that time living in limbo, all that effort, the medical treatments and their aftermath, constant focus on getting pregnant, and look where it has left me”, I say, laughing out loud as if to joke about it. “I’m forty, single, childless, and as for my ovaries, my uterus; well, they’ll be glad to see the back of all the horrible invasive medical treatments I’ve subjected them to”. “And after all that, what do I have to show for it?”. “Nothing”.*

*As I say these words, I feel my old friend, or rather, near enemy, “shame” appearing. It’s screaming at me, “HA – YOU FAILED MISERABLY”, trying to keep me silent so it can thrive. I remember Brene Brown saying, “Shame hates being spoken and thrives on silence” (Brown 2021, 94). To this, I am practising speaking my shame aloud in safe environments like this, in my efforts to manage and reclaim the power shame has taken, as I break free from the prison my soul has been held captive in all those years. My friend, still staring at the fire, looking thoughtful, puts her arm around my shoulder, smiles and says, “It feels like you were in limbo for so long, and limbo is not a good place to be, Marie”. We both sit thoughtfully for another moment, gazing in silence at the now blazing fire... “Now, I’m going to tear myself away from this wonderful fire and cook you a lovely dinner, my Thai green curry”, I tell my amazing friend. She tells me she appreciates me—and my curries. We put on a George Michael CD —Faith, oh yes, volume high —and we both start dancing around the room, just like we did when that album was first released. Still dancing, and now in the kitchen, I begin preparing dinner, while my friend pours two more glasses of red wine. I am reminded just how much I miss her, experiencing this... just like old times, when I also lived in London.*

*My phone rings, it's my sister. I put her on speaker and chat with her as I chop the onion and garlic and make the green paste. She asks if I'll attend one of her kids' birthday parties. She has four kids and lives in Loch Lomond. 'Ah, I can't make it, ' I say without even giving it a single thought, as 'Ah, I can't make it' has been my 'go-to' answer for so long. Well, hold on, I tell myself, maybe I can; I don't have to do this anymore, I remind myself. I've promised myself that I will come out of the isolation I have become so used to living in. Other than my work, I don't go anywhere, my sister reminds me. "I'm worried about you", she tells me – again.*

*Yes, isolation—my chosen shield against the constant reminders of pregnancy and parenthood. To avoid the question that haunts me — has the power to destroy my day and disrupt my carefully maintained sense of well-being in less than a second — “Do you have kids, or are you planning to?” It's a straightforward question, but it carries immense weight, like a weapon that stabs at the deep wound of UI and infertility. I believe that by eliminating this question from our conversations, we would cultivate a more compassionate and understanding world for everyone. If I were granted the power to make one new law in society - globally, it would be to 'ban' the “Do you have kids?” question.*

*I've been looking into adoption, and I've started the highly complex process of adopting a child as a single person. That would be nice, the party. I think I'll go, and it's unlikely there will be any pregnancy announcements. I don't know, I'll be busy with work. I've been thinking about starting to see a counsellor, but I can't find one who specialises in infertility. It's a shame as I feel ready, but the counsellor would need to understand the complexities of living with UI. Never mind, I'll put it to one*

*side for now. Even at the last Reproductive Medicine Centre I attended, which is a new and recent intervention with a counsellor on-site, the counsellor was not an infertility specialist, which I found strange. I guess they couldn't find one; I know I can't. It all seemed a bit gimmicky to me, as each patient was offered only 2 x 50-minute sessions with her during their entire time at the clinic, probably so that they could advertise that they provide counselling. What are two sessions of therapy going to do for people on this rollercoaster?!*

### **Reconstructing Identity: 'Coming out' of Isolation**

*Marie* is strongly opposed to asking the seemingly innocent question, "Do you have children?" If she could, she would ban it. As she explains, this question deeply wounds her emotionally, as it does my clients, all of whom face various fertility impairments; it acts as a reminder or trigger of their ongoing challenges with conception. Through her stories, *Marie* shows how, as a woman, she struggled with her body's failure to conceive and carry a baby to term, which undermined her identity within the Catholic societal role she held and how she viewed herself personally. All of which she endured silently with prolonged, disenfranchised grief for many years (Carter and Marony 2021; Doka 2002).

However, in Doka's (2002) discussion of infertility and miscarriage, he likens it to 'losing one's job'. This troubles me, especially given the insights I gain daily from client sessions. In particular, I see how the question "Do you have children?" profoundly affects my clients' day-to-day lives and has many nuances to it, much like the experiences *Marie* describes. Nevertheless, I do understand to a degree the point Doka (2002, 80) aims to make, which is that these two "non-death losses" –

miscarriage and losing one's job – both influence a person's identity, and both "cannot be openly acknowledged, publicly mourned or socially supported". He (2002, 81) notes that the two most common questions strangers ask when first meeting are: "What do you do?" and "Do you have children?". While I agree there is a link between how these impact a person's identity, I believe that, in relation to losing a job, they are two very different, albeit challenging, life experiences that should be discussed separately; they are not linked, in my opinion. For example, I agree that losing one's job affects a significant part of one's identity, but not in the same way as a miscarriage, a pregnancy loss, or a failed embryo transfer does, in grieving the loss of a child or a longed-for baby. After all, I have personally experienced losing a job very suddenly and unfairly, as well as experiencing miscarriage and reproductive loss, i.e., failed ARTs, and have lived in the liminal space of longing for a baby, caught in a trap between a lifelong dream and the prolonged unknown. From my experiences, I would say there is nothing similar between them other than that both affected my identity, but in entirely different ways; the job loss was only short-term and not deeply impactful, whereas the reproductive losses and grief from miscarriage have never left me; there has been no end to it.

Further, grieving the loss of an unborn baby can lead to "ambiguous loss", the term coined by Darcy Harris (2017), for an individual, such as in the situation of a miscarriage, or failed embryo transfer following medical intervention, like losing an unborn child through miscarriage or a longed-for pregnancy that did not happen, as *Marie* and most of my clients have experienced. Harris (2017, 33) describes ambiguous loss as,

“The absence/presence dynamic, where an individual is perceived to be either absent physically but present emotionally or absent emotionally but present physically. When conception does not occur, the would-be parent is confronted with boundary ambiguity, as the much-desired baby is very much present psychologically but is physically absent”.

Also, as I introduced in Chapter Two, Elizabeth Bruce, a counselling psychologist and Cynthia Schultz, a public health expert (2001, 64), researchers in complex losses such as chronic illness and infertility, introduced the term “Nonfinite loss”. This also fits the complex losses *Marie* and my clients show/tell in this study and expose in therapy through their experiences of unexplained (in)fertility (UI) in that they cannot see an end to the suffering of grieving an unacknowledged loss that is hidden from view; it is ongoing, as Harris (2017) explains. My co-sufferers, as *Marie* was, are also expected to adjust and accommodate without any support from society or the culture they are surrounded by, since this kind of loss is not understood by society; it remains largely invisible to the world (Harris 2017). I translate Bruce and Schultz’s (2001, 64) descriptions of the features of nonfinite loss as follows:

- There is prolonged uncertainty about what will happen next. This uncertainty is often accompanied by a sense of chronic despair and/or dread.
  - There is often a feeling of disconnection from daily life and what is usually recognised as “normal” in general experience.
  - The depth of the loss is often unacknowledged or unrecognised by others.
- In these types of losses, disenfranchisement is common and socially misunderstood.
- A persistent feeling of powerlessness and helplessness remains regarding the loss.

Additionally, “Chronic sorrow”, also known as a “living loss” further explored by Susan Roos (2014, 65), another writer of complex grief that is not final, following its inception in the 1960’s coined by Simon Olshansky (1962), is another unique kind of loss experienced after miscarriage or pregnancy loss, and any other reproductive loss, as the aftermath of the experience of “nonfinite loss” (Bruce and Schultz 2001, 64), as explained by Harris (2017). She (2017, 65) describes this as an unusual form of grief “that is also ongoing in nature” in that “the loss itself and related factors continue to surface”. Roos (2014, 25) describes it as “a set of pervasive, profound, continuing, and recurring grief responses resulting from a significant loss or absence of crucial aspects of oneself (self-loss) or another living person (other-loss) to whom there is a deep attachment”. Therefore, experiencing chronic sorrow as *Marie* did, and many of my clients do, means being in “response to the ongoing loss experience” (Harris 2017, 65), confronting the painful gap between what is perceived as real and what remains just a dream of what might otherwise be possible. Thus, I strongly contend that UI and infertility experiences warrant further research concerning disenfranchised grief, as Doka (2002, 79) currently places them alongside ‘losing a job’ as unrecognised and unacknowledged losses according to “society’s typical grieving rules”.

Discussing “society’s typical rules” (Doka 2002) in a somewhat different context regarding *Marie*’s shame—her Catholic upbringing—leads me to recall a moment with her friend when she feels safe enough to express her vulnerability by ‘speaking her shame’, albeit in a light-hearted manner. Here, *Marie* is practising letting go of some of that shame in a secure environment. Furthermore, she gains the validation she needs, which has been missing from her Catholic church,

community, and certain family members. *Marie's* close friends are her chosen family; even though she trusts them and shares her vulnerability, it is understandable that she still hesitates to 'speak' her shame and gradually release the silence and power it held over her, which had kept her imprisoned for all those years. For *Marie*, being held captive by shame and stigma was prolonged and intensely painful, as it had permeated every aspect of her life for over a decade. However, she chose to actively begin working through this by practising approaches to manage it, gradually releasing it while reclaiming her agency and power in her life, supported by the safety of friends (her chosen family) and some biological family members, such as her Mum, her older brother, and her sister.

Feeling unworthy of love, belonging, and connection during these years left *Marie* feeling isolated. However, she slowly worked her way out of this prison/trap. Nonetheless, she keeps everything 'surface level' with most of her family and work colleagues for her own protection outside her trusted inner circle and, therefore, still feels somewhat disconnected. She is in the unknown (disenfranchised, ambiguous, nonfinite loss and chronic sorrow), but it feels different this time; she is more optimistic, although, with all her UI experiences, she is highly aware of 'cruel optimism' (Berlant 2011) and feels better prepared for this new unknown, armed with her newfound faith, which is growing stronger. She no longer feels she is in the lion's den, so to speak, as she is gradually reclaiming her power as opposed to feeling hopeless and powerless as she did in her marriage and the Catholic community (the prison).

*Marie* envisions the potential for positive change in her life for the first time as she confronts her shame, stigma, and disenfranchised grief. These feelings mainly stem from stepping back from her Catholic rituals. That day, her close friend offered *Marie* empathy while they sat by the fire. Her friend did not judge her or tell her what she should do. Brown (2021) claims that empathy is the antidote to shame—precisely what *Marie* needed at that moment—and her friend provided it simply by listening and validating her feelings. *Marie* used the term “limbo”. I think of limbo in relation to how Martin Heidegger (1962) examined concepts of being, time, and existence, which can shed light on the implications of living in a liminal space and its connection to states of limbo. Heidegger (1962) described living in a liminal space as indicative of a state of being caught between two points in time—for *Marie*, between different phases of existence: neither realising her lifelong dream of motherhood and starting her own family nor progressing into the next stage of her life (Heidegger 1962). This situation can evoke strong feelings of stagnation, uncertainty, and unresolved grief, similar to *Marie's* experience of being held in a state of waiting. This likely worsened her sense of entrapment, as she felt unable to move forward or backwards, resulting in a profound existential limbo (Heidegger 1962). For *Marie*, this manifested as a feeling of being stuck, weighed down by shame arising from her inability to fulfil what she had always viewed as her life's purpose: to procreate.

## **February 2011**

### **I once was lost, and now I'm found; A Feminist Grace; How sweet the sound**

*I went to the party my sister invited me to, and, after being single for a year, I unexpectedly met someone very special there. We've now been together for three years and have decided to adopt a child or children together after many discussions*

*about how much we both want to adopt equally as much as we each want biological children. Therefore, we are hoping to adopt as a couple. We started trying for a baby unusually early in our relationship since he didn't want to waste any time regarding this crucial life decision of growing our family, just as much as I didn't. However, after two years of trying to conceive naturally, there is still no pregnancy. Although we are getting closer to adopting a baby after the arduous processes, which involve much interrogation into our personal lives, attending meetings at the adoption agency, there is still no baby yet. The adoption process is notoriously slow.*

*Everything is significantly different in my life now; I am happy and contented in a supportive relationship. Everything feels lighter. I feel like I'm learning to enjoy life again; I feel joy again, and I can laugh again without that underlying feeling of dread or that I am doing something wrong or that I am deviant, not following the rules. It's 'us' now rather than 'me'; I no longer feel alone. I am seeing a therapist now, too, and working through the years of living in constant shame and stigma, grief, deep sadness, and the loss of my Catholic rituals.*

*My sense of identity, my role in society, and how I see myself and am perceived are beginning to feel and look different; it's liberating. I am rediscovering my confidence and embracing my feminist faith—my guide and my map—with renewed energy. My faith in God remains strong, and I feel a deep sense of love and support from God, but without the Catholic dogma. Instead of seeking forgiveness in my prayers, I express gratitude for my "new" life—a fresh opportunity to pursue happiness. There is no going back to my previous existence; when my ex-husband tried to persuade me to go back to him, I knew immediately I would never go back. It*

*feels as though I am now living a parallel life, free from the burdens that once kept me on hold, in a permanent state of waiting, hiding my dreams of motherhood and ARTs while practising religious observance and navigating the constraints of Catholicism. Together with my partner, I have decided to draw a line under assisted reproductive technologies (ARTs) and instead embrace the path that feels right for us: adoption and/or hopefully a natural pregnancy, without any pressure.*

### **April 2011**

*It's a bright spring weekend morning, and we're walking together on the Beach where I live, when my partner asks, entirely unexpectedly, "Fancy trying an IVF cycle together, one last shot at it?" in the same tone he would typically say, 'fancy grabbing a coffee?'. He's had no experience whatsoever with IVF or the harsh realities of any assisted reproductive technologies (ARTs), and I always wished he'd remain untouched by it. A shiver ran through me at the very thought of him (and me) being subjected to the world of ARTs. It was the last place I would inflict on him. I do not want to bring this rollercoaster of ARTs into our relationship. In my experience, it is the ultimate relationship destroyer, and once you get trapped in it, it feels like there's no way out again, once in that rollercoaster cycle. Not to mention the guilt and shame I felt for all those years because, in Catholicism, I should not have been doing it at all; a painful reminder of the shameful secret I carried for all those years.*

*Apart from that, ART is just a horrible place to be for any human being. Although I said I would sleep on it in a not-very convincing response, I must admit, I have thought, "What if I were to try another IVF cycle with a different person under*

*different circumstances”? However, it is also a terrifying thought... returning to that trap of ARTs. I know that world, but he doesn't, and I didn't want to take us both knowingly into that lion's den. Dare I? Would it just be one cycle? Or would we get caught in the trap of “just one more cycle... perhaps the next one will be the one that will work... next round will be our turn”, and what about the impact on my health? I am one of the few who experienced the very dangerous ‘ovarian hyperstimulation syndrome’ (OHSS) during one of my IVF cycles. It could have killed me. Am I crazy to take that risk again? And what if.... It tears us apart, too?*

*The next morning, as we walked on the beach by my house, we talked about it, and I shared my thoughts and my fears. He is completely unfazed about this journey of medical intervention, and he wants to give it a try on the basis that they have OHSS more under control now with a new version of IVF that is very likely to prevent OHSS from happening again for me. The technology, we both agree, is impressive and keeps getting better. I can't believe I then hear myself saying, “Let's do one more IVF cycle then if you think you can handle it”. He smiles and says, “Don't worry about me, Askim (‘my love’ in Turkish). I halted in my steps and drew him close, our faces centimetres apart, noses touching. I gazed into his eyes, and he smiled back at me with a sparkle in his eyes. With my eyes piercing through his, I say, “I forgive you for you know not what you do”, The Bible, Luke 23.*

**May 2017**  
**It was always you**

*At The Meadows, Edinburgh, I am walking along the most beautiful, vibrant pink archway, lined on either side with cherry blossom trees. I'm feeling joy I once could only reach in a recurring dream. I feel peace and stillness; bursts of excitement*

*intermittently run through my whole being. I look down to one side through the bright sunshine piercing the pinkness. I pause to record this moment before continuing my conversation with my five-year-old son. I hold his soft little hand, trying not to squeeze his silky, delicate fingers too tightly. He lets go of my hand, picks up some pink petals from the path, and places them into the palm of my hand during our conversation. He then picks more beautiful soft pink petals, throws them up in the air as high as he can, and watches them fall back onto the path as he says in utter amazement, "Look, Mummy". I share his amazement, not only in the throwing of the petals as they fall back down onto the path, as if in slow motion, but in the fact that he, my son, is the one throwing them.*

*He playfully runs towards me, glides his fragile little hand back into mine and holds it. He looks up at me and asks, "Mummy, when I was in your tummy, did you want a boy or a girl?". I reply, "My angel, I wanted you exactly as you are. It was always you. I dreamt of you and this moment we're having right now - many times, except I couldn't see your face in my dream". He squints up at me again and tells me he loves me. I can never imagine being happier than I am right now. He becomes distracted. The playpark catches his attention, and he beams enthusiastically, "Mummy, can we go to the playpark now?" Paradise found...*



A photo I took in May 2017 of the stunning pinkness at The Meadows, Edinburgh

*Our son was one of three embryos implanted in that one IVF cycle we did together. As well as implanting three fresh embryos, we were also very grateful to have the other three embryos from that cycle frozen. They were 'A1 grade' embryos (the only grade that will be accepted to freeze since anything less than this grade, measured carefully by the embryologists, would not survive the thawing process). In this IVF cycle in which we were blessed with our son, we were given a 5% chance of*

*a pregnancy and live birth by the consultant following all the tests we had carried out, alongside 'the issue of my reproductive age', ovarian reserve and egg quality, etc. If we had only implanted one embryo at this time, that percentage would have been even less, with around a 2% chance of a pregnancy and live birth; it all feels so delicate and completely out of my control.*

*I remember the consultant almost sympathising with us before the IVF process even began. He gave me 'that look' that said, "Poor desperate woman... you're going to go ahead anyway, aren't you with a 2 – 5% chance.... I'm going to give you all the statistics, make you aware that pregnancy is highly unlikely..., never mind, a healthy pregnancy to term... and so you don't forget how grim it all looks for you, I'll hand over the statistics report loaded with numbers to take home to keep reminding you how hopeless this looks on paper with this tiny percentage figure in black and white... all the same, I'm going to take your money anyway... your choice... not my problem".*

*I'm not suggesting all consultants share this attitude, but I recognised "that look, " and I've even been told that if by some miracle I did get pregnant, it would be called "a geriatric pregnancy" because of "my age... And they still use that term in the UK for pregnancies in relation to women over 40. It used to be applied from the age of 37. I also want to add that in reproductive medicine clinics, many medical professionals and nurses genuinely care, like our nurse, Linda. She was with us every step of the way and cared... deeply! We planned to implant our remaining three frozen embryos a few years later, aiming for a second child and a sibling for our son, who would later ask for a sibling... and even cry about it... which lasted for*

*several years. However, despite our best efforts, we were unable to achieve another pregnancy. This was devastating for us and our son; it marked the end of our ART journey and the realisation of our dream to grow our family further. It was time to stop; I had always dreaded reaching this point.*

*In my experiences with all the different ARTs I have endured over the past twelve years, attitudes changed as I got older. Over time, I understood from comments and attitudes of more senior reproductive medicine professionals (whose pay packets were affected by the success rates of pregnancies and live births at private clinics) that they didn't really want someone like me, a seemingly desperate woman in her early 40s, reducing their success rates. Not ideal for their clinic's marketing. I get it; it's a competitive business, and each time I go back through those clinic doors as a patient, I become a commodity of this very profitable business. It makes me question why the NHS doesn't do ART for a woman over the age of 40 (also age 37 until quite recently)? Because the success rates are practically 0%. It's the women in their 20s they're targeting. They would much rather have a woman in her mid-twenties with around a 35% chance of a pregnancy to live birth. I have been on this medical intervention rollercoaster for a long time now. I get it; I was practically on the scrap heap. They didn't want someone like me dragging down their success rates. I saw it written all over the consultant's face. Hell, if he could legally refuse us, I'm sure he would have.*

*In saying all that, with my partner, everything was completely different with our final IVF cycle. He brought a light-heartedness to the whole process. He was alongside me during every part of it. He seemed to take all the pressure off me. It*

*was like a breath of fresh air with him. He was somehow able to ignore all the statistics and negative comments thrown at us during regular scans and appointments. He was very understanding of the side effects of all the medications I was pumped full of... I was so bloated with all the drugs. He even injected the daily dose of hormones into my bottom or tummy, wherever he could find a spot that wasn't too bruised from all the other injections.*

*He would take a deep breath and stick the needle in me as quickly and gently as he could, sometimes not able to go through with it the first time. He would step back, walk around a bit, take some deep breaths, and then come back again and get it over with as quickly as possible. He would then apologise each time for hurting me. He felt bad for doing this, and I felt bad that he had to do it, because I couldn't. I could not stick a needle into my body and then press all the liquid hormones into my body.*

*Unfortunately, I am pretty squeamish, the worst kind of candidate for reproductive technologies with so many injections involved. I tend to get lightheaded when injected, and I have a history of fainting from having any injections, which is why I thought it ironic that I, of all people, would find myself in this situation. However, my partner somehow managed to inject me every day for those 2 weeks of each month to blow up my ovaries to an abnormal size, forcing them to produce an unnatural amount of eggs in one month while shutting down my natural menstrual cycle, getting ready for the egg retrieval (and that's if there were any. Some women go through this whole process and get zero eggs as I stated in an earlier vignette).*

*My partner managed to do this while making me laugh, and he still had that “sparkle” in his eyes throughout that whole IVF process.*

*I was concerned about him though – “he who knows not what he does”... the first timer in all of this... it could crush him, the way it does many hopefuls going for it for the first time”. However, the faith he had in it all seemed unbreakable. His faith was inspiring. It reminded me of my newfound faith and to own it and show its strength, too. But my truth is that he carried me through this cycle of IVF. He was my main source of strength. He effortlessly made it bearable, even fun at times. I somehow let go of all the impact on me from my previous experiences of ARTs and the shame, secrecy, stigmatisation and grief I carried through my earlier ARTs.*

*They collected 12 eggs at my egg retrieval this cycle. After the embryos were implanted and following the 2-week wait that felt more like 2 years, we did a home pregnancy test, and it was negative. It was part of the extreme highs and lows of the rollercoaster of ART. We were due to go back to the clinic the next day, where they would carry out their own pregnancy test from a blood test – more injections – I feel like a piece of art, covered in deeply colourful blue and purple bruises. There is a lot of wooziness and almost fainting for me again. However, I mastered the art of stopping myself from fainting through my experiences with UI and medical intervention. If I got my head between my knees quick enough, at just the exact right moment, I would prevent the fainting. The couple of times I have fainted, I felt quite humiliated for some reason. It’s so undignified, but then every part of the IVF procedure takes your dignity from you, anyway. I know fainting is not my fault, but the whole fuss it creates when I have fainted those times does take me back to my*

*childhood when my parents would praise me for making the least amount of fuss possible. And if I did “cause” a fuss, well, that would be frowned upon and not like the well-behaved child I usually always was.*

*Nevertheless, another needle to take blood was in store for me the following morning at the hospital, where I would use my technique to stop myself from fainting, head between knees as soon as the wooziness and feeling I was going to vomit kicked in, nailed it; didn't faint! We already knew from the pregnancy test we did last night that we were not pregnant. When the nurse comes back to see us, however, she has a beaming, wide smile on her face and announces, “Congratulations... It's positive”. We are pregnant?! What! But we told her we did a pregnancy test just last night, and it was negative. “Ah, that's why we insist you do not do your own test before your appointment at the clinic, as it's all about the timing”. And secondly, she told us we were the only successful pregnancy in that whole group of cycles. Oh, I feel a kind of survivor's guilt at this moment, and how I would have been one of those in the group with “a big fat negative” in all my previous cycles. Linda, the nurse, would take care of us from there until we were transferred to the hospital for the usual checks at around 6-7 weeks of our pregnancy.*

*When we leave the clinic, we are in shock; the joy we both feel is like nothing else. Driving home, we were both smiling, giggling, looking at each other, smiling more, giggling a bit more. We didn't discuss how we felt; there were no words. Just looking at each other, smiling, and deep breaths; that's all. The only thing we discuss in the car on our way back is my suggestion to buy one of those fairly newish pregnancy tests on the way home. These tests not only show a smiley face if you are*

*pregnant, but also tell you how many weeks or days pregnant you are. I say, “Oh, let’s get one of them. After all these years of seeing so many negative pregnancy tests (apart from one basic one), I just long to see the positive double line instead of a single negative one, plus one of those smiley faces on a stick telling me I am actually... pregnant. I’ve got to see this”. My partner nods while still wearing the biggest smile I have ever seen on his face.*

*We stop and pick one pack of those fancy pregnancy tests; we tried to hide our excitement while in public. We arrive home. I do the pregnancy test immediately. I have to say, a part of me is expecting to see a single negative line again. Having been on this rollercoaster for so long now, I have learned that anything is possible; it might have been a mistake at the hospital. All I can do is prepare myself for the possibility. Five minutes later, I ask my partner to check the test result, as I just can’t. He picks it up, looks at it, still with the widest smile, he turns this white stick around to face me... There it is... right in front of my face: two solid double lines with the smiley face and the word “pregnant” on it! I lost count of the number of times I would hold that stick and stare at it... until one day, that little window with the smiley face, double solid lines, and the word “pregnant” started to fade away, and that little window gradually went blank again... And then I went and bought another one of those tests and did it all again... It was magical to see; I just had to do it all again...*

*Around 7 weeks into our pregnancy, out of the blue, I start bleeding. This feels familiar. This happened between weeks 11 and 12 of my first-ever pregnancy, and it was a miscarriage. It feels exactly the same as before: light bleeding that gets heavier, and then some twinges and slight pain in my abdomen that would get*

*stronger. I feel frozen in shock. I am alone at home studying-writing an essay to be handed in at Strathclyde University. We live in my partner's flat in Glasgow now, and he is at work.*

*I start to remember the exact moment this happened to me before, just after week 11 of my first pregnancy (only a couple of weeks away from my 3-month scan) when I lived in Fife. I remember my Ex-husband was playing in a Professional Golfers Association (PGA) Championship Golf Tournament, and all I could do was leave a message with the PGA for him to call me when he finished; it was a big event and meant a lot to him. It was hours later when he called me back, and I told him about the bleeding and pain I was in. He got to me as quickly as he could and helped me clean up, helped me into his car, and rushed me straight to the hospital in Dundee. On the way, he asks why they didn't come and get him. I explained, through the pain getting stronger in my abdomen, that they did ask me if it was something urgent, and only if it was would they send out for you from the golf course, but I just wasn't sure what to do, so I told them it wasn't urgent. I said, "I realise now I should have told them it was urgent, as I've been sitting in the bathroom in agony all this time, bleeding and knowing something is horribly wrong. I could feel it. What was I thinking?". When he responded with, "I wish you had; my game wasn't on point today; you'd have been doing me a favour", I instantly felt hurt and angry, and my thought was, "Are you really making this about you? I'm in agony, probably losing my baby right now". He made it all about him, even during my sitting in pain having a miscarriage.*

*I pull myself back to the present. This same thing is happening again to me physically, but I am here in Glasgow with a different partner. I am bleeding, preparing myself for whatever is to happen next. I call my partner at work. He gets back to me immediately. I tell him what's happening. He calls the clinic on his way to pick me up. They are prepared for me when we arrive; they are waiting for me with a wheelchair ready. Linda, our lovely nurse, looks genuinely worried. I can see she has done this many times before; she has everything prepared in the scanning room. She gives me an empathic look as if preparing to tell me the worst news.*

*They help me to the table. My pain is fading into a mild pulse. Linda, the nurse wastes no time in starting the scan. It is now only Linda, my partner and me in the room. She sighs as she removes her earplugs. Then she looks into space as if in disbelief. She appears confused but also wears a glowing smile and immediately says, "Your baby is safe; all is well." Linda seems very happy, albeit somewhat perplexed. She and my partner dance around the bed I'm still lying on, clapping their hands and embracing each other. I lie still and laugh in disbelief as they both hug me, then help me sit up a little. The pain in my abdomen appears to be easing. I tell Linda that I now have a small pulse-like sensation. She says that this can happen and might happen more, but I must come straight to the clinic immediately if I experience any more bleeding or pain.*

*I'm sure Linda thought this was a miscarriage; I did, too; everything felt eerily the same as the miscarriage I had. This is a moment of joy, and all 3 of us stay with that and enjoy this incredible moment. I will never forget the happiness on her face, my partner's face! It does something special for me; it reassures me of my newfound*

*faith, without making me feel ashamed or punished. Linda then confidently asks us with that joy in her voice, "Would you two like to hear your baby's heartbeat?" My tears appear to be trickling quietly down my cheeks; I couldn't stop them. Both Linda and my partner tear up too, as I quietly say, "Yes, please." The breath-taking sound of our baby's heartbeat softly and courageously fills the room, the three of us silently listening in awe... and disbelief! I don't want the sound of our baby's heartbeat to stop filling this room... or my life. In this moment, I feel a strength in me that I have never felt before; it was powerful. God is with me; God is with us, protecting our baby!*

**May 2017**

**Hannah's Hope - Marie's Hope:**

*Marie's final IVF treatment indeed resulted in the live birth of a healthy baby boy after twelve years of trying to conceive again following a miscarriage from her first pregnancy with her ex-husband fifteen years earlier. After all those years of navigating medical interventions, she portrays 'Paradise found' in her deeply personal description of engaging in an ordinary activity, such as walking in the park with her five-year-old son, using phrases like "it was always you", "I wanted you", "I dreamt of you and this moment we are having right now." (She did dream of her son many times in a recurring dream, once ironically during the procedure under anaesthetic following her post-miscarriage treatment; this is a cruel paradox – perhaps, as Berlant (2011) describes an example of her "cruel optimism", referring to infertility.*

Snyder (2000, 48) and colleagues, who developed a cognitive, goal-oriented theory of hope and conducted several thematic research studies on hope, state that

it consists of “a trilogy of goals, pathways and agency”. *Marie* clung onto “*for dear life*” (as her mum once described) to this pregnancy, perhaps with a newfound yet narrow ‘pathway’ to hope and her renewed faith after leaving Catholicism behind. *Marie* no longer felt alone on this journey; she felt her partner’s involvement alongside her through the experience of IVF, sharing the emotional aspects, which made it very different from the ARTs she had endured previously. Perhaps this was her renewed faith connecting with her partner’s unwavering belief that they would have a baby one way or another. Nevertheless, *Marie* dared to set a goal once more and believe in it, this time without the shame or punishment she had previously experienced through her prolonged struggles with UI. The prospect of regaining her agency was in sight, and she courageously began to rebuild her hope, holding on tightly with her partner’s support. He was fully invested in this journey with her. He maintained strong hope for both of them during times when *Marie* found it hard to cling to hope, especially during bleeding episodes likened to those of a miscarriage, of which there were many more. Perhaps this support helped her to establish a realistic goal again: a pregnancy to term, motherhood; dare she? Perhaps *Marie* felt the process Brown (2021) describes, in which hope is rediscovered through adversity and struggle, only to become possible again after hope has been tested? Snyder et al. (2000, 47) confirm that “hope is learned”. Despite the physical threats (bleeding and numerous hospital visits for scans) to this pregnancy, *Marie* dared to set a goal and follow the pathway she and her partner had charted, her partner firmly believing in it. Thus, *Marie* reclaimed her agency and built the courage to hope again; she believed she could do this with her partner’s support and her own growing faith, which became stronger, especially after hearing her baby’s heartbeat each time she rushed to the hospital, switching her fear to hope; hoping and believing the

bleeding episodes would not be a miscarriage; it was challenging, but she did build hope again.

### **Coming out: of Assisted Reproductive Technology (ART) – of Otherhood**

*Marie* remained conscious of her experiences of loss while also working on the cognitive process of rebuilding hope, again. Therefore, as part of her journey, like Hannah in the Bible, she was indeed blessed with a son, signalling the end of her participation in ART, except for implanting the remaining three frozen embryos in the years following her son's birth. Sadly, this resulted in no further pregnancies from that final IVF cycle. Nonetheless, *Marie* believes that, although she felt 'survivor's guilt' for being the only successful pregnancy among those ten women in the same round of IVF where she was blessed with her son, it remains essential to share her story of having her son, as there is hope for others through these experiences. Her 'paradise lost', a phrase also used to describe the psychology of infertility by Throsby (2004), drawing parallels to the themes of loss and longing in John Milton's epic "Paradise Lost" (1667, 116), has now become her 'paradise found', having her longed-for child. *Marie* overcame many hurdles, including a marriage at eleven weeks of pregnancy, the loss of her Catholic religious observance, and some so-called friends and family members, all contributing to a loss of identity during this twelve-year process of trying to conceive. However, *Marie* discovered a new faith—her feminist approach to believing in God—that restored her confidence and allowed her to rebuild hope, stronger than she had ever done before.

**January 2024**

**What am I not hearing from God's silence?**

*I am sitting quietly in my office at home for the first time since returning from our trip. Alone, I reflect on the conference, relishing in this moment of musing and introspection. Filled with excitement, I delve into the vast pages of notes I took over those few days. I was desperately trying to grab moments during the rest of our trip to look at my notes and reflect on my thoughts about the conference. However, we were busy getting on with everything else we had planned as we combined my conference in Tampa with a holiday to Miami, Orlando, Key West and The Bahamas.*

*My mind dances the 'cha-cha', stepping forward and then back. Not too deep, take it slowly; 123 – Step - back 23 - Step. I think of the writers I have admired all these years. I observed some of them as they demonstrated their work at the conference, listening, learning, and asking questions. Shall I dare go deeper into the layers of my autoethnographic writing and narrative inquiry, dancing a more evocative 'tango', as these writers I regularly read and at the conference do? Dare I, as Stacy Holman Jones (2016, 231) suggests in an essay about critical thinking in autoethnography, "story and perform the world in all its shifting, partial, unfinishedness; in the way it spins—and spins us— in a dance of feeling and imagination?" I hope to share my critical autoethnographic writing as I practice 'doing theory' and 'thinking story' as Della Pollock (2006) suggests.*

*I strive to 'show' theory "collaborating" with story in "embodied relation," evocatively, as a "reflexive participant," creating deeper understandings of "acting," "being," and "knowing" (Jones 2016, 233). As I practice illustrating the "critical" in critical*

*autoethnography, I endeavour to put “theory into action” (Jones, 2016, 233). This makes me think of T.S. Eliot’s (2021, 132) The Love Song of J. Alfred Prufrock as I ask myself again, “Do I dare” start to dig deeper into a new excavation that might “disturb the universe?” What will happen if I dare to? How will it impact me, my research, and my readers? Dare I go there?*

*Ellis & Bochner affirm that critical autoethnographic writing combines evocative and critical, reflexive and performative, cultural and political, theoretical and analytic (Bochner 1994, 2002). Hence, this provides me with the opportunity to explore the marginalisation of people suffering from living with infertility and unexplained infertility (UI) since I am dedicated to contributing to the improvement of this experience partly by critiquing the social injustice that arises from it (Adams, 2017). I do this self-reflexively and with critical insight while employing critical autoethnography as well as drawing on critical literature to inform my work, and “critically engage or critique culture” (Boylorn and Orbe 2020, 6). In my study, I utilise critical autoethnography to enable critical self-reflexivity and cultural interpretation, as I explore and find meaning in embodied experiences, intercultural problems, and relational interludes (Boylorn & Orbe, 2020). Consequently, I try to push beyond the straightforward reporting of a lived experience by deconstructing it by virtue of critical analysis and theorising. Further, I inquire through my critical lens into narratives that might challenge and, at the same time, represent culture by “bring[ing] attention to the ways cultures are created and compromised through institutional, political, social, and interpersonal relations of power” (Holman Jones 2018, 5).*

## **January 2024: Orlando**

*I had a wonderful performative dream during our Florida trip, just before I woke up on our first morning in Orlando. I had written a beautiful poem in my dream. The moment I woke, I excitedly told my husband, "I just wrote a beautiful poem in my dream", and I recited it to him there and then, almost to the end; the end seemed to fade away a bit, but I could fix that. Our son then woke up. I greeted him good morning, and as we hugged, we started chatting as we always do in the mornings; he told me how he had researched all the rides at Universal Studios and updated me on which roller coaster was the slowest and shortest ride and how we could start with that one. "Sounds great, good work", I said excitedly. "Guess what?" I tell my son I had written a poem in my dream, and I will record it right now before I forget it. He responded, "Good work too, Mummy".*

*As that warmed my soul, I picked out my son's clothes ready to wear and said to my husband we should go for breakfast and get to the park as it would get busy, and we needed to have a full day there to explore everything before we head off to a different park the next day as per our schedule. During breakfast, I asked my husband, 'Oh, what did I say the first line of my poem was again? If you remember the first line, it will bring the rest back to me, and then I will record it straight after breakfast. He mentioned a few words I had said, but they didn't quite sound right. And then, and then, and then.... I did not record my poem, and I forgot it. Did I imagine it, or was it beautiful, just like all those beautiful writings I heard at the conference? Or was my generous unconscious creative mind wrestling with my imposter self, saying, 'Look, you can write poetry too – go for it'? I wish for that poem to come back to me one day.*

## **January 2024: Edinburgh**

*As the Edinburgh rain gently and steadily taps on my office window, inviting me to look up at the pale grey Scottish sky, I think about my walks those mornings along the beautiful Tampa beach to attend the conference, bare feet in the soft gold-like sand, contrasting the deeper stronger turquoise blue waves splashing my ankles and the warm but not too warm sun on my face. I looked down occasionally and picked a couple of unusual-looking shells for my son; one large dark brown, no edges broken, strong and resilient, typical clamshell shape and the other long jet black, broken, relatively thin and fragile, but with vibrant blues and pinks appearing as the bright Florida sun hit it at different angles. I carefully placed the shells in one of the shoes I was carrying for my twenty-minute walk to The Dolphin Bay resort, where the conference was taking place. My first conference in person, hoping it would live up to all my expectations, especially the people I have been reading these past few years: Tony Adams, Art Bochner, Carolyn Ellis, Ron Pelias, and Kiltrina Douglas, to name but a few.*

*From working at my desk in my office in Edinburgh, I faintly hear my son and his two friends laughing their heads off as they play in the living room. I should check on them, as it sounds like a football is being played with. Instead, I smile and wonder what has made them laugh so hard. Then, I hear my husband laughing with the joiner as he takes food and drinks down the hallway. I hear the joiner, who is regularly in our house working these days throughout the renovations, say, "You'll make me fat". My husband's love language is food, for sure, food and touch. 'A feeder'; that's what my Mum calls him; he really looks after her. I love that he always makes a fuss of her; she does too. I am smiling again. I feel blessed, all snuggled up*

*at my desk in my small, cosy office space, surrounded by books (some of which I acquired at the conference in a raffle), papers, journals, and client notes. It's so cold out there today, but it's good to be home.*

*My thoughts drift back to the conference. The first two people I met after I wiped the sand off my feet and put my shoes on in reception were Carolyn Ellis and Tony Adams. I should have freshened up properly in the bathroom; however, hoping I looked presentable enough, I was excited by the buzz of voices I heard and hurried upstairs. They both warmly welcomed me, and I eagerly told them, like a child on her first day at a new school, how Tony's writing inspired me regarding narrative inquiry and how Carolyn and Art's work had drawn me to autoethnography alongside Jonathan Wyatt, who first introduced me to autoethnography at The University of Edinburgh. Carolyn responded coolly, 'So that makes me your grandmother,' and I said, 'Sorry, Tony, but I think that makes you my dad'. We all laughed, and I wondered, 'Is this moving too fast? Am I perhaps a little too familiar for a first meeting with some of my mentors?' I reflected on how differently I would have behaved at my corporate meetings—strictly professional. Nevertheless, I quickly began to feel at ease with Carolyn and Tony, like part of the 'family'.*

## **2024: Tampa, Florida**

*After being very warmly welcomed by Carolyn Ellis and Tony Adams, I then walk into the large room, looking around in awe as it steadily fills with people. A buzz of chatter fills the space, and it feels like Christmas Day for me, finally among many of my mentors. My excitement dances inside me, and at the same time, I try to*

*present a 'normal' exterior — simply a person walking into a room, like a swan gliding across the water — yet inside I am bubbling with excitement. I sit on a chair at the end of a long table and introduce myself to Lisa beside me. Lisa asks, are you a microwave or a crockpot? I respond, "I'm more of a crackpot." Oh no, what have I said? I joke when I'm overexcited. She laughs though and it seemed to brake the ice. Lisa explains that there is so much to process at conferences that she cannot do it quickly like a microwave; she is a crockpot (slow cooker). I assure her I am also a crockpot. This conference is filled with rich moments and wonderful people who now hold a special place in my heart. We even move rooms to watch the most stunning Florida sunset on day two, a beautiful, memorable moment.*

*In and out of presentations there was a sharing of writings, critical explorations, discussions of narratives in grieving – loss – love – hate – illness – violence – passion - being stocked – humour - writing, not writing - challenging assumptions – gender, sexuality - the meaning of qualitative research and how it has evolved/concerns raised (Carolyn Ellis) – inspiration/aspiration/experimentation, urgency of hope in a time of despair, educating anxiety, goodness, beauty, hearing writing from his 'tearing down the walls' book (Mark Freeman) - American politics concerning being an educator – companionship – suffering – silencing - putting meaning into motion and justifying the 'auto' in autoethnography (Art Bochner) - social construction becoming narrative – relational process, relational being – how we think about truth, epiphanies (Mark Freeman) - psychology and then another narrative, like having a relationship on the side, letting the para narrative slip out, creating the unconscious, critical movements, everything we do is lodged in language, duoethnography, let all the voices speak, writing with his wife (Ken*

*Gergen) – narrativizing, a moral responsibility, challenging the dominant narratives (Pat Sikes) – being mentored by Art Bochner when I said here is a list of the reasons why I hate my father and I want to write about it, and Art asked ‘what is his list, your father’s?’ changed my narrative, changed my life, changed my relationship with my father’, ethical principles, seeking permission for what we write (Tony Adams) – nature of reality in a digital age, virtual reality, what is real, closest to magic I could get to – vulnerability, self-care, suicide and end of life, abortion clinic experience, men’s illnesses – black joy, the joy in death (Chris Omni) - flirting with flirtation, pain and brokenness (Eric Eisenberg) – leadership, the need to lead differently (Patricia Geist-Martin) – autoethnography chooses us, it pulls your soul, it pulls us together (Keith Berry) - who we really are beneath the layers, the layers are the ‘ethno’ around the ‘auto’ (Gupta Himanee) - embodied remembering, what you might find in music (Kitrina Douglas) and Karaoke; yes Karaoke until 11 pm! These are just some of the ‘takeaways’ from my notes to give a flavour of the conference. I added to this list: ‘infertility and unexplained infertility.’*

### **January 2024:**

*On day two of the conference in Tampa, we had some workshops. One of many experiences that stood out powerfully for me was when we formed groups by topic and, at round tables, discussed them. I chose ‘loss and grieving’; I thought that was closest to fertility impairment. One person talked about the very recent and unexpected loss of his mother. He was a Christian Evangelist Minister who expressed his anger at God and discussed the ‘spiritual bypass’, a term coined by John Wellwood (2000); he had decided to take it because he was awaiting an*

*apology from God for 'killing his mum'. In our discussion, he asked, 'What am I not hearing from God's silence?'*

### **Embodied Anger: Hearing God's Silence in Personal Loss**

*While trying to stay with his experience, his question forcefully triggered me, jolting me back to a time when I was furious at God. I felt his raw, intense anger. I had embodied it in that moment. It took me straight back to having a miscarriage from my first pregnancy with my first husband, who seemed to recover very quickly after the event, for which I would never fully forgive him. I also nearly never forgave God for 'doing this to me' just as my friend at the round table had said: 'Why would God do this to me? He said I'm not angry on behalf of my mum because I know she is now with my dad. I am angry for me. God took her from me, and I will never forgive him; why would he do this?' I felt both his and my raw anger, making my body hot, his body, his face raging.*

*Oh yes, I feel your anger, my friend. As soon as I was physically able after the miscarriage, my body marched my rage down to St James's, the Church where I was devoted to attending mass every Sunday and received the Sacrament of Holy Communion as a practising Catholic. I had no idea what to do or if I intended to achieve something, as my rage had taken over me; no rational thought was involved. This was the first time I had raged at a level I felt I had lost control. I stormed into St James's. Taking my anger to that peaceful place that usually brought joy to my soul felt wrong. I managed to sit down in a pew, still trembling with rage, much like my friend at the round table was as he spoke. He said he was not going to attend the conference because his mother had only just passed away, and it was unexpected.*

*He seemed so vulnerable with his anger. I could see it in his eyes. He was even raising his voice, but the rooms were large, and our different groups were well-spaced across two giant rooms.*

*I sat in one of the many empty varnished, dark-wood pews adorned with detailed carvings on the outside of this dramatic yet peaceful church. I was trembling on the outside and confused on the inside. In the face of my inability to carry a pregnancy to term, I contemplated my identity. Would I, a perceived deviant, be shunned as an imposter and an outsider in this Catholic community? Would I be the subject of pity, gossip, and suspicion, stigmatised for deviating from the traditional Catholic path of marriage, babies, and happily ever after? I had ticked one of those boxes at that time: I was married. However, after many years of suffering unexplained infertility, my marriage would end in divorce, and then I'd be 'cast out' for sure. Having felt held and protected by this institution until now, where do I go, and what will I do now?*

*Now, I challenge the Vatican, the Pope, who dictates that seeking medical intervention is unacceptable. During Sunday mass, the pews are generally filled with devout Catholic women, their devoted husbands and their perfect little Catholic babies and children, conceived naturally. Only two or three others quietly prayed as it was not a time for mass or any other sacrament. St James's was special to me, I think, because it was so dramatically characteristic, an ancient church situated just off the stunning west sands beach in St Andrews, built in 1910, very ornate, sitting next door to the historical St Andrews University; creating a sense of not only solid resilience, grounding, peacefulness, but confidence every Sunday that I walked*

*through those magnificent heavy dark wood carved arched doors with hefty wrought iron handles on them. This act alone would dissolve all my concerns and bring me strength and security every Sunday, a knowing that everything would be as it should be, and I trusted and believed that God would never hurt me or give me more than I could bear. But not this day. Being in this sacred church was alien to me in these circumstances.*

*I sat on the pew looking directly forward at the altar, fuming at God as I stared into that unusually empty space, thinking about how God could let this miscarriage happen to me. He knew how much I yearned for this child, and he allowed me to get pregnant, and then he killed my baby at eleven weeks; how cruel could God be? As I sat simmering in my anger, Father Cairns walked across the altar from the little door at the side that leads to the room at the back. I'd always wanted to see that room and the chapel house where Father Cairns lived. On Sundays, as I sat through mass, I would imagine how it might be laid out with antique furniture, original parquet flooring and an old-fashioned four-poster bed in Father Cairns' bedroom with a framed picture of Jesus above it, draped with Victorian heavy burgundy curtains held with strong tie backs with heavy gold-coloured tassels on them. This theme, I imagined would continue throughout that historical chapel house. The kitchen would still be equipped with dated appliances, and they'd be well looked after; clean; everything would be clean. It would be cold inside that impressive, sturdy B-listed Victorian house with thick stone walls and a direct view of the magical, mysterious North Sea just behind it.*

*My anger was briefly interrupted by seeing Father Cairns in his black suit and white collar, rather than how I would typically see him in his purple and gold clergy cassocks, swaying behind him as he walked slowly and purposefully, knowing his way around the altar. I saw him looking and smiling at the two others sitting quietly in separate church pews. He then looked directly at me, nodded, and smiled. I did not smile back. I hung my head and hoped that he would have disappeared when I looked up again. Nevertheless, he was walking down the aisle towards me when I raised my head.*

*Father Cairns was standing in front of me before I could move. He smiled again and said softly, "We don't normally see you here on a weekday. Welcome". I looked directly at his well-worn smiling face and growled, "I had a miscarriage. Why would God do that to me? Why?". He calmly asked me to follow him to that little side room I'd always been curious about, just off the altar. There was a single pew, with one spongy kneeling pad covered in red leather-like material, like the ones the altar boys use at the side of the altar while serving mass. He asked me to kneel into it. I did so. He put his hand on my head, closed his eyes, and prayed. I felt held, and before I could stop myself, I quietly sobbed. He kept his hand on my head and continued to pray out loud.*

*Despite the differences in our losses: my friend at the round table's loss of his mother, the loss of a person who had been. Mine, a miscarriage, the loss of a person that never was, they both had one thing in common: our mutual anger at God. I thought carefully about what I would say to him. I could see the desperation, confusion, and anger on his whole face as he looked at all of us, shaking his head,*

*his eyes looking for answers. The loss of his mother is very recent and raw for him. My heart aches for him. I thought again about his question, "What am I not hearing from God's silence?". I think now of this prayer, Psalm 28:*

*"A Prayer for Help (1)  
To you, O Lord, I call; my Rock, do not refuse to hear me.  
For if you are silent to me, I shall be like those who do go down to the Pit. (2)  
Hear the voice of my supplication, as I cry to you for help,  
As I lift up my hands toward your most holy sanctuary".  
(Gabelein, 1939, 131).*

*I glanced around all the faces at the table, all of us hesitant to speak, an uncomfortable silence hanging over us. I broke the silence, not because of my shared discomfort, I was used to that sometimes happening in my sessions with clients, but because I wanted to take the risk of saying to him something that Father Cairns said to me back then during the times of my Catholic religious observance as my anger moved fluidly to sadness that day as his hand sat steadily on my head. I offered a prayer to my friend at the round table that, although it is hard to hear right now, perhaps he would come to a place where he would believe God did not kill his mum and that God would take his anger and carry it for him, even while he is blaming God. His face softened, and he responded in a lower tone, "So you do not believe God owes me an apology? I took the 'spiritual bypass' to await God's apology". I responded confidently from my 'feminist grace', my faith in God without the complication of Catholicism, guilt, shame, punishment, etc., "I believe you are suffering, and God forgives, that forgiveness is a single act – to give (for – give) without expecting anything back, and I believe while we suffer and feel lost, God will forgive us for blaming Him. He loves us. I once also raged at God and blamed him*

*when I was lost in grief". His face softened a little more, and he looked at me, smiled and gently said, "Thank you, Marie".*

*Terry Muck, Dean of the E. Stanley Jones School of World Mission and Evangelism and Professor of Mission and World Religion, comments regarding God's Silence: Psalm 28:*

*"God's silence can indeed bring us low. It, more often than we would like, hurls us into the Pit. Yet can we not admit that it is in the Pit, and only in the Pit, that some of the most important spiritual lessons are learned? We can endure, indeed even embrace God's silence if we realize that even when God is silent, he still hears. Moreover, sooner or later we realize that God hearing us is all we need". (Muck, 2012, 4).*

*I wish I could have read this prayer and response to my friend at the round table. Nevertheless, while all that I said felt risky, I felt compelled to say what I felt organically from the confidence of my faith I have carried for many years now, following the leaving of my Catholic religion behind and moving forward in my life. It might have been wrong of me not to stay with him where he was in his grief, validate him at that moment and explore it further with him, but he was not my client, and this was not therapy. Instead, I followed my instinct, intending to offer a piece of my confidence in God rooted in my feminist faith, that might offer him some peace. The others at the round table also made comments that helped soothe him. The whole session was filled with richness, tears, sharing, and holding of each other as we dug into each other's narratives. Some of us at the table did not share in that session to give extra time to our friend who had just lost his mother. It was an honour to be there with him.*

*This was only a tiny part of the richness and learning I experienced at my first conference in person, as I sat among my mentors in awe of them and confirmed that I had chosen the right path in autoethnography for my project, or as it was said at the conference, 'autoethnography chose me'. It reminded me why I want to initiate 'reflexivity' in my study and reflect deeply under each layer as I inquire into my narratives and those of my clients within my topic, investigating the intersections between the specific and the universal, society and self, the political and the individual. I saw and heard autoethnography and narrative inquiry first-hand at this conference, as I had done originally with Professor Jonathan Wyatt and others at the University of Edinburgh, where I was first inspired and instantly taken with autoethnography. It was magical for me to join this group in that space and place at the conference.*

*To inquire into my narrative and those of my clients through the cultural lens, to become instruments for social studies through which audiences benefit from the appreciation of one's reality in society and the social effects contextualising our lived experiences, I endeavour to improve the experience of fertility impairment for others, as I aspire to social justice with my project (Adams, Jones, and Ellis 2015). I wish to do autoethnography, as Stacy Holman Jones (2005, 765) puts it, by "setting a scene, telling a story, weaving intricate connections about life and art, experience and theory, evocation, and explanation.... And then letting go, hoping for readers who will bring the same careful attention to your words in the context of their own lives". Now I wonder, is this how all conferences are going to be? The bar has indeed been set high.*

## **Faith Beyond the Shadows of Catholicism:**

As I reflect on the echoes of *Marie's* words shared during a pivotal moment at the conference round table, *Marie* revisits the past and contemplated the profound questions they evoke within her, such as, how unexplained (in)fertility (UI) and this uncertain diagnosis affected her faith in God as a white, educated Catholic woman who has cherished her Catholic rituals and beliefs since childhood, an essential part of her identity? My reflections on *Marie's* Catholic beliefs and her fear of letting go bring me back to that moment of intense vulnerability at St. James's Chapel, when *Marie* sought solace in Father Cairns's prayers. Was this a temporary crutch that alleviated her pain momentarily? Nonetheless, in that act of surrender, *Marie* placed her trust. She rendered her power simultaneously, believing that Father Cairns's connection to God could provide the help she felt powerless to secure on her own.

This experience underscores the deeply ingrained notion that priests possess a direct line to God, a belief that had shaped *Marie's* understanding of faith from a young age. Raised in the Catholic tradition, *Marie* adhered to its tenets and rituals, believing in the promise of eternal life for those who follow God's commandments and live according to the teachings of the Catholic Church. As she knelt before Father Cairns that day, the weight of her struggles felt both heavy and light: heavy with the burden of her doubts about her Catholic faith yet lightened by the act of surrendering her worries to Father Cairns. *Marie* was perhaps unconsciously continuing the practice of a ritual belief in the priest as a higher power who could somehow heal her pain or uplift her spirits, a notion she had also been taught since childhood. However, she knew deep down in her innermost feminist self that the reality was that this man, Father Cairns, could not miraculously heal her. I think of

Henri Nouwen (1979), the Dutch Catholic priest and theologian who authored many books on spirituality, including discussions about the necessity for a more authentic relationship with God. Nouwen (1979, 9) states, “The great illusion of leadership is to think that man can be led out of the desert by someone who has never been there”. The reality was that all Father Cairns could do was pray for *Marie* with his hand resting on her head.

*Marie*'s Catholic upbringing instilled in her a profound respect for the rituals and symbols of what she had considered the 'only' faith. Every prayer she uttered connected her to generations of believers in her family who had sought guidance and solace before her. The sacramental nature of her Catholic faith provided a framework through which she could navigate her emotions, even when they were shrouded in fear- that was until she began living with UI. However, that moment of reliance on Father Cairns and the Church also brought about a deep internal conflict for her. *Marie* grappled with the notion of relinquishing her Catholic faith in exchange for reassurance of her authenticity through her feminist faith. Therefore, perhaps her Catholic faith, which was once a source of strength, had become more of a temporary crutch, limiting her ability to confront her own challenges as she might with her feminist faith —the 'feminist grace' she had found within. Grace was what she needed all along.

Thus, the conflict she experienced in accepting Father Cairns' intervention while yearning for “the real”, the “personal”, and the feminist voice she later discovers within herself created a tension that resonated in her heart. *Marie* felt vulnerable in this tension, but she knew she had to surrender, not only momentarily,

to Father Cairns that day, but also to her Catholic faith and the church. Brene Brown (2012, 34) states, “Vulnerability is not weakness. And that myth is profoundly dangerous. Vulnerability is the birthplace of innovation, creativity, and change”. *Marie* needed to emerge from her isolation to find the courage to build hope again, and for that, she needed to make changes in her life, beginning with her newfound faith.

The echoes of Father Cairns’ prayers lingered, prompting her to question this crutch that seemed to distract her from her pain momentarily. *Marie* recognised that her journey with adhering to the doctrines of the Catholic Church was at an end. She was surrendering to her longstanding struggle with Catholicism, not abandoning it; she was letting it go. It no longer served her. “Surrender is not about giving up, but about letting go of the struggle,” says Judith Orloff (2021, 3), a psychiatrist, author, and speaker renowned for her work in the fields of psychiatry, spirituality, and emotional healing. *Marie*’s ‘tango’ of faith would continue eloquently with God’s love, and her feminist faith would now guide her toward a more authentic journey, each step a dance between authenticity and reassurance, directing her toward a deeper understanding of herself and her relationship with her newfound faith.

These were some of the issues that forced *Marie* to confront the dissonance between her Catholic beliefs and her instinctive faith in God, as well as the faith ignited in her by her inner feminist, alongside the realities of her unexpected journey with fertility impairment. Medical intervention, among other issues including the eventual breakdown of her marriage and divorce—another aspect of modern life that Catholicism does not accept—clashed with *Marie*’s continued practice of

Catholicism. This prompted her into many years of introspection and challenge, leading her to gradually distance herself from the religious institution and her Catholic rituals, such as attending mass every Sunday.

Given the importance of family and children in Catholic doctrine, *Marie* found herself disillusioned, battling to reconcile her UI experiences with her beliefs. With the faith *Marie* had trusted in Catholicism unwaveringly since childhood, leaving her feeling unsupported, she then began to question and gradually separate 'faith and religious observance'. In desperation, to fill the void and help deal with the prolonged pain of the 'presence of the absence'; the absence of her monthly menses while pregnant for 11 weeks - that heralds the new life within, and then the presence of her monthly menses after miscarriage – revealing the loss/absence of the longed-for new life within. Thus, the path towards motherhood took an unexpected fork in the road as she turned to medical intervention.

There would be no clear point of transition from 'normal' to 'abnormal' for *Marie*, as she always kept her fertility impairment strictly private, much like the complexities faced when a gay person 'comes out'. I strongly agree with Gayle Letherby (1999, 364) when she suggests from her extensive research that "some individuals perceive being open about their 'infertility'/'involuntary childlessness' as comparable to "coming out" as a lesbian or a gay man," and that they are "in some ways not meeting hegemonic expectations of them". There would be a gradual process of attrition as that hope for the 'normal' conception month by month, year by year, erodes incrementally. The arrival of each monthly menses is another stab at

the slowly disintegrating dream of motherhood. Another unspoken tragedy of the no-child status.

For *Marie*, this marked a departure from the traditional Catholic view: Man and woman, marriage and sex (for procreation) = babies and happily ever after. In saying that, her journey through unexplained (in)fertility (UI) and the losses it brought prompted a radical reassessment of her Catholic faith and the rules she once followed unquestioningly. This was a painful and prolonged process of disenfranchised grief for *Marie*, with her monthly menstruation serving as a reminder of her ongoing failure to conceive a child—the ‘present absence’, the monthly reminder of the absence of new life within. However, this process enhanced her reflexivity as she gradually began to think more deeply and clearly about her ‘self’ and life purpose, ultimately freeing her from certain burdens that no longer served her. These life changes were liberating: a departure from religious observance, divorce, and the anticipation of a new beginning. It also opened the door to a newfound faith in God, but without the rigid rules established by Catholicism.

However, before the opening of a new door, one closes. What about divorce and these rigid rules set out by Catholicism? How does one find new beginnings, a different life? Moreover, how does one recover from a miscarriage when the loss has not first been acknowledged, accepted, understood or mourned like other losses, such as the loss of a loved one or kin (Doka 2002)?

## **Speaking of miscarriage - Back at St James's Chapel**

Father Cairns' comforting presence that day, while momentarily soothing the 'absence' in *Marie's* womb, ultimately served to highlight the limitations of a faith that seemed ill-equipped to address the complexities of modern life and the deeply personal nature of fertility and identity. It felt as though the little control *Marie* still held in her life back then was slipping away, prompting her to question whether she was unworthy to communicate directly with God, and she eventually unleashed the confidence of her inner feminist, her newfound faith in God, in her life, in herself. The weight of her perceived ongoing failures in conceiving a child and fulfilling her role as a woman left *Marie* grappling with self-doubt and diminished confidence. In saying that, there are times when, understandably, *Marie* finds herself reverting to that place of comfort and old habit, the church, the clergy, or the gentle smile of a familiar-looking priest.

Her background in Catholicism, combined with her personal experiences of UI, urged *Marie* to question the internal conflict between the option of medical intervention, ART in her desperation, longing for motherhood and the deep-rooted beliefs set firmly in the Catholic faith she was raised in. This internal battle ultimately led her to confront and come to terms with her conflicting thoughts, life plan and needs as she navigated the complexities of pursuing her dream – the longing in her heart and her soul that would not stand still: having children. All while troubling the doctrine of the religion that had shaped her identity from a Catholic child to a Catholic woman.

Over time, *Marie* faced her once strong and then crumbling belief system, Catholic religious observance, now needed critical questioning to get to the bottom of the heavy weight of shame and guilt she had been carrying for so long, entangled with her disenfranchised grief and loss of identity. After several years, one of the realisations for *Marie*, for example, was that the broader general Christian view around the constraints of Catholicism helped in that *Marie* still felt loved by God since the more expansive 'rules' did not exclude a woman who chose the route of medical intervention to help with fertility impairment. Thus, it was a start for *Marie* to feel supported, more honest, genuine, trustworthy, doable, and liveable within assisted reproductive technologies (ARTs) while still feeling loved by God. This took her to an even deeper internalised need to confess, a confession to God and indeed herself that she could no longer follow the religious observance of her Catholic faith, the religion that she believed her whole life was the only faith; this was deeply embedded in her from childhood. *Marie* had been, but a product of the part of Western culture that relies on religion steered towards producing a specific self by way of what Foucault (1988) posits "technologies of the self",

"The obligation to confess is now relayed through so many different points, is so deeply ingrained in us, that we no longer perceive it as the effect of a power that constrains us; on the contrary, it seems to us that truth, lodged in our most secret nature, "demands" only to surface . . ." (Foucault, 1988, 96).

Her faith steadily evolved as *Marie* navigated this tumultuous, confusing landscape. Her newfound faith surfaced and showed itself as a more personal and direct relationship with God, untethered from the dogmatic constraints of institutionalised religion. This transformation was not without its struggles, as she

struggled with the guilt and shame that are all too often a consequence of a Catholic upbringing in the context of fertility challenges and the choices they necessitate. *Marie's* relationship with the Catholic church's religious observance, which was "so deeply ingrained" in her that it held all the power over her, gradually weakened (Foucault 1988, 96). However, her newfound faith, guided by her inner feminist, and her direct communication with God, strengthened as it felt to *Marie* like "that truth lodged" in her "most secret nature", did indeed "demand" to "surface" (Foucault 1988, 96). That truth was ultimately a choice led by *Marie's* inner feminist, strengthened perhaps by the inner feminists of the women before her in her family in the act of her Mum, her grandmother urging her to "*do better*", not to allow the restrictions of the prison Foucault (1977) described of having to choose marriage and children or a career because trying to have both would be frowned upon in Catholic society.

Therefore, this lack of choice for the women before *Marie* in her family meant sacrifices by these married Catholic women who could not '*have it all*': marriage, children, careers, and lives outside their marriages and families. Perhaps *Marie's* mother's untreated postnatal depression-infused comment, when she said "*Don't have children, it'll ruin your life,*" was her way of expressing something about the demanding nature of choice and the truth that was always lodged in *Marie's* (and her own) "most secret nature" (Foucault 1988, 96). Perhaps her mother wanted *Marie* to "*have it all*" because she could not. As Chodorow (2003, 1187) states, "our current cultural climate, and perhaps feminism itself, stressing the incompatibility of career and motherhood, provide a cover for internal conflicts and fears, enabling women to mask conflicts and ambivalence about motherhood by turning them into conflicts

between motherhood and career.” Thus, as I reflect on my own insights from feminist scholars bringing UI and infertility into this dialogue, I think back to the roundtable discussions at the conference and hear the echoes of *Marie’s* words. Her words to her friend at the round table that day in Tampa, Florida, continue to resonate, reminding me of the ongoing process of questioning, learning, and growing that defines both the personal and professional life, and this research.

The process of writing about the connection between understanding how the Catholic religion, faith, and UI created an identity rupture in *Marie* highlights the complex relationships between what faith means to a person and religious observance, all while living with disenfranchised grief and shame under social stigmatisation. Therefore, the healing experience for *Marie*, combined with it being her first time writing about something she believed she would never do due to her Catholic guilt and shame was deeply rooted in the confessing of them, Catholicism and the act of releasing the religious institution from one’s faith, *Marie’s* faith.

**14<sup>th</sup> May 2024**

**An Arrival and Departure of a Mother: An Unexpected End to This Chapter**

“It’s not looking good: quality of life over quantity?”

*As I sit up on wee mummy’s bed opposite her, pillows tucked behind my back, resting on the bottom end of the cream-coloured metal bedframe so that I face her in her cosy quite cluttered bedroom with my open laptop balancing on a cushion in front of me, I tell myself to write something. I look up beyond the blank page on my laptop screen... a colourful handmade decoration hanging on the wall at the right side of wee mummy’s bed catches my eye. A cute little handmade flower in blues and yellows is glued piece by piece onto paper with words describing her beside each of*

*the initials: NANA. I recognise it; my son gave it to her a few years ago. I gasp and find myself crying; happiness, sadness, joy, smiles, and laughter appear in my mind's eye all at once as I read my son's beautiful, heartfelt words to his Nana.*

*I have never sat still or stayed long enough in this room to properly see what is here, not in any detail. I remember the day my son gave his Nana the handmade gift: family gathered around my dining table in Edinburgh, us opening our gifts for Mother's Day after breakfast — Mummy, me, and my sister. It felt more like Christmas Day, as it always does on Mother's Day for me, with so many presents, flowers, and plants. My husband always makes such a fuss about Mother's Day on my behalf. My hubby and my son sat amongst us, my son looking up at his Nana and Aunt with so much joy and excitement in his eyes as he watched them open his handmade gifts and cards. I have a video of it. I find the video and watch it, tears running down my cheeks.*

*My sister cries in the video as she opens her nephew's gift, and we all watch Wee Mummy read out the lovely words her grandson wrote. My son... it still feels surreal to me, calling someone my son; even after twelve years of doing so, I feel like I'm an imposter in motherhood; a part of me still in 'otherhood'. I pause in surrealness when I say the words "my son" as if I'm not supposed to. I realise in those moments that there is no end to the wound of unexplained (in)fertility (UI) as I witness the pain on my own face in the video, watching myself look over at the 'real natural mothers' at the table, almost in awe of them. I stop the video and wipe the tears from my face. I look over again at my son's beautiful little creation on the wall and say, "I didn't realise you'd put that on your wall, mummy. Why that one? He has*

*given you so many lovely drawings and writings." I didn't get an answer. She is heavily medicated and exhausted.*

*I miss my son and my hubby terribly while staying with Wee Mummy. Then I remind myself how lucky he is to be in his father's safe hands. I feel proud of the young human he is evolving into, and although I feel like an imposter sometimes, I sincerely feel grateful for my motherhood; paradoxically, the biggest blessing of my life, with it carrying the scars that twelve years of UI and medical intervention alongside my many other endeavours before finally carrying that last pregnancy to full term, left. It strikes me in this moment that he has also brought his Nana, as well as other family members, so much joy; I hadn't realised this before. Wee Mummy has ten grandchildren, my son being the last and youngest, even though I am the second eldest of my siblings. I know how special my son is to her; they are very close.*

*Ordinarily, my wee Mummy would be at Church every morning, carrying out her duties, busily tending to the sick in her community and administering 'Holy Communion' to her fellow Catholic parishioners of St Peter in Chains as one of its Eucharistic ministers. Alternatively, she'd be off on another adventure with her walking group to a historical castle or ruin on the west coast of Scotland, meeting her friends for coffee and going to her knit-and-natter group along the shore in East Ayrshire where she has lived since leaving Glasgow (and my dad) 25 years ago. She is a very active and popular lady. To see her lying in her bed like this so suddenly and heavily medicated on morphine, barely able to move, is incomprehensible to me.*

### **Three weeks earlier**

*Wee Mummy returns from her cruise to the Caribbean, mentions pain in her left shoulder, and arranges an x-ray. 'Something' shows up on the x-ray; she is sent for a CT scan, and 'something' shows up on that too. Mummy then receives an appointment at the hospital for a biopsy. I rearrange my diary and go with her. I hold wee mummy's arm as I notice for the first time, she suddenly seems frail. We walk into the small, overheated consultation room with no window. I wonder how the consultant can bear this stifling, uncomfortable heat with no natural airflow. He is sitting behind his desk with the CT scan on a screen at the end of it. After introducing himself, he opens with, "It's not looking good". He informs us that there is a 'mass' in Mummy's lung, and it is cancerous. He goes on to explain that the pain she has been experiencing is coming from the broken rib the cancer tumour has caused. He then points to it on the screen as if that would make it better for us. He proceeds to tell us that they cannot operate or give chemo or radiotherapy because the tumour is 5cm, and he doesn't think my wee mummy's health is up to even a biopsy, never mind further investigations.*

*I feel myself shrinking into a tiny ball the way I used to in front of ART consultants in the patient chair with the 'white coat' opposite me behind a desk in a position of power; that all-familiar feeling in that chair of disempowerment in a hospital; it still comes so naturally to me. Nevertheless, I push myself back into the role that I have played since my early childhood as defender and protector of my vulnerable wee mummy, and I challenge this. I struggle to catch up with him, and I can see my wee mummy is in shock: "Let's take a breath here; this is all too much", I say. "We were led to believe this appointment today was for a biopsy". At this point, I*

*lose my composure and struggle to stop the tears running down my cheeks. I feel very uncomfortable crying in front of others. I have failed to resolve anything for my wee mummy today. She puts her hand on my arm and tells me I look so worried, but “We mustn’t worry. All is well”, my gentle, vulnerable, yet resilient Mummy tells me, smiling, “Remember Marie, she repeats, all is well – this too shall pass – we must trust in God”. Unusually, I am the weak and vulnerable one - it feels odd, out of place; wee mummy steps up and looks after me, but I can see the bewilderment in her eyes.*

*I feel my heart racing - breaking.*

*I am devastated.*

*I am overwhelmed.*

*A week later, I would make the difficult decision to arrange an interruption from my PhD studies. I am unable to focus on my project or make progress on my thesis despite my initial excitement and dedication to organising my writing into chapters. In saying that, I appreciate this time, I get to spend with my beautiful wee mummy. I continue to work remotely with clients from her house, where I now spend a significant amount of my time.*

### **11<sup>th</sup> June 2024**

*As I sit on top of my Mum’s bed beside her, this time looking at holiday photos and reminiscing, my mum tells me my son, “is the biggest blessing and miracle in our lives”. “Isn’t he, Mummy?” I say as we look at him adoringly in the photos. “God answered our prayers on that, mind. I had everyone I knew praying at Lourdes for*

*his blessed arrival, year after year, through all your fertility struggles. We never gave in, and God gave us that miracle in 2012, our miracle, Marie”, she states proudly. ‘Oh yes, He sure did, Mummy. Just look at what your prayers at Lourdes achieved and how God gave him to us”, I respond. I always have a little chuckle to myself when my Mum suggests I had my son after twelve years of fertility struggles miraculously and purely from her own and her friends’ prayers at Lourdes and that it had nothing to do with the vast array of holistic and medical interventions I endured over those many years, not to mention the books I read and research I carried out on fertility impairment... strict diets and giving up of alcohol and my social life, becoming isolated, focus on nothing else but my fertility, or indeed my prayers. I find it sweet, though, that my wee mummy simplifies it all: my years of suffering and struggling into the straightforward answer to prayers at Lourdes; Perhaps it was. As I continue to flick through the photos, trying to prolong her engagement, I notice her still smiling, but now with her eyes closed. “That’s enough for tonight, Mummy. You enjoy the land of nod,” I whisper gently. “We can look at more photos tomorrow.”*

### **1<sup>st</sup> July 2024**

*I’m exhausted. I’m tired of updating family and friends and responding to message after message. This different kind of ‘rollercoaster’ seems to show a common theme of the UI experience: it swiftly moves between desperate glimmers of hope, followed by devastation and hopelessness, and back around again. I listened first-hand to the consultant assuring my wee Mummy and me, despite my list of desperate questions, how they could not carry out any of those treatments because of the size and nature of the cancer tumour coupled with the condition of her heart and her health, and that if there were a way they could cure my beautiful*

*wee Mummy, they would do it. However, the difference between this diagnosis and that of unexplained (in)fertility (UI) is the certainty that they cannot cure my wee mummy's cancer, a devastating certainty, but a certainty, nonetheless.*

### **13<sup>th</sup> July 2024**

*It is the day before my birthday. I am sitting by My beautiful wee Mummy, not beside her on her bed at home anymore since she now lies in a bed with rails on either side at a lovely hospice for end-of-life cancer patients. Only yesterday they informed me that we are looking at short weeks, which I must pass on to all the others. I sit beside her, attentively listening to her every breath and frail whisper as she spends even more time asleep than awake, which makes me think of the words of the consultant at the 'biopsy' appointment, "quality of life over quantity".*

### **18<sup>th</sup> July 2024**

*I met with the doctor as usual this morning in Wee Mummy's room at the hospice. There is a turn of events. The doctor informs me that over the week, Mum's condition has stabilised due to her reacting well to a new mix of medications. The doctor said it is now looking more like short months than short weeks for Mum. She goes on to explain that while they thought they were bringing Mum to the hospice for end of life care, they can now send her home, or we (the family) can arrange a care home in her community. I have mixed emotions. Mummy has become extremely frail and barely allows us to sit her up to sip drinks and take medications orally. It was so traumatic for her to move here. This situation has taken me by surprise. I never anticipated that the day we left Mummy's house in the ambulance weeks ago, Wee Mummy would go back home again.*

**21<sup>st</sup> July 2024**

*It's good to be back in Edinburgh for a couple of days while my sister is at the hospice, although I miss being with my wee mummy; it's a strange feeling not being right beside her. I can only liken this feeling to when I left my newborn son in the hands of someone else for the first time, that someone else being my wee mummy. If I'm honest, I am also worried that she might pass away without me being there for her; I need to be there for her, I must be with her at that time. It seems fitting that I've always been there for her, and I need/she needs me to be with her as she transitions from this world. Thus, I am grateful for my sister's video call. Without having to tell her, she knows I need these video calls when I'm not there. My son tells Nana he misses her as he pulls his football boots on at the door, ready for training. Mummy smiles and whispers, "Love you" to my son.*

**27<sup>th</sup> July 2024**

*I've been at the hospice for four days and was due to go home yesterday when my sister arrived. I decided to stay an extra night though. I sat by my wee mummy, holding her hand. I said all that was in my heart, talked about our unconditional love, how I felt, what it was like for me growing up, something I've never done with her. I was always guarded and didn't share so that I could be there for her; I explained that. I apologised for anything I've done to cause her upset, at which point she tried to respond; I think/hope to say I hadn't. The hardest thing for me to tell her was to admit I felt a little resentment towards her; I explained why; she knows; it was always left unspoken, the unresolved "Don't ever have children, Marie. It'll ruin your life" comment. Despite that, I reassured her of how much I loved her and described how amazing I felt because of her love for me and how strongly I felt it*

*when I was a small child, particularly before my younger two siblings came along and how that's when I noticed my Mummy lost her smile; I was around eight years old. That's when I started looking after her; our roles reversed. From then onwards, she became 'My Wee Mummy'.*

**“Pray for us, sinners now, and at the hour of our death, Amen”.**  
**(Gaebelein, Arno C. “The Book of Psalms.”, 1939)**

*Tonight, my sister asked me to pray ‘the rosary’ with her after we had a bite to eat at Wee Mummy’s bedside; ‘The rosary’ prayer is a big part of wee Mummy’s life; she cited it every day at her church with a group of parishioners, and my sister often did it with her. We each hold one of her hands, standing on either side of her bed; my sister leading the first half of these prayers, and I the second.*

*My beautiful Wee Mummy passed and transitioned into God’s arms around 9.30 pm as we recited her favourite prayer (The Rosary) to Our Lady while tenderly holding her hands. We completed the rosary before informing the nurse.*

*We had arranged every detail, but she never did get to go back home.*

## Chapter Six

### Faces and forms of unexplained (in)fertility (UI)

“Where no counsel is, the people fall: but in the multitude of counsellors there is safety”.

(Proverbs 11:14)

In this chapter, I shift from *Marie's* narratives to two distinct stories of my clients, illustrating how, at a certain point in our UI journeys, amid loss, we let go of hope only to attempt to reach a new moment when we feel brave enough to rebuild it, as *Marie* has practised many times over. The work here demonstrates how profoundly it affects each of us when everything falls apart during our UI journeys, and how, as patients of reproductive medicine, we become accustomed to this, facing hit after hit, loss after loss. I use the term ‘us’ because I am the writer, researcher, storyteller, *Marie*, and psychotherapist, all of whom are interwoven throughout this study. As many of my clients undergoing medical intervention have expressed in various ways, and as *Marie* has shown in the vignettes of this thesis so far, we try to protect our hearts throughout the medical cycles and beyond. During these processes, we learn not to cling to hope any longer. We do not know whether or how we can rebuild and reclaim our ruptured identities after losing ourselves on the rollercoaster of unexplained (in)fertility (UI) coupled with medical intervention. This chapter aims to explore other stories of unexplained infertility (UI) beyond *Marie's* re-remembered journal writings, while honouring and drawing from a segment of my client group affected by UI. It offers different insights and introduces a range of UI aspects that are not necessarily covered in *Marie's* narratives but share common themes: shame,

stigma, identity issues, and disenfranchised grief. This chapter also highlights some core tasks of therapy for UI, illustrating the importance of the language used in UI, digging further into the concepts of ambiguous and nonfinite losses, and chronic sorrow. In doing so, it also provides me, the therapist, with a deeper understanding of *Marie's* experiences, which, in turn, supports my counselling of my UI clients more. Hence, I now address my sub-question: How can counselling and psychotherapy support the processes of UI and infertility?

Unexplained (in)fertility (UI) took *Marie* on a profound, unexpected journey, from believing she could resolve anything to sitting hopelessly in the dark, feeling anguish and becoming silent about it, let alone seeking therapy. I now find myself sitting in the dark with my clients, providing a space for trust to be shared, accepting and understanding their stories as they express their suffering, a space which *Marie* never found for herself at that darkest of times. Brené Brown (2021 73) states, “Only when we know our own darkness well can we be present in the darkness of others”. This brings me to silence and voice: one of my clients, for instance, I know only her anguished voice as she cries and sobs throughout each session from start to finish, sharing *her* injustices regarding *her* UI and IVF experiences, gasping for breath at times, only pausing to wipe her tears. That is her voice to me. And mine? My voice, along with my silences, holds significance for her; however, she ‘hears’ or ‘reads’ them as we speak and understand the language of UI, offering and receiving agency, giving voice to the different faces and forms of UI; bringing the experiences of UI to life. In the counselling room, I believe there is no privileging, giving, or taking of voices (Mazzei and Jackson 2012, 246).

Regarding anguish, being labelled with the diagnosis 'unexplained (in)fertility' (UI) in my own experience, as well as for most of my clients, has resulted in prolonged and negative effects on life due to the uncertainty of this diagnosis. In my opinion, 'anguish,' which is also linked to disenfranchised grief, is the most fitting emotion associated with UI in my personal experience as a co-sufferer and as an infertility counsellor. In Brene Brown's (2006, 46) grounded research into emotional connections to human experience, she aptly describes 'anguish' as, "The toughest emotion of all, a sense of heartbreak, despair, hopelessness, even foreboding, an almost unbearable drawn-out traumatic swirl of incredulity, grief and powerlessness, a fear of moving in closer to what we do not want to relive".

Additionally, as a feminist researcher, I partly base my values on those of Linda Hammer Burns, Sharon Covington from the USA, and Darcy Harris in Canada — all of whom have been mentors to me through their passionate writings as experts in counselling infertility and reproductive medicine. As I continue to learn from their invaluable insights as researchers and infertility counsellors themselves, I regularly reflect on how I can better support my clients through their complex and deeply personal journeys and improve my infertility counselling processes accordingly. My experiences as a counsellor, coupled with my own journalled, unexplained (in)fertile (UI) experiences presented in the previous chapters, shape my research and often mirror the struggles faced by those I support. Furthermore, as a specialist counsellor dedicated to infertility across the broader spectrum, which has become an integral part of my identity and one I cherish deeply, I remain resolutely committed to this fertility impairment battlefield, standing shoulder to shoulder with each of my clients as they confront their unique reproductive losses and challenges whether it intails

medical intervention or not. I carry the weight of each client's story, and together we experience the power of empathy and resonance. Each of my clients is a warrior fighting their battles, and in one way or another, they are survivors too.

In my counselling room, we do not valorise scars, wounds, pain, or broken hearts. Instead, we speak the language of infertility and unexplained infertility (UI), exploring associated causes when known. Due to the scope of this study, however, I concentrate on the uncertainty surrounding unexplained (in)fertility (UI), where my clients and I collaborate to seek UI's meaning for each individual and navigate the prolonged agony of being trapped in a liminal space between identities or outcomes, with no clear resolution in sight, or as many of my clients describe it, "life on hold." Through this process, we uncover each client's unique path forward.

My client base includes heterosexual couples, same-sex couples, and prospective single parents. Whether it involves the female partner in the heterosexual couple undergoing therapy—which is often the case—both members of the couple or an individual, together we explore their experiences with the wide range of infertility related issues and experiences: assisted reproductive technology (ART) or outside of it, stopping medical treatment, adoption, surrogacy, donor conception, egg preservation, relationship issues, sexual problems, involuntary childlessness, miscarriage, stillbirth, termination for medical reasons (TFMR), and more. Because this study focuses on UI, I specifically include heterosexual couples here, as there is no definition provided for UI that covers same-sex couples' infertility journeys within this research field. For example, as researcher Jennifer Toadvine (2014, 4) from Widener University, USA, found in her phenomenological study of

twelve lesbian couples with infertility, she states, “Lesbian couples must conceive outside of traditional intercourse, but failed conception through these other methods is not discussed when infertility is defined”. I have observed the same lack of support and literature regarding infertility in gay (men) couples in this area of research, as society, the medical model, and most studies tend to focus on heterosexual couples. Suzanne Slater (1999, 38) from the University of Illinois agrees that “Omitting lesbians and other non-heterosexuals from language, books, and other major vehicles of the mass media, cultural image-makers suggest powerfully only heterosexuality is normal”. I will explore these broader topics related to infertility in a more in-depth discussion beyond the scope of this thesis in separate journals after completing this PhD project.

For now, having received my clients’ permission, I recount their stories for the first time as a witness. After considerable thought, I have selected the following two clients, represented through client examples, to highlight some of the diverse faces and complex forms of unexplained (in)fertility (UI). This exploration of the experiences of two individual clients in therapy stimulates a discussion on counselling those facing unexplained (in)fertility and the importance of having a uniquely positioned infertility counsellor to address such specialised understanding and needs, while inviting you to truly grasp its unspoken depths. My clients’ spoken words, as well as my own spoken words as the counsellor, are presented in *italics*. All client names have been replaced with pseudonyms.

Let's go into the counselling room:

First, meet Vivian...

Vivian started therapy with me over three years ago, following her attempt at *“giving other counsellors a try.”* She requested a ‘consultation’ first to ensure she was not *“wasting any more of my time talking to counsellors who claim to understand infertility, and then it becomes apparent they don’t.”* Vivian was testing me. It felt more like an interview to determine whether I was the right person for the job. After our twenty-minute consultation, during which she angrily fired infertility language and abbreviations at me as if from a cannon, one after another, testing whether I understood their meanings—and I passed each test—she asked if we could begin therapy the following week. We have continued to meet consistently every other week since.

I already knew from her initial email that Vivian and her husband, Ryan, had reached the end of an arduous reproductive medical journey spanning six years, which included three IUI cycles and six IVF cycles, without a baby to take home. Vivian explained, *“We got in over our heads... we are broken... feel exhausted and completely lost in it all... as in we have even lost ourselves... we give up... we are done... defeated”*. They had just made the very difficult decision to stop medical treatment. However, they needed to know, with the guidance of a specialist infertility counsellor, that they were doing the right thing in stopping treatment and needed to discuss where they could go from here.

Vivian, a 39-year-old woman, and Ryan were eager to start a family soon after their wedding eight years ago. However, after two years of trying to conceive with no pregnancy, they were diagnosed with unexplained infertility (UI) following initial medical checks, which revealed no medical issues with their fertility test results. Determined to have children, they wasted no time embarking on a journey of medical intervention, having been encouraged and led to believe by their GP that this was the solution to having a baby.

I will never forget the first question Vivian asked me. She told me she had read the details on my website and understood that I, too, had experienced unexplained infertility (UI). She asked me as if my answer would mean life or death to her, *“I need to know... following your experiences of reproductive medicine... did you have a baby?”* I looked directly into the pain in her eyes. I saw her yearning for me to say what she wanted to hear: that she needed me to say that I, too, emerged from the other end of reproductive medicine without a baby in my arms. I knew what she wanted to hear and why she needed to hear it so desperately.

Before I answered her question, I anticipated that she somehow knew what I was going to say. She physically braced herself; as I looked into her eyes, she closed them. I responded to her question sensitively and carefully, recalling my pain from the past and remembering others telling *me* they had a baby while I was amid *my* perceived ongoing failures, hopelessness, and anguish during those stages of my medical journey. *“I did have a baby from my ART journey, Vivian,”* I responded as quickly but as gently as I could, leaning into that pain with her. I spoke very slowly, not taking my eyes off hers, even though they remained shut, and continued,

*“I’m sorry... I know that’s not what you wanted to hear, and you don’t have to try to explain it... I know... I understand... and I’m sorry for the pain this is causing you... I understand that my happiness in this instance equals your deep pain and that it’s nothing personal. I will also understand if you are unable to work with me because of it.”* Vivian slowly opened her eyes again and relaxed her face slightly. She looked around as if still processing my answer, and eventually looked directly back at me, and said, *“I’m sorry I asked you that... I just had to know... it was very painful to hear... thank you for how you answered it though and for relieving some of my guilt and shame about asking... it means a lot that you understand and validated me like that.”*

I saw Vivian’s scars, her struggles in that first client session—I saw the unforgettable battles she had fought in pursuit of her dreams of becoming a mother; I saw it all in her eyes. Her eyes told the story more than her words. Vivian still begins each session, to this day, as she did in that first session, with a written list that she aims to get through each time, ticking it off as we progress. At first, she displayed her warrior self to me—her pride as a high achiever in life, as most of my clients are, her confidence, her successes in all other areas of her life, her resilience, the fighter, the hardened survivor of reproductive medicine. However, over time, her vulnerability found a place in the counselling room, despite our sessions taking place online.

Vivian was deeply invested and recounted every micro-detail of each stage of every IUI and IVF cycle that began with hope and confidence. After undergoing ovulation-stimulating treatments and having her mature eggs surgically retrieved, Vivian and Ryan successfully created grade ‘A’ embryos in vitro in all six of their IVF

cycles. However, all embryos ceased to develop before reaching the blastocyst stage, the necessary stage (stage six) for implantation into Vivian's uterus. Unfortunately, none of their embryos survived past day five, falling just short of the required stage six for implantation. They were just one step away each time from *"Pregnancy occurring if any of the embryos implanted themselves in the lining of the uterus"* (Bozdag et al. 2008, 410). Kluger-Bell (1998) observed that the significant involvement of women during treatment cycles, coupled with the technology that visualises the entire process, can create an attachment and emotional bond to a potential pregnancy, particularly during ultrasound monitoring of the follicles. Vivian was deeply invested in her embryos and had immense love for them. Hurwitz (1989) described a failed in-vitro fertilisation (IVF) cycle as more than just the loss of an imagined child; it closely resembles the loss of a real child, given the awareness of the potential mother regarding existing embryos, as it was for Vivian.

Vivian and her husband, Ryan, felt confusion, anger and a sense of injustice each time they nearly reached the end of these physically and emotionally demanding IVF cycles. They tried every method of IVF and medication combination available, including ICSI. Both were devastated by the negative results and found it extremely difficult to decide to stop ART. Although they felt they had lost control over all the stages of the medical cycles, aside from looking after themselves physically, they nevertheless held on to a small element of control, a sense of power by *choosing* to persist with the six IVF cycles they had. Linda Hammer-Burns (2017, 184) emphasises that systematically identifying and addressing the key adaptive tasks involved in managing the treatments for UI can significantly enhance individuals' and couples' sense of control and mastery over their experiences with it.

Additionally, I noticed that Vivian was initially quite matter-of-fact about her heartbreak over the loss of each embryo; however, she later explained, *“I wasn’t taken seriously by the medical staff at the clinic, my very few friends and family who knew, or even the counsellors I met before you, when I initially expressed my unbelievable deep sadness and heartbreak over the loss of my embryos... and that... well... shut me down. I thought I wasn’t allowed to grieve my lost embryos, that it was ridiculous... that it wasn’t acceptable, not okay... so... I stopped expressing my real feelings about it.”*

Therefore, we devised a plan to name, process, validate, and commemorate the loss of each of their precious embryos, marking the hopeful beginnings of each one. Vivian managed to obtain only two images of them from the clinic, which I had asked her to inquire about, as most clinics keep images of the embryos in their early five to six stages before implantation. I aimed to validate her feelings and encourage her to express her disenfranchised grief over the loss of her embryos, her longed-for babies, so she could own and feel confident about the significance of her narrative and her losses. I wanted to show Vivian that her emotions were *acceptable* and more than *okay*, and that grieving her embryos was essential for her healing. While this brought back memories of the support and care I lacked during my many lost embryos through *my* IVF cycles—such as remembering not daring to discuss with anyone the embryos I lost, as I was acutely aware of the lack of understanding or acceptance of this within my society and culture, even among my own friends and family, I was nevertheless able and prepared to offer Vivian what she needed; what I needed back then: acceptance and validation, naming these significant complex losses, invisible to society, and providing a non-judgmental space and opportunity for

healing. The plan we made to mark these losses for Vivian and Ryan was fitting, beautiful, and memorable, yet not memorialised in a traditional sense, as they did not wish for it to be an obvious, publicly visible marker since it was so personal to them. It was an honour and a privilege to be invited to contribute to the intimate and personal commemoration of each of their embryos, which reflected their wishes. Some clients seek my input, while others do not; it is a deeply personal matter. I also realised that although my personal experiences with ART influenced my understanding of Vivian's struggles, I must avoid projecting my own story onto hers. Although this part of the process brings back the pain of my past losses, I find that each time I work with clients, a part of my heart also heals in remembrance of each of my precious lost embryos and my miscarriage; there is a shared healing experience at play, yet it remains unique for each client and co-sufferer/counsellor.

Furthermore, I evoke 'paradise lost' as fitting here, which I discussed in Chapter Four, in honour of Vivian and Ryan, as it illustrates their loss of embryos and, ultimately, their envisioned children (Burns 2006), since Vivian regarded each of her embryos as her babies. 'paradise lost' in this sense of complex loss is central to the experience of UI, as Vivian faced the 'death' of her longed-for children—her embryos—who were "psychologically present but physically absent" in her womb and her life, as well as in her husband Ryan's life (Burns 2006, 9).

I have never met Ryan; however, Vivian speaks of him, his concerns, their relationship before and after UI, and the issues caused by it that had not existed prior to this season of their marriage. Vivian and Ryan agreed that Vivian could not physically or emotionally endure any more ART. Additionally, they could no longer

sustain further treatments financially, as they had exhausted all their savings. They had borrowed money and incurred debt to cover the last three cycles of IVF. This couple were “*completely broken and devastated*” (words taken from my client notes) when I first met Vivian. She said, “*I had to give up my full-time job during all of this... the pressure and stress it was causing... I was taking too much time off... my projects and my team were feeling my absence. I felt so much guilt about letting my team down... and then... the shame of losing all our savings... I feel like such a fool... It took a long time and a lot of hard work to build up those savings, and now we're in debt. It's all so shameful.*” Vivian continues, “*Unexplained infertility (UI) became my full-time job. In my UI career, I've learnt that you need to become better than the detectives in MI5 to investigate it for yourself. I wish I'd had an actual diagnosis, as the doctors just leave you to figure it all out by yourself when it's unexplained.*”

I strongly resonated with Vivian’s comment about being left to figure things out alone and feeling like a detective myself, investigating everything I could on my own. I had similar thoughts during my years living with the unexplained infertility (UI) diagnosis. I also longed for a ‘proper’ diagnosis, something tangible I could aim to have corrected or fixed through medical intervention. Most diagnoses come with a corresponding solution or outcome; even cancer, where you either survive it through medical treatment or it claims your life; there is a definite outcome. However, with UI, as I have shown in this work, the suffering is prolonged, and ongoing issues persist with no tangible solution in sight; ART is merely a gamble—a very physical, emotional and financially draining one.

Additionally, as a researcher, I increasingly notice how little UI is discussed as an 'illness', albeit an 'unexplained' one. This highlights the impact on ART patients, my clients, who suffer from prolonged anguish due to the unknown—this liminal space involves disenfranchised grief and the extended emotional toll of medical interventions (ART). Even in today's post-modern world, where we tend to deconstruct taboos and acknowledge topics like infertility more, these experiences remain somewhat silenced. Arthur Frank (1995) discusses his illnesses, a heart attack and cancer, describing a 'remission society' of people living with illness or disability. Those with illnesses are more than mere victims or medical patients; they are wounded storytellers. I see this reflected in my clients as they eventually share their stories with me in therapy, in the hope of giving a voice, a face, a form, and of making meaning from their suffering from UI. I believe the absence of a medical explanation contributes significantly to their anguish, as it did for *Marie*. However, when they transform their silent, shame-laden, and stigmatised experiences into narratives shared in therapy, they find healing through this storytelling as a part of the therapeutic process.

Regarding diagnosis and becoming a patient, Arthur Frank (1995) draws on the work of authors such as Oliver Sacks, Anatole Broyard, Norman Cousins, and Audre Lorde, as well as from people he met during the years he spent among different illness groups, and recounts a compelling collection of illness stories, ranging from the well-known—Gilda Radner's battle with ovarian cancer—to the private testimonials of people with cancer, chronic fatigue syndrome, and disabilities. Their stories are more than accounts of personal suffering: they are filled with moral choices and point towards a social ethic. Frank (1995) identifies three basic

narratives of illness: restitution, chaos, and quest. Restitution narratives anticipate recovery and highlight the technology of cure. In chaos narratives, illness seems to persist indefinitely, with no respite or redeeming insights. Quest narratives involve finding that insight as illness is transformed into a means for the ill person to become someone new. Vivian would fall into the chaos narrative during her UI experiences, with UI feeling endless, offering no respite or redeeming insights. From the perspective of a co-sufferer, and as a practising counsellor working within this topic as well as a researcher of it, I think of Vivian's comment about the ART patient being left to figure out UI—the unexplained—by herself, as isolating, since the medical model, i.e., reproductive medicine, is unable to find a medical reason for it. Therefore, ART remains a gamble—just another roll of the roulette wheel for Vivian and every UI sufferer.

There was immense pressure on Vivian once in the system of medical intervention as her identity is then determined by the outcomes of her medical treatments, not to mention conforming to the consultants' and doctors' professional identities in a highly profitable but high-risk business, which also relies on her potentiality to reproduce, agree Whiteford and Gonzalez (1995). Consequently, once in this process of medical treatments for UI and infertility, women feel bulldozed into not giving up until they either succeed in a successful pregnancy or they exhaust every option available to them. Whiteford and Gonzalez (1995, 36) add that we must respect women equally for their reproductive as well as their productive positions in society, otherwise this cultural norm of “flawed social identities for infertile women will remain”. The rampant expansion of the ‘medical fertility industry’, nevertheless, regenerates this ‘flawed social identity’ by presenting to women with fertility

impairments that they are obligated to lay bare to assisted reproductive technologies (ART), despite the physical, financial, and emotional price, prolonging and promoting “the hidden burden of infertility” (Whiteford and Gonzalez 1995, 36).

This study revealed the social construction of a philosophy that harms women suffering from UI and infertility. The damage caused to women, as demonstrated here, is compounded by women believing they are inadequate, which leads to stigmatisation because they ‘failed’ to meet a ‘cultural norm’ as Vivian felt she had (Whiteford and Gonzalez 1995). This emphasises the power of stigma, isolation, and shame that women with UI and infertility endure. This research also shows that these processes are the development of a medicalised body that becomes a commodity in the ‘infertility industry’ during these experiences, for Vivian and for all ART patients.

After taking some time to recover from all the medical treatments and for Vivian to process in counselling, marking each loss, Vivian and her husband had a holiday together, after which they decided, following much discussion, that they could not remain involuntarily childless, and would like to adopt. Between the medical intervention and adoption processes, it has been the most trying and testing time of their lives. Vivian described her many complex and invisible losses throughout her therapy as *“grief with nowhere to go, having love to give to children but with nowhere to direct it”*. She continued, *“We have so much to offer children, a lovely home, committed and loving parents... and so much... love. Those beautiful little embryos, each and every one of them; they were our children, my children, and they were just... discarded... Yes, we have made these connections in therapy... it all makes sense now. Discarded... that was the word they used... my embryos, my babies...”*

*my children... discarded... they died, Marie, and I carried all that shame... I thought it was all my fault. My biggest fear was always that I might not be a good enough mother... that I would let my kids down, the way... my parents let me down. My little embryos... I couldn't help them; I couldn't save them. I had no control over any of it. It all felt so... hopeless. I was... a helpless, powerless bystander in my own body. We were nearly there... but... I couldn't save them... I would have given anything to save them if I could have. All that suffering... years of suffering... for nothing. Nothing but heartache and pain... no baby to take home at the end of it all; a void that no one around us truly understands. No one even barely knows about all we've been through... Well, apart from the few I told you about. The pain, the heartache, the loss from the medical treatments; it never leaves you. I thought it was me... it was me who wasn't good enough. I couldn't even produce embryos that would develop sufficiently to implant. I tried... I put everything I had into trying to get pregnant... I mean... everything... but... there was always an underlying feeling that I wasn't good enough... the other reason I wanted to come to therapy. I felt... a lot of shame. You were the first person I've ever spoken to about it... never... not to anyone... and I'm glad I've now brought it here... to you... Now I know and understand that all my shame stems from my childhood trauma. I now believe, through this therapy, that it's okay that I wanted to correct the wrongs of my childhood traumas, with my own children. I wanted to be there for my children, to step in and stop any bullying if it were to happen. It was wrong that nobody did that for me. My own mum... she didn't stop it... she could have and yet... she didn't stop it. But I now understand why she couldn't... and... I've forgiven her, and my brother, even my dad... because of the work we've done together in therapy. I no longer carry all that shame... and I am ready to be a good parent... I'm ready".*

I remember the first time Vivian brought her childhood trauma to therapy, *two years* into our fortnightly meetings, and it was agonising for her. It seemed far more challenging for her than it was to bring her UI and ART trauma story. Nevertheless, commendably, she believed she needed to address it before commencing the adoption process. Throughout this part of the process, I sought to embody a stance of empathy, allowing Vivian's emotions to guide our exploration. This meant recognising the discomfort that also arose for me when she confronted her childhood trauma and its link to her/my unexplained infertility (UI), as my own narrative unfolds through my client work and makes more sense each time, creating meaning and a deeper understanding of my clients. I understood with Vivian that my role was not merely to provide acceptance and understanding but to facilitate a dialogue that honoured her experience. I aimed to be a mirror, reflecting her strength and vulnerability simultaneously, while also challenging her at times to confront the internalised shame that had silenced her for so long. We have worked through her childhood traumas, linking them to and leaning further into her fertility journey. Carolyn McLeod (2002), an expert who writes about women's autonomy in reproductive medicine, states that trauma symptoms relate to a loss of control and feelings of helplessness and powerlessness, which can affect self-trust, relationships, and decision-making. McLeod (2002) adds that infertility and its medical treatments can evoke these very feelings, and often do. The feelings of powerlessness and helplessness, combined with the loss of control that Vivian experienced during her medical interventions, transported her back to the lack of power and control she remembered from her childhood.

Vivian and Ryan have been participating in the adoption programme for the past eighteen months, and it has been extremely challenging. Vivian states, *“They play good cop/bad cop with us. I feel interrogated after each meeting, like she’s trying to trip me up; it’s very unnerving. The childhood trauma did come up, and I’m glad I’ve explored that with you and now understand it better and how it is linked to this, as it was strange... I had practically forgotten about it until I started my medical treatments. I’m relieved that Frankie, the social worker, spoke to you, too, Marie. I don’t know if she interrogated you the way she does me, but I don’t expect you to tell me what she asked you or what you said... I would appreciate an indication of how it went, though. Anyway, I feel so much better that we got to the bottom of where my shame comes from, and that I’m not hiding it so much anymore... I mean, I think about it in a different way now. too. I continue to work on feeling good enough in all areas of my life, as an extension of what we address in our sessions. It’s been challenging but worth it. It’s actually sinking in now that this time we will come out the other end of something hellish, but with an outcome... with children, unlike IVF. I can’t believe we’re finally starting to look at sibling profiles of children available, now that we’ve been accepted... it only took nearly another two years of our lives. I can’t tell you how strange that is, though. It’s like... we feel so bad when we turn down children’s profiles ... You know, we have said ‘no’ to severely problematic kids. I realise being here at this stage is because I’ve now understood, accepted, and let go of so much, in letters that I’ve written and destroyed, from journalling, marking all my losses... realising how powerful my writing has been-the letters to my body, my womb about being infertile and how that made me feel towards my body. I now understand that these were all invisible, complex losses related to fertility challenges, thanks to your teachings on the difference between these losses and other types of*

*grief. I learned how to cope with and heal from these losses. I initially didn't realise it was a different kind of grief. I was so confused before about how and why I felt the way I did, but you taught me how to understand it, and I have felt the healing. Anyway, still... here I am... you know... I struggle to even look at the profiles of kids who are available in case it's a 'no' from us, but we've got to get this right. I mean, how do we choose our children? And because they are only sending sibling profiles between ages 4 and 7, that also breaks my heart... I mean I'm ready for this... You know... I'm in a different... a good place now. I am ready to adopt, but it hit me that I might never... hold a baby. I longed to hold my babies in my arms, carry toddlers around... but I won't get to do that... they'll be too big by the time we get them. I definitely made the right decision not to accept being Godmother to my friend's baby... You know why Marie... because I couldn't even have held her at the christening. I couldn't have... I have to protect myself. I couldn't hold my neighbour's new-born baby... you know, my neighbour across the road, I told you about, who just had a baby. I had to ask Ryan to buy the gift... as you know, I got as far as buying the card, but when I went to buy new-born baby clothes... I just couldn't do it... I ran out of the shop in tears. If only we had started the adoption process six years ago instead of pouring ourselves and our savings into IVF, we could have adopted babies by now, but now we are too old. It feels so unfair. Yet, despite the hell we've been through, I'm also grateful for the healing that has come from this journey. We are finally on the brink of having our family, and I finally believe we will have our children".*

As I have walked alongside Vivian, I find myself contemplating the ethical implications of my role. For instance, I have asked myself how I could support her

and Ryan in navigating the societal and cultural narratives that often diminish the importance of her losses. My goal is to assist in empowering Vivian's voice, encouraging her, not only to acknowledge her grief and reclaim her narrative in a world that frequently overlooks the emotional impact of UI and infertility but also to find *her* way of expressing and owning *her* pain, wounds, and *her* broken heart that ached for her lost embryos and all her other losses. In this relational space, I became acutely aware of the power dynamics at play—how my role as a therapist could either validate or dismiss her experiences.

First, I aimed to create a safe space where Vivian felt confident in sharing her fears and desires without the risk of judgment or worry that I would not understand her language of UI since we established this early on in our therapeutic relationship. I understood the nuances of what it meant for her not being able to buy a newborn baby gift for her neighbour or attend her friend's baby's christening as Godmother. I recall having similar experiences during my own UI journey and made sure to remind myself that they were different, yet shared a common thread: our unique versions of disenfranchised grief, ambiguous loss, nonfinite loss, and chronic sorrow (Boss, Roos, and Harris 2021). We explored what these incidents signified to her, me, and us collectively, thereby creating acceptance and validation of how challenging these day-to-day incidents can be when in the depths of living with UI.

This involved being open and transparent about *my* limitations and recognising that I was also learning alongside her, rather than viewing myself as 'helping' her from a position of authority. In this context, I strive to implement the principles reminded to me by one of my mentors, Jonathan Wyatt (2021, 84), that it is crucial to

recognise that the therapeutic process is co-created, with both therapist and client contributing to the healing through their shared engagement and presence. Wyatt states (2021, 85), “helping is not something someone “gives” or “does” to someone else but something that arises within the relational process, in the encounter between therapist and client”. Furthermore, my ontological stance is rooted in the belief that healing occurs within a relationship. By holding space for Vivian and encouraging a trusting connection, I facilitated a transformative journey—one that helped her integrate her past traumas with her future aspirations, find meaning in them, and move forward when she was ready. As she began to envision a family through adoption, I felt a deep sense of gratitude for the opportunity to witness Vivian’s experiences and her path of resilience and self-discovery.

This takes me back to UI being increasingly recognised in this field as an “emotional roller coaster” (Watkins & Baldo 2006), that is rarely discussed without its counterpart, reproductive medical intervention, ART. Vivian and Ryan’s rollercoaster journey has been profound, complex, prolonged, and challenging, to say the least. Darcy Harris (2017, 32), the associate professor and writer on political grief, ambiguous loss, whom I introduced in Chapter One, agrees that UI represents a hidden form of loss, with those not affected often harbouring unrealistic expectations about treatment success, making it nearly impossible to share these experiences. Therefore, providing clients with the opportunity to name and discuss their experiences openly offers a sense of enfranchisement to the feelings of grief and loss that so often go unacknowledged.

It is also essential to recognise not only the loss of a biological child but all other losses present, acknowledging that these losses and grief are subjective, as seen in Vivian and Ryan's loss of their embryos. Harris (2017, 34) states, "clinicians should follow the lead of the person sharing the experience to understand better what infertility means to that individual, and how daily life, hopes, dreams, and views of oneself have been affected." She also suggests that using terminology such as "ambiguous loss, chronic sorrow, and non-finite loss" (Boss, Roos, and Harris 2021) can help accurately describe and normalise the emotions associated with UI and infertility. I have found that using these terms with Vivian, along with 'disenfranchised grief' (Doka 2002), has had a positive impact. Vivian has expressed that hearing these words makes her emotions feel more real and understood, which makes her feel seen, heard, and validated — in contrast to her emotions appearing invisible or ignored, as they often are outside in her culture, society, clinics, and even among her friends and family. Vivian described feeling "*shut down*" and "*ridiculous*" while grieving the loss of her embryos.

Harris (2021) provides further explanation of women describing "ambiguous loss" in ART, which would clarify Vivian's loss of her embryos at stage five, just before implantation at stage six, if they had progressed to that next step. Harris (2021, 164) states, "ambiguous loss is often described by women in infertility treatment who feel that they "lose a baby before there is even implantation of the embryo into their uterus". Covington (2006) refers to this as pre-implantation miscarriage. Glazer (1997) has called it a 'technical miscarriage'. Harris (2021) further explains that unsuccessful reproductive medical cycles can be difficult for patients to define when their embryos are in a petri dish and do not develop into

blastocysts and fertilisation (stage 6 of the IVF process), as they are still psychologically present for the woman, as it was for Vivian. Harris (2021) confirms that the grief these women experience is as strong as when pregnancy is not confirmed following a transfer of the embryos into the woman's uterus (stage 6). Therefore, Vivian, was left to "deal with the loss of a baby (or babies) whose physical presence was real but existed only under a microscope" (Harris 2021, 165). Whether an ambiguous loss is "physical or psychological", I agree with Harris (2021, 165) that people feel confusion over not only what to do but what role they are to play, and therefore grief is frozen, uncertainty is prolonged, relationships are conflicted; hope is lost, as it was for Vivian and Ryan.

Vivian and Ryan endured in their different ways six protracted IVF cycles due to their understanding and belief that the more cycles they attempted, as encouraged by the reproductive medical model, the greater their chances of achieving a pregnancy to term and a live birth. For instance, a study by Oshrit Lebovitz et al (2018) conducted in Israel noted that, unusually, their national health insurance covers the costs of multiple assisted reproductive technology (ART) treatments. It concluded that women aged up to 44 who undergo a minimum of six IVF cycles using autologous oocytes (their own eggs) have about a 29% likelihood of achieving a live birth. Although this underscores the advancements in medical reproductive technologies and the potential for achieving a live birth through more sophisticated methods with multiple IVF attempts for women aged up to 44 (2018), six cycles of IVF can take a significant toll on women both physically and emotionally, as it did for Vivian and Ryan. Additionally, there is a financial burden on couples, particularly

outside of the unique situation in Israel, with each IVF cycle costing approximately £8,000 or more, totalling £48,000 for six cycles in the UK, for example.

Furthermore, what if, after enduring six cycles, there is still no pregnancy? At what point should the couple stop, walking away with the scars of this struggle as Vivian and Ryan did after six cycles? Franklin (1998) found that the very existence of ART makes it difficult for women to accept infertility; women feel compelled to at least 'try ART.' From this perspective, ART is a "forced choice," says Franklin (1998, 110). Secondly, the tendency to measure success in treatment stages (e.g., successful ova extraction, fertilisation, and embryo implantation) increases the desire to have a child of one's own. For example, as with Vivian and Ryan, studies have found that even when treatment does not result in a live birth, reaching a 'measure of success' at a particular stage in the cycle can encourage a desire to 'keep trying' (Franklin 1998). Ultimately, Vivian and Ryan discovered that "trying" created a more profound sense of desperation for a child than before treatment (Franklin 1998, 112). This research indicates that infertility forces women to re-evaluate their use of ART. Over time, living with infertility can lead to a crisis that prompts couples to reconsider their approach to parenthood. Some women in this study accepted a life without children, while others questioned the importance of biological ties and opted for adoption, as Vivian and Ryan did.

Vivian remains in therapy, and they have selected their children after a challenging adoption process; siblings, a girl aged five and a half, and a boy aged four. At various points of their journey with reproductive medicine and adoption, Vivian lost hope. She felt broken, while she struggled with how differently her

husband, Ryan felt and reacted to all these processes, causing issues in their relationship, which she regularly brought and still brings to counselling. Despite this, she said that they still tried their best to lift the other when one fell, as they gradually stopped attending social gatherings and withdrew from friends and family at different stages of this. Consequently, both were unconsciously learning to live with the ongoing experience of prolonged disenfranchised grief in solitude. Roos (2014, 65) refers to these experiences as “living losses.” Harris (2019, 312) explains, “it is common for those experiencing non-death losses to become isolated, as friends and family members tire of not seeing ‘progress’ in the person’s grief, or the loss is not one that they can see, comprehend, or even acknowledge. For example, as Harris (2019, 312) states, “a couple going through infertility treatment for many years may look fine on the surface, with their appearances betraying the potential devastation to their relationship, finances, plans, and hopes for their future” (Harris 2019, 312). Vivian and Ryan had been experiencing their “living losses” Roos (2014, 65) continuously without respite for eight years, and continue to learn to live with them.

I remember instances of Vivian’s “*falling apart*”, her brokenness, displaying sheer hopelessness and ambiguous loss (Harris 2021) when she could not find joy or happiness in any other area of her life, as all her hopes and happiness were reserved for her ability to conceive or grow her family; many of which mirrored aspects of *Marie’s* journey. Harris (2017, 34) also refers to these as “nonfinite losses” because they have no end. They are complex losses that require ongoing understanding and adjustment, which I continue to work on alongside Vivian. These ‘nonfinite’ losses affect a person’s identity and future plans, making it impossible for them to plan for the future. In some ways, the loss continues for the rest of the

person's life, explains Harris (2017). As Vivian said, "*it never leaves you*". Vivian and I also work together on mourning the person Vivian once was. In counselling infertility, I address the loss of my clients' former selves, friendships, family connections, innocence, sense of fairness, beliefs, religion, spirituality, and the dynamics of their relationship with their partner (Harris 2017, 33). I also see this as helpful in finding a way to live with the everyday reminders of these losses, such as shopping, functions, and parties revolving around children, while also building a new identity. As Harris (2017, 34) says, "The intense and focused nature of infertility treatment often transforms individuals who conceive or adopt after failed medical attempts".

In working with Vivian to navigate her disenfranchised losses (Doka 2002), which unfolded through distinct processes, beginning with the profound loss of not being able to conceive or carry a pregnancy, the loss of her embryos, the loss of relationships and friendships, the loss of herself as she once perceived herself, to the loss of her hopes and dreams of being able to carry her biological babies and toddlers in her arms, and the loss of certain aspects of her marriage. Vivian's diagnosis of UI was a profoundly personal experience, resonating socially, economically, religiously, and spiritually for her.

Through it all, Vivian engages in therapy while I stand with her shoulder to shoulder. I witnessed how broken she was, as *Marie* had once been, without any therapeutic intervention. Perhaps I wanted to right some wrongs for *Marie*, too, in supporting Vivian, providing the support *Marie* lacked when she was lost in UI. Nevertheless, alongside this guidance in therapy, once Vivian had worked on

naming and processing her losses, consistently working on what failure, shame, stigma, and disenfranchised grief meant for her and how she would manage them, we carefully selected the point and time when she was ready to begin rebuilding hope once more; begin re-constructing her new identity. I could see that within Vivian, an unwavering new spirit and a deep-rooted determination had emerged that could not be torn down or defeated by her experiences with UI and reproductive medicine. Even after numerous moments of devastation, when the weight of her yearning felt almost insurmountable, she rose once more, standing tall and embodying the power of hope once again. Like a mountain weathering the fiercest storms, Vivian became a symbol of strength, a beacon of unshakable love for her future children, and another advocate for UI patients and individuals, demonstrating that even in the face of despair and brokenness, her battles with her perceived failure and shame, which she worked through and continues to; one can find enfranchisement and indeed find the strength to rebuild hope again. Vivian “*was ready*” to reclaim her new identity after experiencing vast and significant disenfranchisement, ambiguous and non-finite losses, and chronic sorrow; some of the language of infertility and UI (Burns and Covington 2006; Doka 2002; Boss, Roos, Harris, 2021).

## Another Battle for Parenthood

*“To contain the whole of death so gently even before life has begun, and not be angry – this is beyond description”.*

– Rainer Maria Rilke  
(Rilke 1995)

Meet Lucia and Milo...

A couple in their late thirties, living together, diagnosed with UI after not being able to conceive for just over one year of actively trying. After undergoing all the initial medical checks, which indicated no medical issues, they were referred for IVF by their GP, as they were told they *“Ticked all the boxes for that being the solution to their problem.”* On the second IVF cycle, *“we felt we’d won the lottery when we got pregnant.”* However, tragically, at almost six months pregnant, they had to undergo a termination for medical reasons (TFMR) after a scan revealed severe structural abnormalities that would not be compatible with life or, at best, offered only a slim chance of survival for the baby, but with significant suffering.

The couple started therapy with me just over two years ago, and we still meet every fortnight. The first time I met Lucia and Milo online, the TFMR was very raw. It had only just happened, and they were both visibly distraught and angry. The first session was intense. They wanted to process the TFMR and make decisions from this point on, supported by a therapist who specialised in infertility and child loss. I was recommended to them by a previous client of mine, who had recommended me through a friend of theirs. Lucia sobbed while Milo sat quietly crying beside her as she told me, *“I held her... we saw her... we both held her... we named her, Ava. We can’t believe this has happened... we don’t know what to do... we’d like to try to figure it all out... There’s so much to think about...we were asked at the hospital if*

*we wanted photos, a funeral at the hospital, or if we would rather pay for a funeral outside the hospital. Do we invite friends and family if we do have a funeral, and how the hell do we tell them what happened? We just don't know what to do, where to start. We are in shock... we can't think straight. And what's even worse is that we're both so consumed with our own grief that we can't be there for each other, leaving us both feeling alone. Just a week ago, we felt on top of the world, like the luckiest couple on earth... and then... these cramps and pains... and... after a scan... all of this happened. We have lost Ava... we have lost our baby. We had it all... and then... we lost it all... just like that... everything we ever dreamed of... all... gone... and in the most horrible, cruellest way imaginable... I mean, I'm thirty-nine, so will I ever get pregnant again... will I ever carry my own baby... was it something I did wrong? Were we really that naïve? We didn't see something like this coming. Look, I'll just tell you, Marie, as I promised Milo I would... I've also gone to a very dark place... thought about... suicide... I'm not going to do anything... but I promised him I'd tell you this. I'm sorry for pouring all of this out at once onto you. You just met us for the first time, and... like this. Honestly, if you had met us only a week ago you would be meeting two very different people. Yet here it all is—the deepest darkest shame and guilt I carry are unbearable. How could I have allowed this to happen to my baby? It feels like the worst possible experience, and I truly believe it is—the agony of not being able to keep my baby safe and healthy is the worst feeling imaginable... I don't have words for it... except I really would rather not be here... I don't know if I can live life after this... I don't want to worry anyone, especially Milo, as he's already going through enough... and I know he's really worrying about me right now, but... I just can't see how I can carry on after this. Look I know I have to find a way, which is why we have come to you, Marie. I can't help but think though...*

*why me, why us? I'm not saying I wish it had been someone else... I wouldn't wish this on anyone... but why us?"*

### **Holding Space for Grief: Navigating Perinatal Loss**

I am sitting in my counselling room, ready to meet my new client couple online for our second session. I hesitate to open my client notes again, recalling how painful it had been for them both in that first session. I take a deep breath and open my client notes again for this couple. The first things I wrote on what was a fresh page for my new clients that day, as my heart ached for them:

\*Both feeling ALONE\*

\*Lucia-suicidal thoughts-urgently address\*

\*Milo barely spoke-respectfully giving the space to Lucia as she needs it\*

I remember the terrifying thoughts I worked hard to banish from my mind using affirmations while I was pregnant with my son. These thoughts concerned how I would manage if I miscarried again; the fear of losing the pregnancy I held on to “for dear life” (as my mum once said). On top of that, losing your pregnancy, your baby at nearly six months, feels brutally hard as the pregnancy enters its final trimester, when we believe we are past all the delicate stages and worries of losing our longed-for baby, even naming your child as Lucia and Milo did. The thought of losing your baby at any stage of pregnancy and having no control over it is unbearable, from my experience and that of my clients. Although these sessions were online, I could feel the depth and complexity of their suffering—the many losses they were going

through, and their uncertainty about where to start; Lucia, unsure whether she could even face *"life after this"*. I believe they will get through this, but now is not the time to say it; now is the time to acknowledge, validate, name, understand, and be alongside them in their losses; the most challenging part of all my counselling processes because I feel them strongly. I think of their baby, Ava, and how, based on my experience with other clients in this situation (TFMR), holding her might prove to be healing later, when they are ready to work through that part of the process.

I think of Linda Hammer Burns (2000) and agree with her that parents should have the option to see and hold their baby in these confusing and shocking circumstances, as this can help facilitate their recovery and moving forward when the time is right. Burns and Covington (2000) confirm that a significant body of research on perinatal grieving draws from fundamental theories from Freud, Lindemann, Parkes, and Bowlby. Covington (2006) further explains that grief is a prevailing emotional reaction to loss, encompassing feelings of anger, shock, sadness, and guilt. Mourning, on the other hand, is a cultural process in which individuals find their way through these emotions, and bereavement is the period during which grief is processed. Covington (2006) further states that the mourning process traditionally follows a pattern of emotional disorganisation after shock, eventually leading to reorganisation. However, in experiences of perinatal loss, as seen in the example of Lucia and Milo, grief can be tumultuous and unpredictable, a rollercoaster of emotions. Several factors influence mourning, including childbirth experiences, previous pregnancy losses, gestational age, maternal age, relationship quality, physical and mental health, religiosity, fertility history, and the possibility of future pregnancies, with the latter being one of Lucia's fears. Furthermore, although

mourning is a general experience, it is shaped by cultural contexts that may discourage open discussion of loss and the expression of grief, ultimately affecting how individuals adapt to their experiences (Burns 2006).

I remember saying to Lucia at the point when there was an appropriate pause, “*Lucia, please take your time and say everything you want to say, no matter what it is,*” as I actively listened without judgment. As the session went on, I was also able to validate and name her profound losses, not only of her baby but of her pregnant identity, the assumptive world she had all planned out in front of her with her daughter; how much was taken from her along with her baby; the innocence, the confidence she held for her future in motherhood already accepted in society due to her pregnancy being visible and public knowledge. Burns (2006) adds that losing a baby late in pregnancy or shortly after birth presents a uniquely emotionally challenging experience characterised by different aspects of grief, mourning, and bereavement. Burns (2006) continues to explain that, unlike losses of older loved ones, perinatal loss is prospective, centred on the hopes and dreams for a child known only to the parents. This multidimensional loss encompasses not just the pregnancy or baby, but also the innocence, health, reproductive capacity, and future relationships. Mothers may experience intense feelings of guilt, shame, envy, and self-blame, which are less common in other types of loss.

Lucia and Milo unpacked the unique, multidimensional aspects of *their* perinatal losses, expressing these prospective and complex elements of loss, such as shame, guilt, shock, relationship concerns, reproductive capacity, and the loss of the hopes and dreams they held for *their* daughter, Ava. Milo patiently waited until

Lucia offered him the chance to say something, which he said through his gentle, quiet tears, *"I'm in shock... obviously we were not expecting this to happen... I'm worried... I'm worried about Lucia... I'm worried that we haven't been able to communicate with each other since this happened. I know it's only just happened, but... I feel so alone... I can't seem to reach Lucia... I want to be there for her, but for the first time in our relationship, I don't know how to be... I feel quite helpless... yeah, I'm very worried about her... I'm worried about us."* In this first session, I believed it was essential to validate and name both their losses, which they experienced in different ways. I used terminology from UI and TFMR loss, which can be confusing, complex, and invisible; losses that society often lacks the language or means to address. Therefore, I introduced terms such as perinatal loss, nonfinite, ambiguous loss, and disenfranchised grief, which hold significant meaning for clients, especially when they first hear them (Doka 2002; Burns and Covington 2006; Harris 2010). This provided Lucia and Milo with something tangible to take away from the initial session as we connected these terms specifically to them, as I sensed they needed recognition and validation of their losses.

I also aimed to encourage both to accept that they each have the right to grieve in their own different ways, as I firmly believed they did not need to sit silently and separately in their shock, shame, anger, and isolation out of fear of societal stigma for these unacknowledged losses. Moreover, pointing this out to them seemed to make a difference. As I suggested, it was okay to be at different stages in their grief. In that moment, I witnessed them looking at each other as if they had experienced a new realisation that was useful. They then explained that they had been angry at each other for not being in the same place at the same time in their

grief. This seemed like a significant challenge for both of them, therefore, we explored it further as to why it was okay for each of them not to be in the same grief space as the other, since initially, each wanted the other to feel the same way they did at the same time. It was essential to allow each other to be in different spaces during their individual grief, which they told me in our second session, helped ease a lot of the pressure they had been feeling. Burns (2006) explains that grieving a perinatal loss is a deeply personal experience, shaped by personality, culture, and life experiences, and that couples may grieve in different ways, that “these different responses do not indicate better or worse coping” (Burns 2006, 216).

Additionally, Harris (2021, 166) confirms that in her counselling practice, working with infertile couples, often one partner might articulate feelings of loss that align with the concept of ambiguous loss, but the other does not, and this can manifest in emotional withdrawal by the partner as a way of coping with “the intense experience of infertility, or as obsessive thoughts and rumination about their situation”. In such situations, the affected partner “becomes emotionally unavailable, hindering their ability to address the needs and feelings of the other partner” (Harris 2021, 166). These ambiguous losses can significantly worsen the challenges already faced by couples undergoing infertility treatment or perinatal loss.

Consequently, we also established some personal coping strategies as part of the therapy process, such as making a list of possible ways to honour their baby girl, Ava’s memory, one item at a time. They agreed to review this list when they felt ready. I invited them to consider asking the hospital to take appropriate photos of their baby. This would give them time to make important decisions about the funeral,

or even, if they changed their mind about having a funeral, as has happened with some of my clients who have experienced a TFMR. In such circumstances, they would have the photo as a memorial if they wanted to. I also provided details of a wonderful support group (Tommy's - The Pregnancy and Baby Charity) that would be available between our sessions if they needed it. My message to them, as to all my clients, is that "you are *not* alone", even though you feel isolated. This is very important, as I never want anyone experiencing infertility or UI to feel alone, as *Marie* did for many years; another wrong I would like to (w)right.

In therapy, we also explored ways to accept that feelings of shock, anger, and disbelief that the TFMR occurred are natural and acceptable. Burns (2006) explains that several factors complicate the grieving process for perinatal loss. First, the lack of anticipatory grieving means that loss often happens suddenly, leaving little time for preparation. Additionally, there is often no visible object to mourn, especially in early losses that may not be publicly recognised, which limits opportunities for communal mourning. Lucia and Milo did have a funeral for their nearly six-month-old Baby, Ava, though it was strictly attended by a minimal number of family members and close friends. However, generally, social support can be limited, as cultural norms often make perinatal loss a taboo subject, leading to feelings of shame and isolation, as it did for Lucia and Milo. Also, the anticipatory nature of this grief means that parents like Lucia and Milo will mourn not only the loss of the baby but also the future interactions and experiences that will never happen (Burns 2006, 218).

### **Strength in Partnership: Individual and Shared Grief and Reclaiming Agency**

During our therapy sessions, Lucia and Milo reviewed the list we had created, which they said was also a source of comfort to them as something tangible to take away—making decisions about the funeral, how to inform friends and family of the loss while protecting themselves from hurtful or flippant comments, both of which were likely to happen. We also discussed how they would support each other, recognising where each of them was in their grief and how to navigate their coping strategies. It is important to emphasise how vital it is to include Milo in these interactions, even though Lucia often dominated much of the space and time in therapy, as he was significantly affected by the emotional and financial strains of the medical treatments and the perinatal loss of their baby girl, Ava. Initially, Milo felt helpless witnessing Lucia's devastation over her losses while carrying the weight of his own grief. Validating the experiences of male partners is essential for comprehensive support, as noted by Daniluk (1991) and El Kissi et al. (2013).

Further into the therapy process, we carefully and gently explored the sensitive issue of whether, how, and when they might feel ready to rebuild hope and consider the future, whether it be further ART or choose not to; a part of reclaiming their agency. I believe it is crucial to recognise and observe the timing when a person or couple shows signs of readiness to rebuild hope and move on to the next stage, whatever that may be. Lucia and Milo decided to pause pursuing further ART for another six months at that point because of the profound impact that the loss of Ava had on each of them. Those six months have passed, and they have embarked on arranging another three IVF cycles, which would be their limit. After that, they both agreed that if all three cycles were unsuccessful, they would not pursue any

further treatments or avenues, allowing only for the option of conception to occur naturally without feeling pressured to do so. They decided they would not pursue adoption or surrogacy; they have also leaned into and faced what was once their greatest fear regarding expanding their family: being involuntarily childless. This is a challenging and courageous journey, one that is too difficult for some.

Nevertheless, while Lucia and Milo found it very challenging to explore, as it involved navigating the changes this experience had brought to their relationship, they believed it was worthwhile, as it helped them make decisions with more confidence, agency, and certainty. They continue counselling with me every two weeks, and around four months ago, Lucia and Milo were cautiously and hesitantly delighted to announce at the start of a session that they were pregnant from the second of their planned IVF cycles. They are now safely out of the first trimester and have undergone additional scans due to the TFMR experience; so far, the pregnancy is progressing healthily into the second trimester. They would like to remain in the safety of therapy until this baby is born. We have been working on their fears of a TFMR happening again and are taking every possible precaution to ensure everything is checked regularly with the pregnancy.

Lucia and Milo have shown remarkable strength and courage. They continue to do so as they face everything they have endured—from perinatal loss and uncertainty about their future family plans to managing nonfinite, ambiguous losses, and disenfranchised grief, alongside an identity as parents that was taken from them so abruptly. Their journey has also involved relationship issues with friends and family, as well as with each other, compounded by the loss of innocence and

enjoyment during their second pregnancy, which has been fragile and fraught with difficulty.

I also believe they face an additional emotional challenge in navigating the extra complications, which are heightened by the fact that they experienced the added difficulty of a termination for medical reasons (TFMR) from an IVF pregnancy rather than a TFMR from natural conception. What I mean by this is that, in the case of natural conception, the loss often feels like a sudden and unexpected rupture of hope, leaving parents to grapple with the shock and grief of a future they envisioned but which was taken abruptly. Conversely, the IVF journey is full of its own challenges, already leaving the couple feeling emotionally drained. Therefore, they carry the burden of a prolonged period of hope and anticipation before conception, making the loss during a TFMR doubly complex. Lucia and Milo also had to reconcile the dreams they nurtured through IVF with the painful reality of losing their baby later in pregnancy, which, being longer and more demanding to achieve, can intensify feelings of disenfranchised grief, isolation, anguish, and helplessness—uncertain whether they will be able to conceive again, how long it might take, or how many more IVF cycles will be needed.

Nonetheless, Lucia and Milo's willingness to understand and confront the intricacies of their disenfranchised grief, while navigating the deeply emotional territory of unexplained infertility (UI) and all that this entails for them, demonstrates their profound commitment to each other and their shared yet complex healing journey. By openly exploring their feelings and accepting each other's unique ways of experiencing grief, they have created a supportive environment that respects their

individual agency while maintaining their bond as a couple. Lucia and Milo's story reminds me of the strength of partnership and love, illustrating that even in the darkest moments, there remains space for growth, understanding, and bravery in rebuilding hope.

### **A Process-Oriented Approach to Counselling Fertility Impairment**

These two examples provide a different perspective on unexplained (in)fertility (UI). As part of my counselling practice's coaching process, I psycho-educate my clients that we must stand up for ourselves and keep fighting; hence, I describe it as a battlefield. The battlefield analogy applies whether clients undergo medical intervention or not. Choosing not to follow the very tempting path of reproductive technologies, as many of my clients do, boldly counteracts societal expectations. Holding onto one's autonomy places them in an equally strong warrior position. I also stand shoulder to shoulder with these clients as they battle through their journeys without medical assistance.

As a larger percentage of my client base is, or soon will be, under medical intervention, I note that the medical professionals are simply doing their jobs as they have been trained. We, as patients, are unintentionally silenced by our experiences of ART, coupled with cultural and societal influences. In my view, the middle ground of this battlefield is the counsellor who supports those facing infertility and UI, helping to give voice to these issues. Harris (2017) agrees that the intensity and ongoing nature of these losses demand a high level of understanding and sensitivity to provide appropriate support for those going through this ordeal. She confirms,

recognising that the multiple losses associated with infertility are crucial; acknowledging these losses and their impacts affirms a deeply painful experience that often remains hidden. She states, “It is hoped that more professionals will come to understand the complexity of this experience and become better equipped to meet the unique needs of those who are infertile” (Harris 2017, 35).

Moreover, Vivian, Lucia, and Milo’s stories matter, as they inform my thesis that this work highlights the fluid nature of identity as we navigate various processes that I employ in my infertility counselling practice, which I discuss further in the next chapter. I see these processes as a construct—a fluid social system—where the complex losses must be supported with great care. The medicalisation of those unable to conceive has transformed how we view ourselves and how we believe others perceive us. I have often wondered why medicalisation exerts such a strong influence, as we find ourselves in it, hoping for a solution but uncertain, naive of its broader effects. I remind myself that infertility or as I think of it, ‘fertility impairment’ is becoming one of the most critical endemic conditions, now affecting fifteen to twenty per cent of couples across the globe (Maté et al. 2020), and while its medically prescribed treatment, In Vitro Fertilisation (IVF), the most common of Assisted Reproductive Technologies (ARTs), is extensively researched, subjective experiences of unexplained infertility (UI) and all fertility impairments and the lack of emotional support remain under-studied (Guzick et al. 1998; Greil 1997). Gameiro and Finnigan (2017, 323), from a more recent study, confirmed that there are currently no effective interventions for patients left to deal with the aftermath of failed ARTs, and that “This need for support is expected to increase as the number of people delaying parenthood increases and therefore so does the number for whom

assisted reproduction will not offer a solution”. Their meta-analyses, based on a long-term mixed methods study from 1978 to 2015, revealed deteriorating mental health in a group of patients for whom IVF treatment had failed (Gameiro and Finnigan 2017). I fully agree with their conclusion that there is a vital need for emotional support aimed at helping people impacted by ART and those having to relinquish their parenthood aspirations (Guzick et al.1998; Greil 1997).

Furthermore, I refer to Foucault (1978), whose writings have deepened my understanding of unexplained infertility (UI) and reproductive medicine, as discussed in Chapter 3, even though he does not explicitly mention fertility impairment. Nonetheless, he (1978) emphasises the complexities of the human experience, the limitations of medical frameworks, and the importance of recognising individual agency. Foucault’s insights, along with those of other authors I have cited in this study, provide a more nuanced view of how people navigate their journeys with fertility impairment, often finding meaning and resilience beyond medical boundaries. For example, when I explored Foucault's core ideas, I learned that while techniques such as medical intervention, social norms, or institutional frameworks govern and regulate aspects of our lives, there remains an inherent unpredictability. As humans, we often resist technology even while engaging with it; I see this daily in my counselling practice, as my clients frequently demonstrate resistance to ART—the unnaturalness of it, that *Marie* was initially concerned with.

After all, I could not have endured my fertility impairment journey without it because, as Franklin (2010) notes, ART exists; therefore, the temptation is always present; it is enticing. The hope that the next IVF cycle will succeed remains

compelling; one more spin of the roulette wheel; this could be my turn; my big win; the one where I walk away with a baby in my arms. My personal experiences with UI, along with those of my clients, have shown that UI cannot be fully defined or controlled by reproductive medicine; it is only one part of the broader UI journey; it is complex.

Instead of gambling with another spin of the roulette wheel, I developed a different kind of wheel for my clients. This idea was inspired by Covington and Feldman's (2006) original table (see below), which served as a guiding framework in my private counselling practice when working with clients undergoing medical interventions (which is most of the time). It involves integrating infertility and UI counselling into my counselling practice using a six-phase model of infertility and UI therapy developed initially by Covington and Feldman (2006). This model emphasises the importance of incorporating both medical and psychotherapeutic services throughout treatment, assisting in normalising the process, and addressing issues early to prevent complications later. Covington and Feldman (2006) outline a six-phase model that highlights the evolving role of infertility counsellors and the integration of psychotherapeutic support throughout the infertility and UI medical treatment journey.

In my counselling practice, inspired by this model, I have adapted it to fit the needs of my client base; it is not linear or step-by-step like Covington and Feldman's (2006) table (on the left of the table). Instead, it influences how I work in my counselling room — an iteration and reconfiguration of their six-phase model (as shown on the right of the table). Although somewhat structured, my processes are

organic; they operate in a “messier” way, depending on when and how they emerge during client sessions. My processes form part of my broader approach, which I have developed and implemented in my practice. I believe they are less daunting for counsellors and clients to navigate together, compared to more rigid, step-by-step methods. This table is intended for the counsellor or health professional:

<b>Covington and Feldman (2006)</b>	<b>In Therapy (with Marie) Processes</b>
Phase 1: Acknowledging a fertility problem: Tasks – support education, information, and resources	Process 1 - Acknowledge the fertility impairment and confirm the diagnosis. <ul style="list-style-type: none"> <li>- Arrange to manage the client’s/patient’s fertility impairment.</li> <li>- Provide initial support and psychoeducation.</li> <li>- Assist clients/patients in normalising their feelings about the fertility impairment.</li> </ul>
Phase 2: Undergoing medical evaluation	Process 2 - Getting on board with the client’s/patient’s situation, whether it be medical intervention or otherwise, by exploring with them. <ul style="list-style-type: none"> <li>- Understanding the emotional and social aspects of an individual or couple’s medical journey, particularly concerning their diagnosis and treatment.</li> <li>- Offering tailored assistance and therapeutic interventions to meet their specific needs.</li> </ul>
Phase 3: Treating infertility problems	Process 3 - Processes of acknowledging, naming, and validating emotions associated with medical cycles - as medical treatment advances, patients often experience renewed hope accompanied by increased stress and anguish. <ul style="list-style-type: none"> <li>- Continue to provide support, with the counsellor’s position expanding to a coaching role in helping clients/patients manage treatment demands and set realistic expectations.</li> </ul>
Phase 4: Further treatments: investigating and treating additional diagnosis	Process 4 - Assist client/patient in managing multiple losses- often a prolonged process, sometimes lasting several years. The client/patient’s fertility

	<p>journey may involve additional treatment that is frequently accompanied by frustration and feelings of failure.</p> <ul style="list-style-type: none"> <li>- Continue to assist and staying closely with clients/patients in working through these emotions while also exploring alternative family-building options.</li> </ul>
<p>Phase 5: Attempting noncoital conception</p>	<p>Process 5 - Explore and psychoeducate on methods of achieving pregnancy, whether alongside (heterosexual couples still actively trying to conceive naturally through sexual intercourse) or without sexual intercourse (same-sex couples and individuals). This involves coaching on ARTs, informed decision-making, and reassurance—clients and patients may feel mentally and emotionally exhausted as they navigate complex choices about assisted reproductive technologies (ARTs), which include:</p> <ul style="list-style-type: none"> <li>- Intrauterine Insemination (IUI): Sperm is directly inserted into a woman's uterus during ovulation to promote fertilisation.</li> <li>- In Vitro Fertilisation (IVF): Eggs are collected from a woman's ovaries and fertilised with sperm in a laboratory; the resulting embryos are then implanted into the uterus.</li> <li>- Intracytoplasmic Sperm Injection (ICSI): A single sperm is injected directly into an egg to achieve fertilisation.</li> <li>- Sperm Donation: Using sperm from a donor in procedures such as IUI or IVF.</li> <li>- Egg Donation: Use of donor eggs in conjunction with IVF for women unable to produce viable eggs (or for same sex couples).</li> </ul>
<p>Phase 6: Deciding to end treatment and redefine family</p>	<p>Process 6 - Re-evaluating Commitments: Assess the effectiveness and implications of ongoing treatment decisions.</p> <ul style="list-style-type: none"> <li>- Consider emotional, physical, and financial factors.</li> <li>- Assist with processing Disenfranchised Grief, Nonfinite, and Ambiguous Losses, including chronic sorrow.</li> <li>- Acknowledge feelings of further fragmented loss related to ending treatment.</li> </ul>

	<ul style="list-style-type: none"><li>- Engage in fertility impairment-related grief work to process emotions associated with the journey.</li><li>- Redefining Family Structure: Explore new family dynamics following treatment ending.</li><li>- Identifying ways to maintain connections and support.</li><li>- Facilitate Resolution: Seek emotional closure regarding treatment ending.</li><li>- Set new goals and aspirations for the future.</li></ul>
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(Covington and Feldman 2006, 496)

From this table (above right), I also created my wheel of processes summarising the methods I use when working with my clients (these are not meant to follow in a strict order, hence the wheel— I numbered them in order to connect them to the table above for you, the reader).



Building on my wheel of therapeutic infertility processes, I now share with you, with their permission, some comments from my clients' notes, which I connect to my wheel to elaborate on each process. Thus, exemplifying the processes outlined above. This validates and honours their faces and forms of UI and infertility, while also bringing their voices into this critical yet still limited conversation, extending beyond the pages of my client notes.

*“Hearing that I have unexplained infertility was a shock; I just want to understand what this means for my future and how we can move forward.”*

**(1.Process of affirming)**

*“It’s a job in itself trying to get to grips with all the medical options available... I can’t seem to get my head around it all... It’s hard enough trying to cope with all these new emotions popping up”.*

**(2.Process of onboarding with the medical journey)**

*“Another new IVF cycle, I feel a mix of hope and anxiety... it’s exhausting... my moods are all over the place with these medications... I’m struggling to manage everything... unexplained infertility has taken over my whole life... I don’t feel in control of anything anymore”.*

**(3.Process of acknowledging, naming, and validating (of emotions associated with medical cycles).**

*“It feels like I’m grieving every time a treatment doesn’t work; It’s chronic... the pain... worse than anything I have ever been through... worse than any other loss I’ve experienced”.*

**(4.Process of managing multiple losses-disenfranchised grieving)**

*“I’m overwhelmed by all the options for assisted reproductive technologies; I want to make informed decisions, but I feel mentally exhausted just thinking about it. It’s hard trying to connect with the medical staff at the clinic. They always seem rushed and not interested in my thoughts or concerns”.*

**(5.Process of guiding and coaching-psychoeducating)**

*“IVF has forced me to rethink what family means to me. Exploring these other options is something I thought I would never consider... I just can’t take any more of these invasive treatments... ending treatment feels like giving up on hope, and that is scary, but we’re ready to move forward and set new goals for the future.”*

**(6.Process of re-evaluating of commitments)**

Hence, I strongly agree with Burns and Covington (2006) and Harris (2017) that specialist infertility counselling is essential for assessing readiness and exploring the implications of all choices involved in UI, infertility, and ART. Accordingly, I believe infertility counsellors must evaluate and work closely with their clients to support them during their decision-making processes in their fertility journeys, particularly regarding when and how to cease medical intervention cycles. In my view, this is

often the most overlooked aspect of these procedures, which is not surprising given that women, couples, and individuals undergoing ART can become commodified, with women frequently regarded only as their reproductive organs, making them seem like objects within the reproductive medicine industry. Consequently, infertility counsellors, medical professionals, and others working with infertility clients or patients must be sufficiently trained to treat each person as a whole individual and understand the impacts ART has on them.

Covington (2006, 493) states that “Infertility counselling is a speciality that combines the fields of reproductive health psychology and reproductive medicine”. I agree with Covington (2006) that all healthcare providers involved in infertility and UI—including doctors, consultants, nurses, laboratory technicians, and administrative staff—should actively support clients/patients undergoing reproductive medical diagnosis and treatment, as Covington (2006, 493) puts it, “treating the patient, not the disease.”

A more nuanced understanding of these challenges is essential for providing effective support. Encouraging a more open dialogue between patients and healthcare professionals can help create a less stigmatised environment that recognises the complexities of UI and enables individuals to reclaim their voices and agency during these struggles. As Covington (2006) highlights, integrating mental health professionals into infertility care is vital for addressing the emotional aspects of these experiences. Hence, I now turn to the final two chapters of this thesis, where I emphasise the importance of counselling alongside well-informed medical staff to better navigate the challenges of UI and infertility, advocating an approach that

considers emotional well-being alongside medical treatment for everyone involved in supporting and managing fertility impairments.

## Chapter Seven

### Discussion

“A child within my mind. I see  
The eye, the hands. I see you also there.  
I see you waiting with an honest care,  
Within my mind, within my body. . . .”

(Elizabeth Jennings 2017)

In this chapter, I consolidate the key aspects of this research within a discussion. I reflect on and elaborate further on the main elements of *Marie's* re-remembered memories, which led her to uncover her newfound feminist faith and identity. This then leads to a broader discussion addressing my sub-question: How can counselling and psychotherapy support the processes of UI and infertility? I connect these reflections with the literature I reviewed at the beginning and throughout this entire research project.

Throughout this study, beginning with *Marie's* experiences of UI, when she found herself standing still in a haze of fear, I have explored those socially constructed memories of *Marie's* and other examples from my clients to find meaning. I have ‘shown and told’ (Adams 2008) my findings by critically exploring them through autoethnography. Through this, I have contributed to a deeper understanding of the often underappreciated and under-researched emotional effects of UI by presenting insider narratives and responding to them in the present. Ultimately, by exploring these experiences, I intend to improve these experiences for others.

## **Beyond the clinic: Balancing the Emotional and Ethical Dimensions of ART**

The often-overlooked impact of assisted reproductive technologies (ART) requires careful thought, as many people do not openly discuss it. As a result, most cultures and societies worldwide fail to recognise the seriousness of the challenges these medical interventions pose to individuals and couples, as I have shown in Chapters Three and Four. Janice Raymond (1995), the feminist scholar specialising in women's health whom I introduced in Chapter Three, critiques the language surrounding reproductive medicine, questioning whether the deaths of women in IVF programmes are 'unfortunate incidents' or, as she describes them, 'medical disasters.' She also questions the terminology used, asking whether it matters if Clomid, a hormone used for superovulation in IVF (the drug that *Marie* was medicated with, which caused her to develop severe Ovarian Hyperstimulation Syndrome (OHSS) during an IVF cycle as shared in Chapter 3), is labelled as a 'potential risk' or a 'debilitating drug'; highlighting the small print most of us forget or ignore in our desperation to conceive and have a baby (Raymond 1995, 15).

Although I disagree with the extent to which Raymond (1995) describes ART as the "disease itself," as discussed in Chapter Three, I believe it is a valuable medical intervention when used ethically and with proper support. While I understand Raymond's (1995) point to some degree, based on my own experience with ART and that of my clients, a person suffering from reproductive medical treatments and losses due to the absence of pregnancies and babies often outweighs the suffering caused by the discovery of UI and infertility itself. I return to gynaecologists such as Kovacs (2010), who discuss women's bodies and reproductive organs as objects to experiment with rather than treating the whole person, neglecting the emotional and

well-being aspects of ART. What is often overlooked in these ongoing medical cycles and reproductive losses—such as Kovacs' (2010) suggestion to “try try try again”—is the cumulative effect of suffering; specifically, how the suffering from ART can increase exponentially. For instance, three failed attempts at IVF are not simply three times the suffering of the first failure; each subsequent failure causes exponentially greater suffering. Therefore, each time an ART patient “tries again,” and the medical cycle fails, their suffering multiplies, intensifying the severity of their pain caused by deepened disenfranchised grief, chronic sorrow, ambiguous loss, and nonfinite losses.

Furthermore, many feminists and expert writers in the field regard infertility as part of academic feminist discourse. Feminist writers in academia, such as Soumya Kashyap and Priyanka Tripathi (2025, 104), recently described it as “The most recent technical invasion of women’s bodies, made possible by ARTs”. Therefore, reproductive medicine has become a central focus of the new wave feminist critique. I now join this conversation alongside these feminists, also asking not about what a woman should be or is, but about what the reproductive industry and its technology might take from a woman and how that affects her. Rajagopal (2021, 106) describes her experience of a fertility clinic: “Initially expecting the privacy and security of a cosy consultation room, the fertility clinic instead resembled an open parade where their self-respect and dignity underwent systematic probing, squeezing and depletion.”

I agree that this situation requires all professionals to adopt a de-medicalised perspective on women’s bodies and reproductive health. “It is time to expose the

truth about the pharmaceutical and medical industries, which are more interested in commercialising the human body than creating a safe working environment,” say Kashyap and Tripathi (2025, 104). Kashyap and Tripathi (2025, 104) further state, “To fully appreciate the significance of medicine in preserving health, we must strive for medical improvements that de-medicalise healthcare and position medicine within the context of women.” I would add that increasing the availability of well-informed infertility counsellors would help improve the experience of UI and infertility, especially in supporting women and couples, and indeed our cultures and societies in recognising, validating, and normalising their unique reproductive losses.

This is why I coach my clients to advocate for themselves about how many cycles they will undergo by psychoeducating them to assert their own values and decisions regarding medical ethics during treatments. Thus, well-informed infertility counselling is imperative for patients in clinics and hospitals. This should be an integral part of global medical ethics, ensuring that individuals are not left trapped in this complex cycle of ART without expert guidance, psychoeducation, and support. In my view, these ethical standards must be enforced to prevent further suffering among women and couples often caught in this trap of medical intervention without proper management or knowledge of when and how to stop, and to learn how to hold onto their values and dignity while going through treatments. After all, we must remind ourselves that ART is a lucrative industry and aims to profit from infertile patients. Unfortunately, this often means ‘selling’ these medical interventions to the naïve potential patient, targeted at women aged below thirty-five, where treatments have a higher success rate for reproductive medicine clinics; patients unknowingly feed the toxic part of this avarice created by greed and profit.

This prompts me to revisit Sarah Franklin's (2010, 8) concept of ART as a "hybrid technology," as discussed in Chapter Three, illustrating how it produces an in vitro fertilisation (IVF) version of "naturally existing biology," thereby establishing a new realm of "artificially constructed" biology. This domain has led us to believe it is "just like the real thing." ARTs and NRTs are marketed as more advanced, redesigned, sophisticated, and even easier to manage than "the real thing" (Franklin 2010, 8). In this context of bio-engineered bodies, reproductive technology has become "second nature," as it is now widely accepted as an alternative method of conception, asserts Franklin (2010, 8). I strongly agree with Franklin (2010, 8) that this ultimately flawed approach can cause reproductive medicine clinics to lack "preventive and curative" capabilities, instead functioning as producers of babies with specific genetic traits. Therefore, as Harris (2017), an expert on grief and infertility, whom I introduced in Chapter One and speak further to in Chapter Six, emphasises, infertility counsellors and mental health professionals must possess a comprehensive understanding of medical treatments, procedures, medications, and terminology related to infertility and UI in order better to support their patients' or clients' experiences. Harris (2017, 34) concurs with clinicians Burns and Covington (2006), asserting that infertility counselling is a specialised field requiring knowledge of both medical and therapeutic aspects to provide effective support. Therefore, in line with my sub-question: How can counselling and psychotherapy support the processes of UI and infertility? - How can medical professionals better support patients with fertility impairments ethically and provide improved care?

## **Medical Hubris, Avarice versus Medical Humility: Narrative Medicine**

Instead of medical hubris — a sense of certainty among medical professionals that they will fix or cure us — which often leads to a dehumanising experience for patients undergoing ARTs, based on my own experiences of reproductive medical procedures and those of my clients, I believe it would be more productive and inclusive if medics acknowledged the limits of ARTs and showed empathy by being open to how patients feel about these invasive treatments. Surely, practising humility by listening to and understanding the patient’s perspective would result in better ethical care throughout the ART journey; after all, as a patient and co-sufferer myself, I would have appreciated humility rather than hubris.

I return to Rita Charon (2006, 4), whom I introduced in Chapter Three, as she explains that practising ‘narrative skills’—an approach that combines medical intervention with attentive listening, understanding, and rapport-building with patients—enables one to “recognise, absorb, interpret, and be moved by the stories” of diagnoses. Charon (2006, 5) further states that equipping trainee doctors and medical students with these skills means they will no longer need to ask lengthy lists of varied questions, such as: “Do you get headaches?”, “Does your throat swell up?”, “Do you feel dizzy?”, “Is there pain in your chest?”, and so on. For example, she encourages her patients to share what they believe she ought to know about their symptoms.

Reflecting on my ‘fantasy’ appointment for *Marie* that day in my first vignette of Chapter Two, I am curious about how it might have gone when she was told her diagnosis of UI, and how different it might have been if the GP had been trained in

and used the skills of 'narrative medicine' and 'empathic witnessing'. Had he done so, perhaps he would have openly asked *Marie* for some background on her personal history and how she was feeling about her diagnosis of UI. At that point, *Marie* would have been given the opportunity to articulate how she felt and ask the questions she had been unable to voice that day.

In Charon's (2006) 'narrative medicine' and 'empathic witnessing' training, exemplified by the 'narrative oncology' writing seminars for nurses, doctors, and social workers in the inpatient oncology department at a Columbia University-affiliated hospital in New York, participants engage in what Charon (2006) describes as 'Parallel Chart Sessions'. During these sessions, medical students are invited to write 'off the hospital chart' about their patient care and to participate in primary care residency sessions in which trainee doctors compose naturalistic descriptions of house visits made to patients. Clinicians are encouraged to write in plain language about their own private and emotional observations, triggers, and experiences related to this patient care. Even without extensive training or practice, clinicians were able to generate complex and moving descriptions of their patients and their interactions with them (Charon 2006).

Thus, by utilising 'narrative medicine' and 'empathic witnessing' tools, and perhaps after practising writing within Charon's (2006) 'Parallel Chart Sessions,' *Marie's* GP (from Chapter Two) could have 'heard' parts of *her* story, subsequently recognising, acknowledging, and integrating her reactions into his practice that day. Undoubtedly, this would have led to a different experience for *Marie*: one of empathy, where the doctor's 'narrative medicine' and 'empathic witnessing' training would have

played a crucial role; something more relational, meaningful, and personal might have emerged that day. Essentially, a more empathic and supportive encounter could have occurred. As Butler (2005, 36) proposes, “All that philosophers, linguists, autobiographers, psychoanalysts, and literary scholars can teach us about giving and receiving accounts of the self is not only salient to clinical medicine but also breathtaking in its power to transform a technical duty into a potent gift of mutual recognition”.

Thus, the GP from Chapter Two might have asked both *Marie* and her (then) husband whether they wished to join the IVF waiting list after explaining everything and having an inclusive conversation about it, rather than simply adding them to this waiting list without asking their permission. I wonder: how the GP might have reacted differently that day had he known the background of their story? Arthur Frank (2013, 328) aptly puts it: “To think about a story is to reduce it to its content and then analyse that content.... To think with a story is to experience it affecting one’s own life and to find in that effect a certain truth of one’s own life. It takes a whole doctor to treat a whole patient, or so the saying goes”.

For instance, Rita Charon (2006) recounts an experience with a patient from her New York GP practice. Charon (2006, 112) asked him what she ought to know. He cried as he shared recent losses, first of his father and shortly after, his sibling also passed away. She asked him, “Why do you weep?” to which he replied, “No one has asked me what I think I should tell, so this is the first time I have had the chance to say it.” This brings me back to Gabor Maté (2011), the physician I mentioned in Chapter Three, who chose to spend additional time with his patients to explore their

personal histories, thus deepening his understanding of the underlying issues behind their diagnoses. Therefore, returning to ‘storytelling,’ I reflect on my appreciation for qualitative research and Arthur Frank’s (2000, 355) discussion about illness and doctor/patient dynamics, stating, “There is value in storytelling as complementary analysis is argued and considers how qualitative methods can inform changing relationships between illness, health, medicine, and culture.”

Although no objective medical cause is identified in the diagnosis of unexplained infertility (UI), patients with UI are offered medical interventions (ARTs), the most well-known of which is In Vitro Fertilisation (IVF). Consequently, these patients often feel pressured to at least try these interventions. While I believe that IVF is an extraordinary medical breakthrough, particularly for specific infertility conditions such as endometriosis—an ailment that can take years to diagnose because it rarely appears on scans, involving tissue like the endometrium (the uterine lining) growing outside the uterus—and can also develop on the fallopian tubes, ovaries, and other pelvic organs. Or polycystic ovary syndrome (PCOS), a hormonal disorder mainly affecting the ovaries during a woman’s reproductive years. As confirmed by Kirkegaard et al. (2024, 1), experts in clinical medicine and biochemistry, “Endometriosis and polycystic ovary syndrome (PCOS) are common gynaecological disorders that constitute a significant burden of disease in women of fertile age. The disorders share a link to female reproduction and infertility”. Although ART directly benefits many individuals with these issues, as there is something tangible to work with, it is also crucial to recognise the widespread lack of emotional support and follow-up care provided to these patients. Regardless of whether the diagnosis is UI or infertility, how do patients cope with the aftermath of these invasive medical

procedures and the heartbreaking outcome of not achieving pregnancy without any emotional support from reproductive medicine clinics after assisted reproductive technologies (ARTs) fail, and patients leave the medical environment without follow-up, as is protocol at reproductive medical clinics?

Additionally, how will these patients manage their disenfranchised grief? Moreover, who will support them in dealing with their fractured identities concerning their womanhood and potential loss of motherhood, stigma, and shame—alongside darker thoughts of possibly being unable to cope at all, which can sometimes lead to suicidal ideation? These are all realities that *Marie* experienced first-hand and that I encounter in my counselling practice, leaving individuals and couples feeling hopeless, especially after ‘failed’ medical interventions.

From a general health perspective and in simple terms, how does this fragmentation—the separation of the mind-body connection—affect an individual’s mental and emotional well-being? Building on a discussion in Chapter Three, Frank (2000) explains how the medical environment transforms a ‘person’ with their own story into a ‘patient’ – a body labelled by medicine and made voiceless. Gabor Maté (2011) also discusses medical interventions—his own as a doctor—that focus solely on body parts, contrasting this with the more holistic view many laypeople hold, seeing body and mind as a whole. Maté (2011) notes that when attention is focused solely on physical aspects and the emotional side is neglected, it can lead to a state of ‘learned helplessness,’ in which the patient becomes accustomed to this condition, which can persist even outside medical settings. Furthermore, what does the absence of psychotherapeutic support and medical follow-up from hospitals or

private reproductive clinics signify for a person culturally within this context, beyond the 'learned helplessness' identified by Maté (2011) that patients might experience from prolonged exposure to medical environments? Based on *Marie's* experience and that of my female clients, this raises questions about their womanhood, misplaced shame, stigma, issues of identity, feelings of injustice, and even a sense of conspiracy, as discussed in Chapters four and five. Ultimately, these emotions can lead to isolation from friends and family, resulting in a complete loss of voice in unexplained (in)fertility (UI), as it did for *Marie*.

Although *Marie* (perhaps naively) invited the medicalisation of her personal experience regarding her difficulty conceiving naturally by consulting her GP, as demonstrated in Chapter two, I believe, following Charon (2006), Frank (2000), and Mate (2011), that if any medical professional had inquired into *Marie's* personal history and incorporated 'narrative medicine' and "empathic witnessing," it might have helped significantly, potentially even uncovering the cause of the issue of *Marie* and her (then) husband being unable to conceive. Arthur Frank (2000, 360) discussed his own and others' illnesses, both within and beyond medicalised experiences, and posed the question, "How would the world appear different if viewed from the perspective of the other, the disempowered, the too-often silenced one?" As Derrida (1981, 41) articulates, "Making the ill hearable requires the deconstructive move of a provisional reversal of this normal priority." This normal priority refers to medical voices relegating diagnosed or ill individuals to what Frank (2000) terms 'patienthood' – which Mate (2011) describes as 'a learned helplessness,' and Foucault (1973) refers to as 'Docility' - in how medical practices shape the way patients are perceived and treated. Foucault (1973) emphasises the

power dynamic in the doctor-patient relationship, thereby rendering patient narratives a minor part of the medical narrative, if acknowledged at all. Particularly since medical voices are favoured by what Frank (2000) terms the conventional 'polarity of credibility,' they subsequently silence 'lay' experiences by reducing them to mere medical correlations.

Furthermore, I fully support Rita Charon's (2006) view, agreeing that if doctors and all healthcare professionals utilised her 'narrative skills', it could revive hope in struggling healthcare systems by providing something invaluable: validation and respect for patients, while also enhancing these essential 'narrative skills' among medical practitioners caring for their patients. I would add to that, particularly in reproductive medicine. Regrettably, this shortcoming persists in reproductive medicine, as shown by my client examples, Vivian and Lucia, who recently underwent these treatments, suggesting that little has changed since *Marie's* experiences with medical interventions around twenty years ago. These clients, much like *Marie* experienced back then, have demonstrated in my counselling room that most doctors, consultants, and nurses did not listen to them or appeared indifferent to their emotions impacted by ARTs such as IVF, even their suffering. As Charon (2006, 5) states more generally, "doctors often lack the human capacities to recognize the plights of their patients, to extend empathy toward those who suffer, and to join honestly and courageously with patients in their struggles".

While I also recognise and agree with Charon (2006) that this area has become a casualty of our cost-cutting bureaucratic systems, I firmly concur with her that patients are often overlooked in terms of their emotional needs. Much is lost when

patients are not listened to in reproductive medicine settings, as I have shown in *Marie's* vignettes in Chapter Three. Consequently, this research leads me to suggest that combining Charon's (2006) 'narrative medicine' with Mate's (2011) approach to exploring patients' personal histories in reproductive medicine could significantly improve the outcomes of assisted reproductive technology (ART). This would not only benefit pregnancies that occur, reach term, and result in healthy babies but also help address the emotional scars and aftermath experienced by prospective parents long after these invasive procedures and complex losses. Therefore, I resonate with Charon's (2006, 7) comment that "A scientifically competent medicine alone cannot help a patient grapple with the loss and find meaning" in diagnoses and treatments. Providing understanding within this medical context would undoubtedly improve medical care by enabling patients to be listened to and validated, thereby reducing their stress levels during ART processes.

For example, I reflect on how the consultants or nurses would consistently instruct *Marie* during her IVF cycles and other ARTs that *she* must reduce her stress levels to give the treatments the best chance of resulting in a pregnancy. For *Marie*, this only heightened her stress and anguish, adding to her feelings of failure and isolation. Being told to reduce her stress levels only increased the pressure on her, which was not only unhelpful but also caused her stress just by being in the medical environment. Therefore, how could she release her own stress when therapy seemed out of reach, not an option, or not visible? "What's in us must out," Hans Selye says (1973, 693). Unfortunately, stress causes the treatments to fail (the doctor's words in *Marie's* experience), they insisted. My clients are still told this by medical professionals today during their ART cycles, leaving them as patients feeling

it is *their* fault when IVF ‘fails.’ This is why I believe patients need infertility counselling combined with “narrative medicine” alongside “empathic witnessing” throughout medical treatments to help them let go of stress and shame, while also trying to manage their disenfranchised losses, chronic sorrow, ambiguous and nonfinite losses (Doka 2002; Charon 2006; Boss, Roos and Harris, 2021).

That said, I recognise that medical professionals are not trained in the ‘narrative medicine’ skills necessary to address the emotional needs of ART patients. As a result, I understand why this vital aspect is frequently overlooked. Most doctors are generally unprepared to respond to the emotional and personal needs of their patients, as this is not usually considered part of their ‘job description’. Furthermore, due to their demanding workloads and long shifts, medical professionals and medical students are often encouraged in their training to detach from their own physical needs, neglecting their own bodies (Charon 2006). A particular heart breaking and ironic example: a doctor who began haemorrhaging from a miscarriage herself during her hospital shift still delivered her patient’s baby while experiencing the early stages of her own miscarriage. When later asked why she had not addressed her own miscarriage first, she responded, “My patient was delivering, and she needed me there” (Charon 2006, 112).

Charon (2006, 354) states, “Narrative medicine as a discipline has reintroduced the ‘Voice of the Physician’ into a profession that traditionally denies or buries the personal voice”. As part of “narrative medicine” education for medical students, for example, “empathic witnessing” now includes the personal self to inform medical practice. “Reflective clinical practice requires self-examination,” says Charon (2006,

355). Until recently, few medical educators would have written about “empathic witnessing” or “narrative medicine,” let alone considered the doctor’s “personal identity”—including personal or familial illness background, gender, class, ethnicity, and sexuality—all of which could potentially influence their ability to understand, clarify, and represent patients’ stories. Research on patient-doctor dialogues suggests that the doctor’s personal, cultural, and emotional factors indeed influence communication with patients. An example of this is evident in how the race and gender of both doctors and patients influence clinical interactions. “Physicians’ own bodies and the very personal experiences arising from their bodily identities have yet to be acknowledged as an essential element in learning professional empathy,” states Charon (2006, 356).

While I value the field of medicine for its dedication to investigating, diagnosing, and treating the physical body, I have also developed a greater appreciation for medical professionals during this research, especially throughout my re-examination and critical re-remembering and re-writing of *Marie’s* experiences from her original journals. As I re-lived and explored her time spent in medical environments receiving treatment for UI from different perspectives, I now feel empathy for medical professionals rather than contempt, as I once did. DasGupta and Charon (2004) argue that the disconnect among physicians arises from the widespread influence of Cartesian dualism. This likely stems from Descartes’ assertion that the mind or soul is a non-physical substance responsible for thoughts, self-awareness, and consciousness (DasGupta and Charon 2004). In contrast, the body is a physical substance in the material world. This distinction suggests that physical processes cannot fully explain mental phenomena; in this context, they are regarded as

separate. Furthermore, the subsequent traditions of Western science, psychology, and civilisation tend to prioritise the mind over the body (DasGupta and Charon 2004).

However, I believe that doctors' disconnection from their bodies goes beyond the "Western predisposition to dualism" (DasGupta and Charon 2004, 357). Moving from feelings of being lost and confused as a UI patient to developing appreciation and empathy for medical practitioners regarding this separation—heightened by the underlying divide between doctorhood and patienthood—I see its relevance more clearly today as I observe these experiences with my clients. Therefore, I assert that "narrative-based practice" (DasGupta and Charon 2004; Frank 2000) is urgently needed in reproductive medicine hospitals and clinics to promote 'empathic witnessing' as part of assisted reproductive technologies (ARTs). Charon states (2006, 378), "Such wholeness must involve a self-aware practice that incorporates professional and personal realities." This, combined with infertility counselling, would, I believe, transform the experiences of infertility and UI patients, assisting them to work through and manage the invisible, complex losses such as ambiguous loss, chronic sorrow, and disenfranchised grief (Burns and Covington 2006; Harris 2017; Doka 2002).

### **Reflecting on Shame, Stigma and Therapy**

This reminds me of Chapter Four, where I discussed shame as a central theme in religion, faith, loss, and hope, using *Marie's* experiences of shame stemming from her perceived inability to conceive. Additionally, when diagnosed with UI, she felt disconnected from all she had previously learned in her religion and society. The

vivid journal entry describing her response to this diagnosis appears in a vignette in Chapter Two, illustrating how her world shifted beneath her and left her adrift in the uncertain waters of prolonged grief for many years. This internal struggle caused deep feelings of shame and stigma. Thus, I wonder, what stops people from seeking medical advice or intervention from the beginning? Since I have identified shame and stigma as two major themes influencing individuals experiencing UI throughout this study, I draw on Luna Dolezal's (2022) work, the healthcare expert I introduced in Chapter Four, who examined the relationship between shame and stigma. Like Charon's (2006) integration of "narrative medicine" and "empathic witnessing," a recent study by Dolezal (2022) highlighted a point directly related to 'health shame and stigma,' although, like Charon's "narrative medicine," it is not explicitly aimed at reproductive medicine either. Nonetheless, Dolezal (2022) argues that, while the burdens and consequences of stigma and shame are well-documented in health literature, there remains uncertainty about how individuals experience and cope with these issues. I would add that this is especially relevant in the context of UI and infertility, as these topics remain highly taboo in society today, which is why I have included vignettes and examples throughout this study. I maintain, along with Dolezal (2022), that shame-related emotions, defined as the persistent anticipation of shame, best reflect the experience of living with a health-related or health-relevant stigma.

Stigmatising health conditions can lead to serious negative effects, such as delays in treatment, reluctance to seek healthcare, increased emotional distress, and even poorer overall health, says Dolezal (2022). She further explains that stigma can be just as harmful as the illness itself, and marginalisation disrupts mental health and

life satisfaction, which is closely related to the experiences of UI I have discussed throughout this writing. To address this issue, healthcare professionals must develop what she calls 'shame competence' (Dolezal 2022). This involves understanding shame, recognising its potential triggers, and gaining insight into patients' coping strategies. Additionally, practitioners should be aware of their own shame and how it might influence their interactions to avoid unintentionally causing embarrassment or deeper shame for the patient. Dolezal (2022) argues that this competence should be promoted in medical settings to develop emotional intelligence and open conversations about shame. She also emphasises that healthcare providers must be trained and equipped to prevent both direct and indirect shaming, considering factors such as race, disability, and gender in their communication. Avoiding stereotypes and dehumanising language is also crucial for building meaningful relationships and recognising shame-related stigma, which is vital, as social power dynamics can intensify shaming in healthcare contexts. I believe the lack of 'shame competence' (2022) in reproductive medical environments has contributed to *Marie's* and my clients' health-related stigma and shame, which negatively impacted their UI diagnosis and experiences.

Dolezal (2022) affirms that recognising and addressing shame can improve care outcomes for those experiencing stigma related to health. Dolezal (2022, 856) states, "Stigma has been associated with delays in seeking treatment, avoiding clinical encounters, prolonged mental distress, mental ill health among many other factors that negatively impact health outcomes". She suggests that gaining insight into the experiential aspects of shame-related emotions would enhance healthcare professionals' awareness of stigma and its effects in clinical interactions. Therefore, I

also support, along with Dolezal (2022, 857), the integration of ‘shame competence’ and ‘shame-sensitive’ practices within healthcare, including in reproductive health care, with UI and infertility being a deeply personal experience, particularly connected to shame.

*Marie’s* stigma was discussed in more detail in Chapter Three, partly through the lens of Foucault’s (1973) concept of the ‘medical gaze.’ In Chapter Four, I spoke to her shame and identity rupture concerning her Catholic faith, which was a significant part of her life. This brings to mind John Amodeo’s (2022, 21) description of shame as a “sneaky obstacle,” which fits with the complex nature of Catholic shame, characterised by its hidden and secret aspects. Amodeo (2022, 23) states, “Shame is a complex and typically hidden emotion. We all experience it, but oftentimes we’re not aware of the secret ways it operates”. Gradually, *Marie’s* solid wall of all she knew in Catholicism was torn down throughout the years of her experiences with UI, as if with a sledgehammer.

*Marie’s* shame was deeply connected to Catholicism coupled with her upbringing, arising from a fear of being ‘cast out’ by her Catholic family, church, and community because ART is forbidden in Catholicism. This eventually created feelings of loneliness, unworthiness, and exclusion, leaving her feeling disconnected and with a sense of not belonging. Following Nathanson’s (1992) Compass of Shame, which I introduced in Chapter Four, I use the ‘Compass of Shame’ with my clients to help them identify their triggers and responses, allowing us to learn together how to acknowledge, accept, and progress with their shame and reactions to it. I incorporate this into their therapy when suitable, as we explore its roots, their reactions, and how

to face it with acceptance rather than denial, a significant milestone in counselling for infertility in my experience as an infertility counsellor.



(Compass of Shame: D. Nathanson, 1992, 312)

Response Selection: At this crucial moment, clients in my practice decide how they might respond to their shame. Nathanson (1992) identifies four main responses, each carrying possible positive or negative outcomes:

- **Withdrawal:** Physically or psychologically distancing oneself from the triggering situation. This can create space for reflection but may also lead to denial and increased shame if unresolved. (This mirrors *Marie's* experience, as she tried

to protect herself from emotional triggers related to her UI and medical treatments. In doing so, she slowly isolated herself from her social and family life, avoiding pregnant friends or relatives with children and babies, grappling with guilt over her choices, which only heightened her feelings of shame. Lacking support and feeling unable to seek help, she internalised the belief that asking for assistance was an additional source of shame, which only worsened her existing shame).

- **Avoidance:** Denying feelings of shame and negative self-experience. Unlike withdrawal, where these messages are accepted and situations are avoided, those who use avoidance typically employ distraction techniques to create neutral or positive feelings. They are also motivated to minimise their conscious experience of shame. (This would describe Vivian's situation of consciously denying her childhood trauma through the deep shame she had carried for a very long time, until she could no longer conceal it from the adoption agency, making the courageous decision to disclose it after many years.
- **Attack Self:** Engaging in self-destructive behaviours, such as alcohol, substance abuse, or self-harm, as a way of coping with internalised shame. This reaction can lead to serious consequences, including depression and suicidal thoughts. (This describes the experiences of Lucia and Milo from Chapter Six, who felt overwhelmed by guilt and shame after the late termination for medical reasons (TFMR) of their baby girl, Ava. The emotional burden of their loss was so heavy that Lucia considered ending her life.

Meanwhile, Milo engaged in self-destructive actions, such as registering on a dating site and seeking connections with other women, because he could not cope with or accept his own or Lucia's grief).

- **Attack Others:** Redirecting shame outward, which can lead to aggression or blaming others. (This is similarly reflected in the experiences of Lucia and Milo, who both acknowledged that following their loss, they directed blame towards each other, resulting in toxic behaviours that strained their relationship, and they were desperate to stop this and resolve it. It helped them enormously to learn and understand that this was because they were redirecting their shame outwards, and to the one they each loved and trusted the most. This understanding was a pivotal moment for them and facilitated our work together to address and resolve these issues, ultimately helping them to prevent similar dynamics from arising in the future).

Had *Marie* been in therapy with me now, I would have worked with her to move from the 'Withdrawal' process that caused her to remain in a state of denial and isolation, which was unfortunately left unresolved for many years. This only increased her feelings of shame as she led her 'double life,' keeping her UI secret from most people in her life. I would then gently guide her towards my 'Acceptance' process, inspired by Nathanson (1992) where she could acknowledge, understand, and find meaning in her shame—particularly related to her Catholic religion and UI—hopefully leading to growth and a transformation in how she views her identity and womanhood. Nathanson (1992) emphasises that the effectiveness of the chosen response in discharging shame without worsening it is vital for emotional well-being.

Understanding this can help clients navigate their feelings of shame more effectively, leading to healthier coping strategies and greater emotional resilience.

- Acceptance: Acknowledging and experiencing the shame, which can lead to personal growth. Acceptance may involve coping strategies such as confession, humour, or making behavioural adjustments. (This also reflects *Marie's* journey, which took several years for her to reach a stage of acceptance and personal growth. She recognised the necessity of making transformative changes in her life, ultimately transitioning into a new phase of her identity: her feminist grace, from Chapter Five. This ongoing process is supported by her commitment to research, continuous learning, and personal counselling).

I believe that if *Marie* had had the chance to explore this with a specialist infertility counsellor, it would have helped her understand and manage *her* shame more effectively. I translate and categorise these triggers as follows (Nathanson 1992):

- Limitations of a personal nature: Feeling inadequate about one's physical strength, intelligence, and abilities — for example, feeling weak, foolish, or inexperienced.
- Autonomy: Feelings of helplessness and reliance on others, uncertain about one's independence.
- Self-Assessment comparison: The feeling of being inferior or unsuccessful compared to others – for example, feeling like a failure.

- Self-Identifying: The idea that being special comes from one's perceived flaws or deficiencies - for instance, I am only unique because I am flawed.
- Physical Appearance: Feeling deformed or unattractive, which leads to a heightened sense of shame and vulnerability — for example, I think I am ugly and therefore an embarrassment, making me a target for contempt.
- Sexual identity: believing there is something inherently wrong with oneself sexually.
- Exposure and visibility: feeling uncomfortable when observed, accompanied by a desire to escape the gaze of others, sometimes wishing to disappear entirely.
- Anxieties surrounding intimacy with others: a profound sense of unworthiness, feelings of disconnection and being unlovable, leading to a desire for solitude.

Nathanson calls this phase a “cognitive review” and while the review may well be cognitive (which we usually associate with conscious activity), I think that unconscious associations are also made, leading to a level of response that may surprise even the affected individual.” (Nathanson 1992, 339). I believe the ‘Compass of Shame’ would have assisted *Marie* by highlighting the cognitive and emotional processes she likely experienced in response to shame. This framework encompasses several key phases, or as I see them and list them below, processes

that influence how shame is understood and addressed. I also connect each one with an example from this study):

- **Cognitive Review of Shame-Related Experiences:** This phase involves reflecting on past experiences that resonate with the current shame trigger. Nathanson (1992) has categorised these as I have translated above. This cognitive review can involve both conscious and unconscious associations, influencing the client's emotional response. (This is similar to the situation of my client Vivian, discussed in Chapter Six, whose childhood trauma was closely linked to her current experiences of unexplained infertility (UI). The re-emergence of these past traumas prompted similar emotional reactions, requiring an exploration of her childhood experiences to find meaning and address the issues related to her UI).

### **Belonging, Story Telling and the Dyadic body**

Brown (2017, 27) states that belonging is central to her research on emotions because it underpins all emotions. As a social species, she affirms that belonging is essential for us. Brown (2017, 28) further states, “We cannot survive without one another”. However, if we feel pressured to “fit in” or “conform,” then that is not really belonging, and it sacrifices our authentic selves, which in turn questions our identity even further (Brown 2017). Hence, the impact this had on how *Marie* perceived her entire life and her sense of belonging—growing up in a Catholic family and ultimately struggling to ‘fit in’ as a natural mother and to “conform” to her religious beliefs, culture, and society as she knew it—created a deep sense of disenfranchised (Doka

2002) loss within her. A shift towards questioning her role and place within her family and the broader Catholic community eventually led to a pivotal moment in her identity: a loss of orientation and understanding of who she was, due to her inability to conceive and assume the central role of a woman in motherhood within her Catholic family and community. I believe if *Marie* had the chance to experience the infertility processes I have developed and now work through with my clients, she would have processed her shame with specialist support and guidance and would have arrived at a different place at a different time feeling more confident and effective at becoming a 'dyadic body' (Frank 2013), as discussed in Chapter three regarding illness or diagnoses, which describes the body as shared with other bodies in storytelling. Consequently, *Marie* might have shared her stories much earlier and found healing through a supported journey, preventing much of her prolonged suffering. This is why, as a specialist infertility counsellor, I see myself as a vessel that carries unheard voices, such as *Marie's* long-silenced voice, and those of many of my clients, and I think about how they say they only feel 'heard' when in session with me. Arthur Frank (2013, 23) states of the diagnosed, "We need to become storytellers in order to recover our voices that diagnoses and medical treatments take away".

### **Shame, Healing and Feminism: Is it ever too late for Therapy?**

Taking you back to the opening vignette in my introduction of this thesis, where I share the epiphany *Marie* journalled around sixteen years ago, when her mum said to her "Don't ever have children, *Marie*. It'll ruin your life" after she happily skipped over to help change her baby sister's nappy and expressed her wish to have children herself one day. Re-remembering this comment and a few others like it from

her mother had a profound effect on *Marie*, prompting her to question the emptiness she carried deep within her—a missing piece in her long-standing, unresolved UI puzzle. It was a void she felt for many years—a void that made her feel unworthy, perhaps even preventing her from believing she could be a mother, leaving her feeling ‘othered’. However, she had never understood why. *Marie* was about nine years old when the incident occurred. She uncovered this memory after undergoing hypnotherapy, which was the first therapy she eventually received as an adult, towards the end of her twelve-year struggle with recurrent ARTs during her experiences of unexplained (in)fertility (UI). *Marie* had only four sessions of hypnotherapy.

This reminds me of Butler (2011, 47), as she says, “act for and in the face of the other, and because of this, an occasion and commitment to transformation.” This memory was unknown to *Marie* until her first hypnotherapy session. The feeling of not belonging as a mother did not quite fit with *Marie* until this epiphany; that void had troubled her for many years. *Marie* had not linked her sense of lack to motherhood or womanhood. I wonder if part of that ‘void’ was perhaps that *Marie* did not feel she belonged to her gender as a woman? Judith Butler (2011, 26) begins a discussion by saying “gender seems determined and fixed”. Whereas De Beauvoir (1981,103) states, “one is not born a woman but rather becomes one”. Was this how *Marie* saw her life from this point, because of her (mis)understanding of the world of fertility, where her perception of not belonging in motherhood and therefore womanhood was shaped?

The nine-year-old girl, who was unknowingly exploring her gender and womanhood, was unaware of the lasting effects caused by being silenced when expressing her wish to become a mother herself someday. Nine-year-old *Marie*, confidently and without restraint, celebrating her future motherhood, was sternly warned, “Don’t ever have children, *Marie*, it’ll ruin your life.” In that moment, her sense of femininity and the idea of becoming a mother one day were possibly unsettled, while also conditioning *Marie* from an early age to feel shame for wanting her own baby someday and expressing this wish. That same desire, nine-year-old *Marie* told herself then, ‘she would never express again’. Perhaps it was instead replaced with a fear that having children would “ruin” her “life”.

This epiphany would later help make sense of many incidents in *Marie’s* life as she felt she had somehow chosen a particular kind of life—building a career, making her mum proud—instead of living as Stephen Porges (2009, 223), an expert on the polyvagal theory puts it, “The life that might have been”, the life where *Marie* would speak openly about wanting children and leading a life that included having children without these complex issues. *Marie* desperately wanted to make sense of her later medically diagnosed UI.

Therefore, even in the short excerpt of this epiphany, the issues of identity and feminism cannot be overlooked, as *Marie’s* mother, even in her distressed state, allows her older brother to go wash up and prepare for dinner. However, instead of giving *Marie* the same courtesy, her mother asks *her* to help look after the baby while, at the same time, instilling in *Marie* a sense of worth (Rogers 1961), that “she must never have children” because “it’ll ruin her life”. Furthermore, according to

Porges' (2017) polyvagal theory, *Marie's* brain would have perceived that her safety was at risk, with danger detected as fight or flight responses. At that moment, when she was nine years old, *Marie* consciously chose not to show her excitement about wanting to have her own children and become a mother, perhaps unconsciously, out of fear that revealing this could cause real danger to her life through the polyvagal system, as she heard, "Don't ever have children, *Marie*, it'll ruin your life".

Thus, I wonder, can the maternal body be affected by this experience? This makes me consider research suggesting that stress in the nervous system can cause fertility issues, potentially obstructing pregnancy due to the effects stress or trauma might have on reproductive organs. I do not explore this in depth here due to the scope of this thesis, but I note that it has also been linked to polyvagal theory, as well as studies connecting illness, stress, and emotion (Mate 2011; Porges 2017; Frank 2013).

Furthermore, Porges (2009) explains that humans constantly and unconsciously observe their surroundings to evaluate whether they are safe. It is a sensory experience; always ready to 'fight or flee'. Porges (2017) referred to this as 'neuroception', rather than 'perception,' to aid adults in communicating with children and understanding the goals and behaviours within the attachment relationship. Porges (2009, 5) states, "We have to understand the child's 'neuroception', or we may choose approaches that are suboptimal or at worst harmful." This offers some insight into how *Marie's* mum's comment and its delivery might have affected nine-year-old *Marie*: "Don't have children, *Marie*, it'll ruin your life."

Incidentally, *Marie* later discovered that her mum was suffering from untreated post-natal depression when she made these and other harmful comments, which influenced her views on fertility and the shame she felt about it. Soon after the hypnotherapy session, when *Marie* experienced this realisation, the hypnotherapist suggested that *Marie* gave her mum the chance to respond or apologise (for this and other comments). *Marie* did so, but her mum did not accept the opportunity when it was offered. This was a great shame, as the issue was left unresolved, and that shame continued to haunt *Marie*. It also could have helped restore some trust that was lost. Sadly, this was not to be. Furthermore, *Marie's* Mum's comment did not align with her strong Catholic beliefs, only causing further confusion regarding her religious convictions as a practising Catholic, her faith, her complex and unseen grief, and, consequently, her sense of identity, all of which I explored in more detail in Chapters Four and Five.

*Marie* eventually sought therapy for herself many years after her UI experiences and seven years after her son was born. This marked the beginning of her long-term therapeutic relationship with her counsellor (excluding a brief four-session hypnotherapy experience as mentioned here and in Chapter Three) that she continues today. Combined with the healing, ongoing learning, and deeper understanding of this subject through my work as an infertility counsellor, this has been transformative in helping make sense of the shame, stigma, and disenfranchised grief associated with *Marie's* UI, such as the breakdown of her first marriage, the loss of other relationships, and family issues. Through her counselling sessions, *Marie* has learned a great deal about the importance of empathy and self-compassion in managing her shame and advancing in her healing. Shame, the

primary catalyst for *Marie*'s emotional decline related to her UI journey and the challenges it posed to her Catholic identity, is a social emotion: "Shame happens between people, and it heals between people," states Brown (2021, 124).

*Marie* eventually found a path to healing and continues to practise self-compassion, as well as attend her counselling sessions. By doing so, she embarked on a new process of gradually sharing her stories of shame and UI. Through discovering and practising self-compassion and empathy—both from herself and from the 'safe' individuals she chooses to spend time with—something that lacked in her first marriage and cultural environment during these challenging times—she ultimately confronted shame with the agency and power she gained from her renewed faith in God, liberated from Catholic dogma; her emerging sense of agency and feminist identity, free from guilt and shame; and the self-compassion she experiences through her relationship with God. After all, Kristin Neff (2011, 113), renowned for her work on self-compassion, states, "Shame cannot exist when empathy is present". Where shame exists, empathy is often absent, as noted by Rhonda Dearing (2018), a researcher specialising in shame. Dearing (2018) confirms that empathy and shame conflict. Therefore, we need empathy and accountability to overcome shame. *Marie* navigated this process in therapy and her life with the support of her feminist map—her renewed faith—which continues to spiritually guide her in healing the wounds inflicted by shame and stigma related to UI.

## **Bridging the Gap: Integrating Narrative Medicine and Emotional Support**

Through the subsequent birth of *Marie's* son, there were resolutions, contradictions, and tensions to explore regarding the experience of living with UI and emerging from assisted reproductive technologies (ARTs). As Letherby (1999, 359) suggests, "Women who achieve motherhood following 'infertility'/'involuntary childlessness' still feel that they do not meet the ideal. Both non-mothers and women who achieve motherhood in an unusual way can be seen as the 'other, as 'stranger'." In this chapter, I have consolidated and further discussed the emotional impact surrounding unexplained infertility (UI) through *Marie's* experiences, emphasising the importance of Charon's (2006) 'narrative medicine' and 'empathic witnessing', coupled with Dolezal's (2022) 'health shame and stigma' integration of her 'shame competence' and 'shame-sensitive' practices within healthcare and how valuable it would be if these were to be integrated into reproductive healthcare. By highlighting this gap and suggesting it could be addressed through narrative and empathic approaches between healthcare professionals and their patients—particularly regarding shame and stigma—I have demonstrated how these methods could help people and, in turn, support their journeys through UI and infertility. By recognising the interconnectedness of emotional and physical health, we can develop a more compassionate and effective framework for those facing the challenges of UI and infertility.

In conclusion, the final chapter of my thesis calls on all professionals working with fertility impairments and the individuals and couples experiencing them to embrace narrative-based practices that prioritise our clients' and patients' voices,

ensuring they are heard, validated, understood and valued. I advocate for an increased availability of trained counsellors in this field, enabling us to collectively support individuals on their unique journeys toward healing—addressing their complex losses, rebuilding hope, and redefining their identities following medical treatments.

As I conclude this discussion and reflect on the crucial need for a deeper understanding and a more compassionate approach to Assisted Reproductive Technology (ART), I advocate for processes that prioritise emotional support and well-informed guidance alongside medical interventions for our patients and clients. Therefore, I now turn to my final chapter, which further discusses and concludes my exploration of this gap in the field of fertility impairments, proposing a comprehensive framework that integrates emotional well-being with reproductive medical interventions for all professionals involved in supporting and managing unexplained (in)fertility and infertility.

## Chapter Eight

### Conclusion

“Women who achieve motherhood (either biologically or socially) with assistance, attribute some of the pressure to be “perfect” that they experience to their previous status as ‘infertile’/‘involuntarily childless.’ Some feel that it is harder to be a “proper” mother to “miracle babies” (medically assisted), much longed for babies”.

(Letherby 1999, 366)

In this chapter, I begin by presenting insights into unexplained (in)fertility (UI) that go beyond the usual focus on achieving motherhood. I highlight key findings from this study, including perspectives shared by both *Marie* and my clients, and how these experiences relate to the existing literature on UI and infertility. By synthesising these insights throughout my entire research, I propose recommendations based on the overall findings, contributing to the limited conversation on a deeper understanding of UI and its effects on individuals and couples navigating this complex emotional journey, as well as supporting medical professionals and those working with clients or patients experiencing UI and infertility.

Reflecting on and evaluating the insights gained throughout this PhD project, I have addressed my first research question: What is the experience of ‘unexplained’ infertility (UI)? In doing so, I have demonstrated that UI can manifest in many ways. Consequently, I have discovered, through exploring my sub-research question in Chapter Six and discussing it further in Chapter Seven: how counselling and psychotherapy can support the processes of UI and infertility. Despite the various

faces and forms of the UI experience, core themes run like a thread through all of them: loss and hope; including disenfranchised grief (as well as ambiguous and nonfinite loss and chronic sorrow), stigma-Chapter Three, shame-Chapter Four, and the process of rebuilding a new identity following medical intervention-Chapter Five. However, you might be wondering, as I do from my perspective as a researcher, whether there is an end to the experience or impact of fertility impairment even after having a baby.

### **Does UI ever end? Motherhood, Identity and the Impact of Otherhood**

As I shared in separate vignettes in Chapters Four and Five, *Marie* believes that, even after giving birth to her son, her UI experience is far from over. She is acutely aware that having a baby did not draw a line under UI, nor did it mark the conclusion of the challenges posed by UI. Hence, I question whether the term or diagnosis “unexplained (in)fertility” (UI) is inaccurate, unnecessarily stigmatising, and shameful. As a counsellor specialising in this area, I prefer to use language such as ‘fertility’ or ‘fertility impairment’ with my clients because I see this situation as temporary and fluid, existing in a space where change is possible and alternative directions can be explored. Nonetheless, the emotional impact of UI, long after the rollercoaster of medical intervention and even after childbirth, can be everlasting.

While there is a perceived external transition from “otherhood” (Knight 2017, 230) to “motherhood”, in that *Marie* finally had her son, the feeling of “otherhood” never entirely leaves; a part of it lives on in her. *Marie* often feels like an imposter in motherhood; sometimes she struggles with a sense of not belonging, feeling like she does not quite fit the mould of the ‘real’ or ‘natural’ mother. She often has one foot

still in 'otherhood.' Thirteen years after her son's birth from an IVF cycle, she continues to wrestle with the lingering stigma of UI, always striving for perfection in parenting, desperately trying to prove herself worthy as a mother, while recognising this and working through it with her counsellor. Rajagopal (2021, 233) made a powerful statement in her memoir, after eventually having her son after several attempts at IVF, much like *Marie*, "I don't feel a sense of accomplishment or triumph in having had a child. I don't have the swagger of a warrior who has waged a tenacious battle and emerged victorious. Mostly, what I have is a feeling of having survived. The feeling of having made it by the skin of my teeth". This statement relates strongly to similar comments my clients make during therapy following childbirth.

For example, a client who returned to therapy after recently giving birth to her son explained, *"I thought having him would bring my confidence back and give me a stronger sense of identity, but it hasn't... I've been feeling even more lost and uncertain than when I was childless during medical treatment."*

Another client, newly into motherhood, said, *"Having my baby didn't erase the pain of IVF... I thought it would be behind me... that I would forget it all, but it feels like I've just woken up from a terrible dream."*

And another client stated, after giving birth to her baby girl, *"I still don't feel worthy of this... I'm worried I'll never fit in."*

Like Rajagopal, these clients grapple with the aftermath of their journeys, as *Marie* still does, recognising that the battle they fought for motherhood does not always lead to an instant sense of fulfilment, nor does it erase the issues that existed before motherhood. Hence, I work with my clients before (when possible), during, and after motherhood, exploring in depth why they want children initially, past experiences that may influence their self-esteem, how they view themselves within their cultures and societies, and delving into their sense of identity, among other things, including imposter syndrome in motherhood. As shown in Chapter Six, I also provide psychoeducation and coaching to guide my clients through all relevant options, including further medical intervention, surrogacy, adoption, holistic approaches, or, indeed, accepting remaining involuntarily childless. I firmly believe these options should be discussed with a trained infertility counsellor who understands and speaks the language of fertility impairment, since this journey involves significant life decisions that can profoundly affect one's sense of identity and future after experiencing complex losses.

### **Religious Influence**

Additionally, the impact of this journey revealed to *Marie* the extensive influence of religious institutions and how, for example, Catholicism shapes our Western society. This taught *Marie* that the power of religious doctrine has not only influenced Western society since ancient times but also continues to exert significant influence on our current society and culture, affecting social norms, identities, and even academia, today, as discussed in Chapter Four concerning St Augustine (1996). This takes me back to Chapters One, Four, and Five, where I discuss how

first-wave feminists raised concerns about women being seen merely as child-bearers. Thus, bioethical issues arose about the use of assisted reproductive technologies (ARTs) to ‘manufacture’ more children, according to some feminists. Also, Richie (2018) and others critically examined the Augustinian lineage (in chapter four), reflecting on how finding a balance in understanding marriage and procreation might ease social pressures to reproduce, thereby addressing feminist concerns and the ethical challenges of assisted reproductive technologies (ARTs). Consequently, a substantial body of literature emerged, showing how new-wave feminist movements have moved on to support and engage with reproductive medical interventions such as IVF, especially as some, including feminist scholars, have experienced infertility or UI themselves. Michaela Meyer (2022), for example, a feminist academic writer, shared her experience of secondary infertility, stating,

“And while I will be grateful every day of my life for my two children, the heightened awareness of just how completely infertility consumed and defined my life down to the smallest detail—from diet, daily planning, mental head space, how I interacted with others, turning the researcher’s eye inward on myself as I meticulously recorded data about every aspect of myself throughout the process—is like a bad dream from which I am just now waking up. I am both traumatised and thankful. It is a paradoxical existence that is difficult to communicate to those who have not been through the process”.

Examples like this help broaden the limited conversation within academia and beyond. In my view, through revolutionary forces such as new wave feminist movements, a more nuanced and balanced understanding of infertility and UI has developed within the academy. Furthermore, with these new insights, I feel better prepared to explore my clients’ suffering and deeply personal journeys related to faith, spirituality or religious practices within the complex realities of their fertility challenges. In this ongoing process of reflexivity and eventual liberation, *Marie*

learned to embrace a more inclusive and compassionate understanding of faith, one that recognises the many ways individuals seek connection and meaning when facing life challenges such as fertility impairments.

### **Faith, Fertility and Feminism**

The profound exploration of ‘fertility and faith’ or rather ‘infertility and loss of faith’, as discussed in Chapter Four, ultimately led *Marie* to rediscover her faith in God through her inner feminist, as discussed in Chapter Five. This became her guiding map, implicitly connecting her first to herself, then to everyone, everything, and to God. This was a meaningful and liberating journey for *Marie*, as it enabled her to discover the connection she needed to establish her new identity. Subsequently, *Marie* can now venture anywhere without fear of losing her way, just as my clients can when they reach the stage of reconstructing their new identities through the work we do together in therapy. Brown (2021, 717) beautifully articulates this by saying, “Even when we have no idea where we are or where we are going, with the right map, we can find our way back to our heart and to ourselves”. Therefore, ‘moving forward’ - not ‘moving on,’ as Doka (2002) reminds us – after grappling with the many complex losses endured by UI alongside Catholicism over many years, *Marie* ultimately discovered her “feminist grace” as discussed in chapter five, which led to the voice she now possesses regarding UI and fertility challenges, a voice that had been silent for so long.

## **The Courage to Rebuild Hope Again - Paradise Found**

Returning to *Marie's* eventual pregnancy, which made it to full term and led to the successful birth of a healthy son, as discussed in Chapter Five, her pregnancy was marked by multiple threats of miscarriage following several bleeding episodes and many scans. Nonetheless, *Marie* and her partner welcomed their healthy baby boy in May 2012. As I stated, it was her 'paradise found', i.e., aside from the ongoing personal issues she continues to work through in her "paradise lost" (Milton 1667, 116). Her hope of having her baby was realised after twelve years of living with a diagnosis of UI, much of it spent as a medical patient, working through her arduous journey of medical intervention and constantly trying new approaches to summon the courage to rebuild hope again. Brown (2021, 97) asserts, "We need hope like we need air. To live without hope is to risk suffocating in hopelessness and despair. It is to risk being crushed by the belief that there is no way out of whatever is holding us back, no way to reach what we desperately need."

Although *Marie's* final IVF cycle, which the consultant told her had only a five per cent chance of resulting in a live birth, she and her partner clung to this slim "pathway" of hope, as Snyder et al. (2000, 86) describes in Chapter Five. According to Brown's (2021, 46) grounded research, "Hope is not what most of us think it is. Unlike hopelessness, hope is not an emotion but a way of thinking, a cognitive process". Brown states that emotions play a role in hope. *Marie*, as Snyder et al. (2000, 87) describe, "learned" to hope again through her own cognitive process by deciding to dare to hope again, alongside her partner's strong support and

encouragement. Thus, *Marie* indeed found the courage once again to hope and believed she could have a baby.

Bringing together the two central, overarching themes woven throughout this study — Loss and Hope — I have shown how *Marie* ultimately developed a new identity after her UI diagnosis and medical intervention. This highlights the importance of her making necessary changes over time. In *Marie*'s situation, this involved distancing herself from people and places she felt 'cast out' and 'othered' by, such as the Catholic church, creating a space for her to find healing, restore herself, and uncover her inner feminist. All these steps were essential to building a new identity and rebuilding her hope. I agree with Frank (2000,136) that, "A self that has become what it never expected to be requires repair, and telling autobiographical stories is a privileged means of repair though hardly the exclusive means." This also demonstrates that something as fundamental as reproduction, which *Marie* had always believed would be the most natural and effortless part of her life to achieve when she was ready, as she had always planned, instead became the most challenging situation of her life — the one that unexpectedly brought her to her knees.

Unexplained infertility (UI) robbed *Marie*, as it does many others, of her lifelong dream of having children for twelve years and later ended her chances of having more children. Following the birth of their son, *Marie* and her partner implanted the remaining three embryos, which they had frozen from the same IVF cycle they had their son from (who was one of the first three embryos implanted). Sadly, the frozen embryos did not proceed to pregnancies to full term: more exponential loss for *Marie*

and her partner. However, this time there was an additional complex loss — for their son to understand at such a young age. Their son asked for, and sometimes cried for, over several years to have a sibling and struggled to understand why he could not have a brother or a sister.

### **Facing the reality of having to stop trying and The Need for Counselling**

When *Marie* had to accept that her time had run out — when she had to stop gambling with ARTs due to her advancing reproductive age leaving her with zero percent chance of having another child now that all of her frozen embryos had gone— she explained as best she could to her seven-year-old son that he would never have a sibling; *Marie* and her partner could not bear to see their son continue to hope once they knew for certain their time had come to stop rolling the roulette wheel of ART. *Marie* and her son cried together as she told him, which tore her heart into pieces. She and her partner desperately “tried, tried and tried again” (Kovacs 2010) to give their son a sibling, who once, through his tears, expressed, “but I would have been a good big brother.”

As UI and infertility patients we keep fighting to build up the courage to find hope again and again, after once having believed in human reproduction as a gift, a natural phenomenon that assures us that when we are ready, we will give birth to our children and live the family life we always imagined, as *Marie* did, and as many of us do, and are unexpectedly robbed of it. UI or infertility can take that hope away from us—and with it, our innocence. As stated in Chapter One, infertility has been compared to the ‘plague’ and described as ‘barren’, ‘unproductive’, and ‘unfruitful’. Therefore, it is no surprise that, even today, it remains a shameful and stigmatised

condition/illness/disease, even a disability. Consequently, I have shown how counselling and psychotherapy aid these processes and why counselling intervention is vital for those experiencing fertility impairments. While most medical professionals may advocate for persistent attempts at assisted reproductive technology (ART), this research demonstrates that a purely medical approach overlooks the significant emotional impact on individuals facing UI and infertility. Moreover, the lack of specialist counselling services available both within medical settings and outside them complicates matters, leaving many without essential resources to navigate and manage their UI and infertility journeys.

My study has shown that Unexplained (in)fertility (UI), or as Kovacs (2010, 2) reintroduced it at the very beginning of this thesis, “unexplained subfertility” or “idiopathic subfertility”, remains an ambiguous, confusing, and challenging diagnosis or experience for most people. The perspective of a gynaecologist like Kovacs (2010) suggests, from a scientific point of view, that couples should keep trying ART, with the chance that one will eventually conceive. Kovacs (2010, 2) recommends “try, try, try again” after each ‘failed’ IVF cycle, perhaps even up to thirty-seven times, as the example he provides in the introduction to this study demonstrates. He notes that “what may happen to couples who have not yet had all their treatment cycles suggests that if a couple keeps trying ART, they should eventually conceive” (Kovacs 2010, 3).

I have questioned the medical ethics of Kovacs's (2010) and others' purely technical medical approach throughout this study, as it is not as straightforward as it appears scientifically for human beings. As a former patient of ART, a co-sufferer,

and a witness to my clients' experiences, I have shown in Chapters Three and Six how we are innocently led into the 'lion's den' of reproductive medical intervention, often without any preparation or support. Medical professionals tell us this is the solution to our UI puzzles, as I discussed in Chapter 3. Just a reminder that one of many studies of IVF cycles involving 14 UI patients found that 83% of those treatments failed (Putowski et al. 2004). Putowski (2004, 2) states that following their critical study of the medicalisation of infertile bodies, they learned terms such as "living laboratories", "hope technology", "mother machine" and "baby machine," and examined how these terms impacted people experiencing UI, seeing them as cogs in the wheel of reproductive medicine and ART; they state, "biotechnology perpetuates the eighteenth-century biomedical metaphor of the body as a machine with replaceable parts allowing for the replacement of perceived 'flawed' body parts, further objectifying them". Deborah Steinberg (1990), a researcher known for her work in reproductive medicine and ethics, as I introduced in Chapter Three, further agrees that reproductive medicine emphasises a deeply entrenched patriarchal perspective that undermines the subjectivity of infertile women, revealing how those without children are often perceived as flawed entities—objects to be fragmented, scrutinised, examined, modified, and ultimately reintegrated into the framework of contemporary infertility treatment such as ART.

### **Medical ethics**

Further, most couples are unable to "try try try again" (Kovacs 2010, 2); or in other words, keep trying 'one more spin of the roulette wheel'. As shared from *Marie's* re-remembered memories and from many of my clients' experiences, it is a gamble and unrealistic for most people to "if at first you don't succeed, try try try

again” in fertility impairment, physically, emotionally, mentally, and financially; humans have their limits. Women can only endure so much invasive medical intervention physically and emotionally, and most couples face financial constraints due to these extremely costly treatments. Moreover, access to essential support, such as expert infertility counsellors, remains limited, making it difficult for those undergoing medical treatments to obtain the necessary assistance. Nevertheless, I agree with Kovacs (2010) on the term ‘subfertility.’ However, for a different reason: I believe ‘subfertility’ should replace the diagnosis of unexplained (in)fertility (UI), as I see UI as a ‘no diagnosis’ or ‘haven’t a clue diagnosis.’ I consider it an ‘anti-diagnosis’—a middle ground, neither pregnant nor non-pregnant, fertile nor non-fertile, as I discussed in Chapter Three.

Additionally, resolving UI issues is subjective and varies from person to person. In my private practice, I refer to UI, infertility/fertility impairment as a ‘season’ in my clients’ lives of fertility impairment because it is fluid in one way or another; with the proper support, they will find a resolution—whether through natural conception, ART with appropriate assistance, adoption, surrogacy, or managing the (not) coming to terms with involuntary childlessness. I believe the UI and fertility impairment experience can be transformative if properly supported; sadly, something *Marie* and many of us did not have. Throughout all UI and fertility impairment journeys, we should at least prepare people for these realities and assist them through their unique circumstances. Therefore, ‘subfertility’ aligns with my suggestion that UI is a season in one’s life, for which we can find a solution, signifying that one’s fertility is not entirely absent in the context of UI. There is still potential, not only to have a

biological child but also to have a non-biologically (socially) related child or indeed continue to manage being involuntarily childless.

Hence, I think it is a mistake to believe that ART alone is the only solution to UI, which is not always the case. While ART can be a valuable option for some, it is essential to recognise that each individual's journey is distinct, and the path to resolution may involve a combination of approaches, including not undergoing medical intervention at all, which is an empowering statement for a person or a couple to make to society, as they are expected to endure medical intervention. Ultimately, the goal is to empower individuals to find their own meaning and resolution in their fertility impairment experiences, supporting them as they navigate their unique circumstances with respect and understanding, whichever path they choose.

### **A Baby at Any Price and the need for Support**

Burns (2007, 211) describes human reproduction as “universally recognised as a psychosocial and biological imperative.” Kovacs’ (2010, 2) term “subfertility,” along with medicalised terms like UI and infertility, have been stigmatised and marginalised across all cultures and throughout history. Despite these negative perceptions, efforts to address childlessness through medical treatments, cultural and spiritual practices, religious rituals, and social adjustments like adoption have persisted. As I mentioned in my introduction, in the mid-twentieth century, psychiatrists primarily focused on treating neurosis, especially in women who were often considered ‘subfertile’ due to ambivalence about motherhood, pregnancy, sexuality, or even their own mothers. The role of psychiatrists at that time was to treat neuroses and

restore fertility. As causes of subfertility of unknown origin UI decreased, infertility counselling shifted from attempting to eliminate neuroses to providing more supportive care. Today, specialist infertility counsellors guide and support patients throughout their reproductive journeys, helping them uphold their moral principles, maintain relationships and family stability, and—most importantly—preserve individual agency and emotional well-being (Burns 2007). However, as discussed in Chapter Six, finding such support for people suffering from UI and infertility can be challenging. Burns (2007, 212) states that the pursuit of “a baby at any price”—regardless of the emotional, social, physical, or medical toll on the intended parents and others involved—has become a powerful consumer force shaping reproductive care and healthcare.

Nevertheless, the twenty-first century has seen a shift in the role of mental health within reproductive medicine. There is a growing recognition that mental health professionals are essential for the optimal care of infertile patients. This shift has resulted from advances in reproductive medicine and an improved understanding of the complex emotional challenges faced by individuals dealing with infertility. However, as Sharon Covington (2006) indicates, there remains no clear international consensus on who should provide infertility counselling services. Covington (2006) believes that infertility counsellors must play a vital role beyond support; they need specialised skills and training to address the interaction between medical and emotional aspects involved with infertility.

I strongly agree with Covington (2006) that counsellors’ responsibilities should include therapeutic assessment and intervention, as well as psychoeducational

support for individuals and couples experiencing fertility impairments, particularly reproductive medical intervention, since I continually stay informed about and provide these services in my private practice as a specialist infertility counsellor. Covington (2006) also suggests that the primary aim of infertility counsellors is to deliver therapeutic care and specialist support within the context of UI and infertility treatment, with appropriate training in how ARTs function.

However, as demonstrated in the *Marie* vignettes and throughout the discussions in this study, preparation and support alongside ARTs are limited or inaccessible, especially for couples and individuals navigating ARTs; even finding a specialist infertility counsellor is a challenge in itself. My clients often tell me that locating such a counsellor is challenging due to the scarcity of professionals with the right skills. Additionally, the UI and infertility patients who become my clients are often already exhausted, struggling to manage their shame, stigma, and disenfranchised grief, which is intensified by disruptions to their identities. Furthermore, based on *Marie's* experiences with UI and my observations of my clients, many feel too overwhelmed to seek private support at this stage and either pursue it late or, for some, I hear about, not at all. Whiteford and Gonzales (1995), whom I introduced in chapter one, interviewed 25 women, a subgroup of North American infertile women who chose medical intervention. These researchers (1995, 28) observed that many women unable to conceive and give birth struggle to find specialist counselling, leading some to give up, as they are already devastated by the “hidden stigma borne of shame and secrecy, which also obscures the exact number of infertile couples”. Furthermore, they (1995) found that most women pursuing medical intervention

become obsessed with it, desperately battling to escape the stigma associated with childlessness, which is worsened by the lack of specialist infertility therapy.

Moreover, this research shows that such preparation and support are neither provided nor easily accessible to those considering ART in the places where they are most needed: reproductive medicine clinics and hospitals. This no longer surprises me, as Burns (2007) states that the term ‘infertility counselling’ is not recognised as a specialised profession by any mental health organisation, nor is it offered with specific training or credentials outside the UK, where the British Infertility Counselling Association (BICA) offers an infertility training programme for trained counselling professionals. Burns (2007) notes that ‘infertility counselling’ has become a common term for various mental health professionals involved in reproductive medicine, including marriage and family therapists, counsellors, psychologists, social workers, psychiatrists, and psychiatric nurses. While some countries, such as the USA, have developed guidelines for subspecialty status—such as those from The National Association of Perinatal Social Workers—these are not officially recognised specialities.

Therefore, this study advocates for establishing specialist fertility counselling services that use specific terminology related to fertility impairment and reproductive loss. The growing consumer-driven demand for reproductive care, characterised by the pursuit of “a baby at any price” (Burns, 2007), often overshadows the emotional and psychological needs of clients and patients. This dynamic can create a power imbalance, where the medical model prioritises outcomes over individual experiences.

Thus, I agree with Covington's claim that infertility counsellors must provide therapeutic assessment, intervention, and psychoeducational support customised to the specific challenges faced by individuals undergoing reproductive medical treatments. However, as shown by the *Marie* vignettes and my clinical observations, access to such specialised support is often limited. Many clients describe difficulty finding qualified counsellors, worsened by feelings of shame, stigma, and disenfranchised grief, which can prevent them from seeking help.

Hence, the theoretical framework of this study challenges the current state of infertility counselling by emphasising the need for a relational approach that prioritises emotional well-being and individual agency while ensuring that the power dynamics between the client and counsellor remain balanced as they each speak and understand the language of fertility impairment. This facilitates a relational approach to therapy. Consequently, this study calls for a re-evaluation of how counselling services are organised and delivered to ensure they are accessible, specialised, and responsive to the unique needs of individuals experiencing all faces and forms of fertility impairments.

### **Knowledge, Therapy and Psychoeducation**

This research suggests that ambiguity within the field of counselling for UI and infertility hinders counsellors, mental health professionals, medical practitioners, and especially patients or clients from accessing essential knowledge, therapy, education, and guidance during these complex and lengthy journeys. Therefore, I, along with other experts in this field (Burns and Covington 2006; Harris 2017),

advocate for the development of more experienced infertility counsellors who can better prepare, support, and guide individuals and couples through the challenges of infertility and UI. As I demonstrated in Chapter 6 with two examples from my client base, infertility counsellors must stand at the forefront of this battlefield—bridging the gap between patients/clients/sufferers and the medical model, culture, and society. This involves working towards connecting and progressing as a united team on the same side of the field: speaking the language of all fertility impairments, openly and fluently, together, reducing stigma, shame, disenfranchised grief, and identity issues—all of which I have shown throughout this study contribute to secrecy, isolation, and silence.

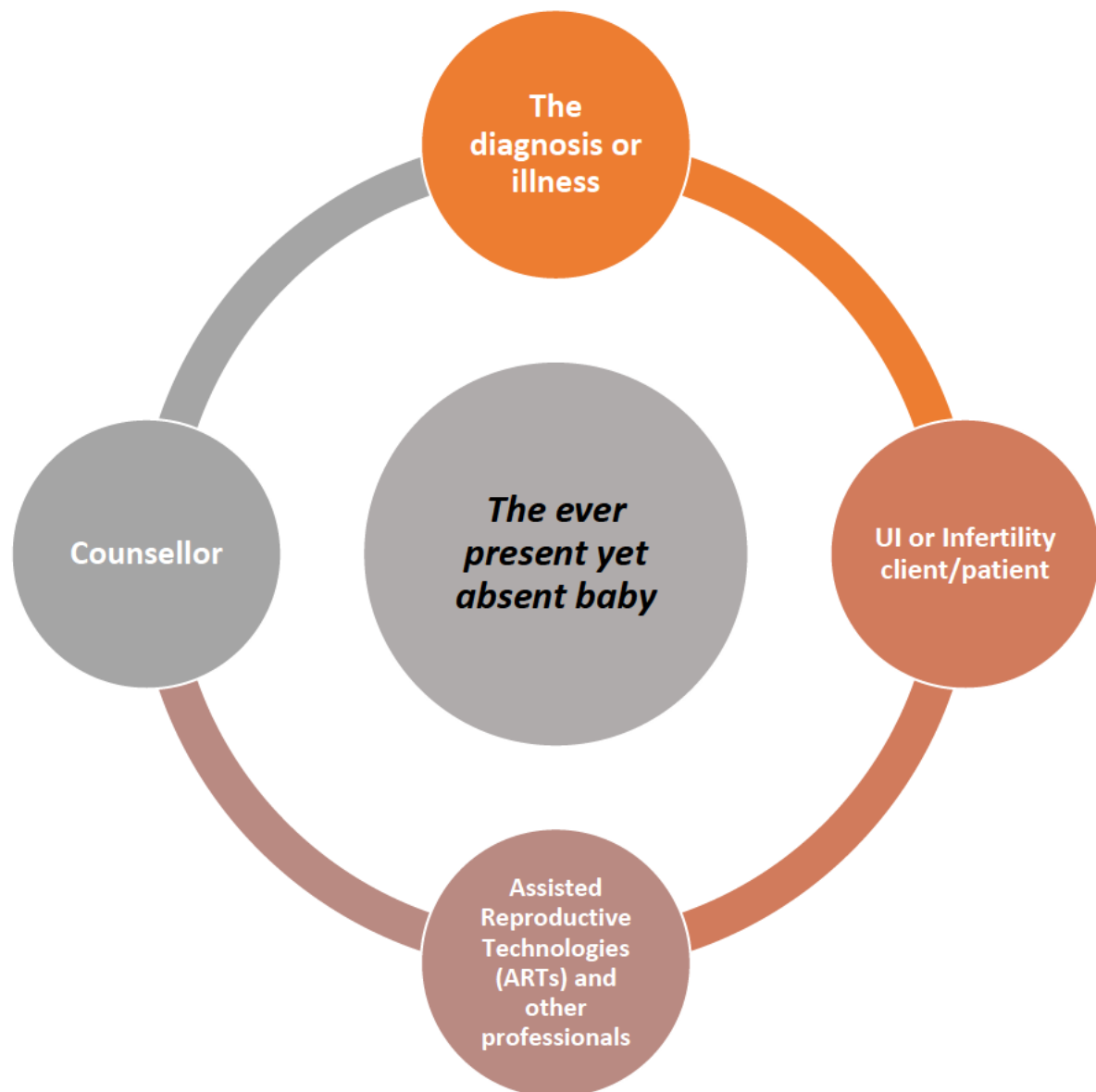
Harris (2017) emphasises that infertility is a hidden loss, often accompanied by unrealistic expectations from those not directly affected. I agree with Harris (2017) that medical professionals should openly recognise the multiple dimensions of loss related to infertility, extending beyond the loss of a biological child. I also concur that, since grief is subjective, healthcare providers, counsellors, psychologists, social workers, psychiatrists, and psychiatric nurses should listen carefully to individuals recounting their experiences to understand how UI and infertility influence their daily lives, aspirations, and self-perception. Understanding terminology, such as ‘ambiguous and nonfinite loss’ and ‘chronic sorrow’, can help normalise these feelings (Boss, Roos, and Harris, 2021). Harris (2017, 32) states, “Recognising the multiple losses associated with infertility is vital; acknowledging these losses and their impact validates a painful experience that is largely hidden from view”.

Further, I also agree with Harris (2017) that supporting individuals facing UI and infertility can be particularly challenging due to the prolonged emotional strain and often disappointing outcomes of medical treatment. While patients aim for pregnancy, it is essential to recognise the importance of the medical care process itself. Research shows that when patients feel supported by medical staff—although, regrettably, this is rare and inconsistent—they are more likely to make informed decisions that reflect their personal values (Harris and Daniluk 2010). Since this is often not the case, medical professionals, psychotherapists, and all professionals involved in this support role need to help patients manage their desire for control, cope with disenfranchised grief, and encourage them to let go of specific outcome expectations. This approach promotes open communication within a trusting therapeutic relationship, as Harris (2017) asserts.

### **Ever Present Yet Absent Baby**

I have demonstrated throughout this thesis that UI and (in)fertility are life-changing experiences for many who cannot conceive or carry a biological child to term. Harris (2017) agrees that, although this does not involve a recognised death, the losses are complex and deeply emotional. For example, what about the ever-present yet absent baby in the room? I put together a diagram that I keep in front of me in my counselling room, serving as a poignant reminder; it symbolises the unfulfilled dreams and silent grief that permeate our counselling sessions—the baby that is never far from my clients' thoughts, yet absent from their lives. The absent child lingers in the minds of our clients and patients, whether recognised or not, emphasising their deep longing for the family they envision. The absent baby is always present in the room with us.

Our clients or patients long for the baby and children they have always imagined. They are desperately trying to find the courage to rebuild hope once more in the most vital part of their lives: having children. As counsellors and medical professionals, we must recognise that our clients are trying to navigate 'chronic sorrow', 'ambiguous and nonfinite losses', and 'disenfranchised grief' (Boss, Roos, and Harris 2021; Doka 2002). I share my diagram below as a reminder to myself and to you, dear fellow counsellors, medical professionals, and all other professionals involved, that we are all supporting people whose suffering is silent and invisible to the world. They often feel isolated and confused as they experience a rollercoaster of loss and hope; stigma, shame, and losing the identity they knew before UI or infertility. They are grieving for something that has not been or may never be.



Recognising and validating these losses is crucial for providing appropriate support. The complexities of unexplained infertility (UI) and infertility, along with the developing expertise in managing them, are specialised fields where professionals must have practical knowledge and training. Harris (2017, 36) agrees, stating, “It is hoped that more professionals will begin to understand the complexity of this experience and become well-versed in the unique needs of those experiencing infertility.” I think here of *Marie*, and all individuals/patients, and connect them/us to Bondi & Fewell (2016, 31) as they state, “people are experts in their own lives”, and

we become so “by virtue of living them”, and that can partly translate “readily into how people learn to become counsellors and psychotherapists”.

### **Contribution to Knowledge**

This thesis advances understanding of unexplained infertility (UI) and its recognition by critically exploring the entire experience of it, including the medical ethics related to assisted reproductive technologies (ARTs). Two key findings emerged: firstly, through a combination of evocative and critical autoethnographic approaches within social constructionism was vital to this research, as it offered the necessary foundation and framework to share the narratives of the entire UI experience from the insider’s perspective and illuminated the emotional, social, cultural, and religious complexities that individuals and couples face as they navigate these challenges. The autoethnographic methodology enabled a range of meanings of the UI experience to emerge, meanings that go beyond being a patient undergoing medical intervention. Nevertheless, ART remains integral to the UI experience.

The second finding that has arisen is the need to shift terminology from “unexplained (in)fertility” or “infertility” to fertility impairment. I frame this as a ‘fluid season’ in life, the terminology I practice with my clients in therapy sessions, rather than a fixed condition or even an illness or disability. In light of these findings, I call for a more supportive and hopeful outlook within our support systems for patients and clients, in both medical and counselling environments. Developing better supported comprehensive systems with specialised and well-trained counsellors and

medical professionals is vital for addressing the threads I discovered in this research that weave throughout these experiences, which extend beyond the inability to conceive.

By calling for improved training and recognition of all counsellors and medical professionals working in this field, this research demonstrates how a collaborative approach bridges the gap between reproductive medical interventions and patients' or clients' experiences. I present in this work how this could ultimately reduce stigma, shame, disenfranchised grief, loss of identity, and isolation, while promoting emotional well-being and agency throughout the UI or any fertility impairment journey. In doing so, I also highlight the lasting impact of UI, even after motherhood. Ultimately, this research and thesis call for improved support systems and compassionate discourse around UI and infertility, providing a deeper understanding of the ongoing emotional toll of these experiences. This understanding could aid personal growth and identity reconstruction through more informed support, improving this experience for all involved.

### **The Dignity of Womankind: Recommendations**

As part of *my* renewed identity as a feminist writer, co-sufferer of UI, and specialist counsellor in this field, I recognise the importance of medical intervention in reproductive health; after all, I am a parent who would not have been able to have my biological son without it. My son, born in Scotland in 2012, is one of thirteen million babies born with assisted reproductive technologies (ARTs) since the first IVF baby, Louise Brown, was born in England in 1978 (Adamson et al. 2025,

41). Reflecting on this research journey, I greatly value how my understanding of these complex issues has expanded, influenced by the narratives in this project and the insights I have gained from literature and my expert mentors in the field. Additionally, the 'feminist grace' I discovered in the years before, during and beyond this research has helped me through the toughest parts of this study, along with my newfound, uncomplicated faith in God, free from dogma. This research has transformed my understanding of the medicalisation of women's bodies and the ethical issues surrounding reproductive technologies more than I ever expected.

Therefore, this study and thesis have not only deepened my understanding of UI and infertility but have also ignited a passion within me to contribute to a more compassionate and informed discourse on reproductive health, as part of my developing identity as a feminist writer, counsellor, and advocate. I am grateful for the opportunity to engage in such meaningful work and look forward to continuing this journey of advocacy, support, and learning to assist those navigating the complexities of all fertility impaired challenges. As I have demonstrated in the rewritings of *Marie's* re-remembered vignettes in Chapters One, Three, Four, and Five, undergoing this experience without informed counselling and support comes with a cost; the UI experience never really ends; it never leaves you. Therefore, I agree with contemporary feminists that it is vital to continue advocating for medical and therapeutic advances aimed at de-medicalising fertility impairments by framing medicine within the context of women, rather than using women's reproductive organs as broken objects or cogs in the machinery of ART.

Consequently, I urge all professionals involved to collaborate more effectively to ensure we treat UI and infertility with proper ethical standards, moving away from viewing the woman's body as a machine in this current 'industry' of reproductive medicine. To achieve this, we must expand our knowledge in protecting and supporting women and couples in reproductive health, assisting in making informed and ethical decisions regarding the range of options available—both within and outside medical intervention—such as surrogacy, adoption, and other safe, beneficial ways to grow families. It is essential to understand women's reproductive systems, but as an integral part of us as humans, rather than merely focusing on reproductive body parts. Additionally, considering how the medical model defines 'natural' without exploring a woman's personal history and well-being regarding her fertility impairment could significantly help bridge the gap in the field of supporting UI and infertility, bringing medical professionals and infertility counsellors closer to the women, individuals, and couples we serve.

Throughout this research, I have troubled UI through *Marie's* re-remembered memories from her journals spanning twelve years, also narrating three of my clients' voices in two examples, illustrating different faces and forms of UI while contributing to this limited conversation. I believe this evidence makes a valuable contribution to the field of knowledge. Additionally, I will continue to pursue my passion for normalising all fertility impairment experiences as a vital aspect of my career. This study has shown that we must support, treat, and stand with those experiencing fertility impairments, assisting them in getting to the root cause of it, rather than solely treating the UI or infertility 'diagnosis' or 'illness' constructed within the assisted reproductive technology (ART) industry.

Considering the complexities of unexplained infertility (UI) and infertility, including its emotional, cultural, religious, societal and medical aspects, my research question was: What is the experience of unexplained infertility (UI)? My sub-question was: How can counselling and psychotherapy assist in addressing UI and infertility? While I did not aim to provide definitive answers, these questions guided a thorough exploration of these crucial issues. Additionally, I have offered recommendations to enhance support systems for people experiencing UI and infertility. By contributing to this essential discussion, my research provides a deeper understanding of the impacts of unexplained (in) fertility (UI). It encourages a more compassionate and empathic approach to UI, infertility, and reproductive health overall, to ultimately improve the experience for others affected by UI and infertility.

Additionally, I have become more urgently aware of the need to advocate to a broader audience beyond my counselling room. That is why, having developed my own methods and processes in my counselling work over the years, inspired by and building on Burns and Covington's (2006) infertility counselling handbook, I now wish to share them beyond my counselling practice. It is only during and after this research that I realise I must share the valuable processes that I have established, used, and been successful with. I believe utilising these processes will only enhance the approaches for all counsellors, psychologists, psychiatrists, and psychotherapists interested in working with UI and infertility challenges.

Moreover, I see my fertility impairment counselling processes, some of which I have shared here in this thesis, as suitable for a training programme that could benefit the National Health Service (NHS) in the UK, trainee doctors, healthcare

professionals, and organisations such as the British Association for Counselling and Psychotherapy (BACP), the Human Fertilisation and Embryology Authority (HFEA), and broader global reproductive health groups. I aim to put this next project into action straight after this PhD project as I feel confident it will be effective, given its success in my private practice over the years, developed from previous research and teachings of my mentors in this field. My counselling fertility impairment processes guide how best to support individuals facing fertility impairments—focusing on themes I have identified in this study: shame, stigma, disenfranchised grief (ambiguous and nonfinite losses and chronic sorrow), and issues of identity. I believe offering my own training programme—one that respects the dignity of not only women but all genders of human beings—can support them in recognising their power and agency as they navigate their ‘fluid seasons’ of fertility impairments.

Thus, I join these contemporary feminists in calling for:

“A different kind of science and technology that respects the dignity of womankind and all life on earth. We call upon women and men to break the fatal link between mechanistic science and vested industrial interests and to take part with us in the development of a new unity of knowledge and life.”

(Arditti et al. 2024, 21).

## Personal Reflections

When I began this exploration into unexplained infertility (UI) and infertility, I had no idea of the profound and transformative experience it would become for me, both personally and professionally. This entire project, being an autoethnography, has been fraught with ethical dilemmas, even up to the conclusion of this thesis. I am, along with many, a survivor of UI, with my own badge of honour. We usually come out the other end of this 'fluid season' of our lives with our own unique badges of honour, different outcomes, whether as a biological parent, a social parent (Letherby 1999), or having come to terms with being involuntarily childless or indeed childfree; my outcome is just one of many possibilities, and I honour every experience and outcome both within my counselling work with clients and beyond in my everyday life.

Given the complex and diverse reasons I have discussed throughout this thesis, I deliberately limited my discussion of my son to what I considered necessary for my work, with his permission obtained each year of this research. While I am, after all, an advocate for not openly discussing our children with strangers or when we are unsure of someone's circumstances, I also feel that I would not be authentic and ethical if I did not share, albeit hesitantly and perhaps with some fear that I might not deliver it in the way I intend to, which is to try to remain transparent right up to the end of this project, that my son has been my strength and inspiration for this research and everything I do since the day he was born.

A further note as an example of ethics in this project: When my son was ten, three years ago, he curiously asked why I work with fertility and whether I was

'infertile' and 'what that meant', also wondering 'how I had him'. We discussed this at the time and have continued to talk about it over the years, using language suitable for his age. Occasionally, he raises the subject again. During these conversations, he has said he would support me if I included him in my study. However, I am very aware of his capacity to understand, his emotions, and his vulnerability at such a young age. In response to his questions about my work in fertility impairment, I have gently described what I do and why I do it.

Over time, I have gradually explained to my son that we conceived him with medical assistance. While he now broadly understands this, I also told him I would not write about him personally or in detail during this project and thesis, but perhaps more indirectly about my fertility journey. He remains curious and seems to have a good grasp of fertility; as a teenager studying reproduction in biology at school, he says he feels he has an advantage in understanding the reproductive organs because of our conversations, and indeed, fertility impairments. I have noted, however, from these chats, that high school lessons still do not cover fertility or fertility impairments.

Nevertheless, this thesis is not only a tribute to all my fellow fertility impairment clients and the global fertility impairment community but also a love letter to my son, expressing my gratitude for the incredible, unconditional love we share, which has inspired me to complete this project and to continue supporting others in their fertility impairment journeys.

Also, this PhD journey has inspired me to become a more proactive and vocal advocate for change within the field. My shift in perspective to reach a wider audience has also motivated me to start my own podcast discussing this often-overlooked topic, as well as to deliver a TED Talk on it. The collaborative spirit created by this PhD has strengthened my belief in the power of community and the importance of developing comprehensive support systems for those affected by UI and infertility. Through this research, I feel a deep sense of responsibility to continue to unleash the voices of those who remain silenced.

I am dedicated to normalising conversations around UI and all fertility impairments, aiding in creating an environment where people feel empowered to share their experiences without stigma or shame, carrying unresolved disenfranchised grief, and losing their identities. Given this, I acknowledge that conversations, although they may encourage relationality and connections, they can also be predisposed to flawed intentions. This is a reality stemming from being uninformed about the complexities of UI and fertility impairments. Hence, I leave you with one final reflection...

The next time you find yourself, perhaps out of habit, about to ask a woman or a couple you have never met or do not know their 'reproductive identity' (Athan 2020), "Do you have children?", pause... Let this study echo in that moment... Consider what such a question might evoke—what histories, silences, or wounds it might touch. Let empathy disrupt routine. You might make their day by choosing not to ask.



## References

- Abbara, A., Islam, R., Clarke, S.A., Jeffers, L., Christopoulos, G., Comninou, A.N., Salim, R., Lavery, S.A., Vuong, T.N.L., Humaidan, P., Kelsey, T.W., Trew, G.H., Dhillon, W.S. 2018. "Clinical Parameters of Ovarian Hyperstimulation Syndrome Following Different Hormonal Triggers of Oocyte Maturation in IVF Treatment." *Clinical Endocrinology (Oxford)* 88 (6): 920–27. <https://doi.org/10.1111/cen.13569>.
- Abbott, John. 1995. Children Need Communities - Communities Need Children. *Educational Leadership*, 52(8), 6–10.
- Adams, Tony E. 2008. "A Review of Narrative Ethics." *Qualitative Inquiry* 14 (2): 175–94. <https://doi.org/10.1177/1077800407304417>.
- Adams, Tony E. 2008. *Learning, living, and leaving the closet: Making gay identity relational*. University of South Florida.
- Adams, Tony E, Stacy Linn Holman Jones, and Carolyn Ellis. 2015. *Autoethnography*. Oxford University Press.
- Adams, Tony E., and Andrew F. Herrmann. "Expanding our autoethnographic future." *Journal of Autoethnography* 1, no. 1 (2020): 1-8.
- Adamson, G. David, Prudence Creighton, Jacques de Mouzon, Fernando Zegers-Hochschild, Silke Dyer, and Georgina M. Chambers. "How many infants have been born with the help of assisted reproductive technology?." *Fertility and Sterility* (2025).
- Ahmed, Sara. 2014. *The Cultural Politics of Emotion*. Second edition. Edinburgh: Edinburgh University Press.
- Alexander, Bryant Keith, Claudio Moreira, and Hari Stephen Kumar. "Resisting (resistance) stories: A tri-autoethnographic exploration of father narratives across shades of difference." *Qualitative Inquiry* 18, no. 2 (2012): 121-133.
- Allison, Dorothy. 1996. *Two or three things I know for sure*. Penguin.
- Amodeo, John. 2022. "The Hidden Shame That Threatens Our World: Healing shame as a key to world peace." *Psychology Today*, October 2022. <https://www.psychologytoday.com/us/blog/intimacy-path-toward-spirituality/202210/the-hidden-shame-threatens-our-world>
- Arditti, Rita, Renate Duelli Klein, and Shelley Minden, eds. *Test-tube women: What future for motherhood?* Taylor & Francis, 2024.

- Athan, Aurélie. 2020. "Reproductive Identity: An Emerging Concept." *The American Psychologist* 75(4): 445–56. <https://doi.org/10.1037/amp0000623>.
- Augustine, Saint. *St. Augustine on marriage and sexuality*. Vol. 1. CUA Press, 1996.
- Baldwin, Kimberly. 2023. "The Gift of Infertility." In *Scientia Moralitas Conference Proceedings*, no. 01270. Research Association for Interdisciplinary Studies.
- Berlant, Lauren. 2011. *Cruel Optimism*. Duke University Press.
- Bezzel, Hannes. 2019. "Hannah's prayer (s) in 1 Samuel 1–2 and Pseudo-Philo's Liber Antiquitatum Biblicarum." *Prayers and the Construction of Israelite Identity* (35): 147.
- Bochner, Arthur. 1994. "Perspectives on Inquiry II: Theories and Stories". *Communication Faculty Publications*, 102. [https://digitalcommons.usf.edu/spe\\_facpub/102](https://digitalcommons.usf.edu/spe_facpub/102)
- Bochner, Arthur P., Carolyn Ellis, and Ron Pelias. "Leaning: A Poetics of Relationships." *Writing Lives: Ethnographic Narratives* 9 (2011).
- Bondi, Liz and Judith Fewell. 2016. *Practitioner research in counselling and psychotherapy: the power of examples*. Macmillan International Higher Education.
- Bondi, Liz, ed. *Towards professional wisdom: Practical deliberation in the people professions*. Ashgate Publishing, Ltd., 2011.
- Bondi, Liz, and Judith Fewell. *Practitioner research in counselling and psychotherapy: The power of examples*. Macmillan International Higher Education, 2016.
- Boss, Pauline, Susan Roos, and Darcy L. Harris. 2021. "Grief in the midst of ambiguity and uncertainty: An exploration of ambiguous loss and chronic sorrow." In *Grief and bereavement in contemporary society*, edited by Robert Neimeyer, Darcy Harris, Howard Winokuer, Gordon Thornton. Routledge. <https://doi.org/10.4324/9781003199762>
- Boylorn, Robin and Mark Orbe. 2020. *Critical autoethnography: Intersecting cultural identities in everyday life*. Routledge.
- Bozdog, Gurkan, Guldeniz Aksan, Ibrahim Esinler, and Hakan Yarali. 2008. "What Is the Role of Office Hysteroscopy in Women with Failed IVF Cycles?" *Reproductive Biomedicine Online* 17 (3): 410–15. [https://doi.org/10.1016/S1472-6483\(10\)60226-X](https://doi.org/10.1016/S1472-6483(10)60226-X).

- Brokovich, Andrew M., and William A. Fisher. "Psychological distress and infertility: forty years of research." *Journal of Psychosomatic Obstetrics & Gynecology* 19, no. 4 (1998): 218-228.
- Brown, Brené. 2017. *Rising strong*. Spiegel & Grau.
- Brown, Brené. 2017. *Braving the Wilderness: The quest for true belonging and the courage to stand alone*. Random House.
- Brown, Brené. 2012. *Daring Greatly: How the Courage to Be Vulnerable Transforms the Way We Live, Love, Parent, and Lead*. Gotham Books.
- Brown, Brené. 2021. *Atlas of the heart: Mapping meaningful connection and the language of human experience*. Random House.
- Broyard, Anatole. 1993. *Intoxicated By My Illness and Other Writings on Life and Death*. Fawcett Columbine. [https://archive.org/details/intoxicatedbymi00broy\\_0](https://archive.org/details/intoxicatedbymi00broy_0)
- Bruce, Elizabeth J., and Cynthia L. Schultz. *Nonfinite loss and grief: A psychoeducational approach*. Paul H. Brookes Publishing, 2001.
- Burfoot, Annette, and Derya Güngör. 2021. *Women and Reproductive Technologies: The Socio-Economic Development of Technologies Changing the World*. Routledge.
- Burns, Linda Hammer and Sharon N. Covington. 2006. *Infertility counseling: A comprehensive handbook for clinicians*. Cambridge University Press.
- Burns, Linda Hammer. 2007. "Psychiatric Aspects of Infertility and Infertility Treatments." *The Psychiatric Clinics of North America* 30 (4): 689–716. <https://doi.org/10.1016/j.psc.2007.08.001>.
- Butler, Judith. 2005. *Giving an Account of Oneself*. Fordham University Press.
- Butler, Judith. 2011. *Gender trouble: Feminism and the subversion of identity*. Routledge.
- Butz, D., & Besio, K. (2009). Autoethnography. *Geography Compass*, 1660-1674
- Caler, Mary Elizabeth. 2012. *In God's Hands: Evangelical Talk about Infertility, God's Will and Family Building*. University of Virginia.

Cameron, Judy. "Negative effects of reward on intrinsic motivation—A limited phenomenon: Comment on Deci, Koestner, and Ryan (2001)." *Review of educational research* 71, no. 1 (2001): 29–42.

Campbell, Joseph. *Occidental mythology*. Vol. 3. Joseph Campbell Foundation, 2017.

Carter, Michael and Jen Marony. 2021. "Examining Self-Perceptions of Identity Change in Person, Role, and Social Identities." *Current Psychology (New Brunswick, N.J.)* 40 (1): 253–70. <https://doi.org/10.1007/s12144-018-9924-5>.

Centers for Disease Control and Prevention. (2017a, March 30). Infertility FAQs [reproductive health]. Retrieved January 6, 2018, from the World Wide Web: <https://www.cdc.gov/reproductivehealth/Infertility/index.htm>

Chachamovich, Juliana Rigol, Eduardo Chachamovich, Helene Ezer, Marcelo P. Fleck, Daniela Knauth, and Eduardo P. Passos. 2010. "Investigating quality of life and health-related quality of life in infertility: a systematic review." *Journal of Psychosomatic Obstetrics & Gynecology* 31, no. 2: 101-110.

Charon, Rita. 2006. *Narrative Medicine: Honoring the Stories of Illness*. Oxford University Press.

Chodorow, N. 2003, "'Too late': Ambivalence about motherhood, choice, and time", *Journal of the American Psychoanalytic Association*, vol. 51, no. 4, pp.1181-1198.

Clark, Elizabeth. 1996. *St. Augustine on marriage and sexuality*. Vol. 1. CUA Press. <https://archive.org/details/staugustineonmar0000augu>

Conrad, Peter and Joseph Schneider. 1980. *Deviance and Medicalization, from Badness to Sickness*. Temple University Press. <https://archive.org/details/deviancemedicali00conr>

Conway, Patricia, and Deborah Valentine. 1988. "Reproductive Losses and Grieving." *Journal of Social Work & Human Sexuality* 6 (1): 43–64. doi:10.1300/J291v06n01\_05.

Covington, Sharon. 2006. "Group Approaches to Infertility Counselling." In *Infertility Counseling: A Comprehensive Handbook for Clinicians*, edited by Sharon Covington and Linda Hammer Jones. Cambridge University Press.

Culley, Lorraine, Nicky Hudson, and Floor Van Rooij. 2009. *Marginalized Reproduction: Ethnicity, Infertility and Reproductive Technologies*. Earthscan.

Daniluk, Judith. 1997. "Gender and infertility." In *Infertility: Psychological issues and counseling strategies*, edited by Sandra Leiblum. John Wiley & Sons.

Daniluk, Judith C. "Reconstructing their lives: A longitudinal, qualitative analysis of the transition to biological childlessness for infertile couples." *Journal of Counseling & Development* 79, no. 4 (2001): 439-449.

DasGupta, Sayantani, and Rita Charon. "Personal illness narratives: using reflective writing to teach empathy." *Academic Medicine* 79, no. 4 (2004): 351-356.

Dearing, Rhonda. 2018. "Shame and Empathy: The Role of Empathy in the Experience of Shame." In *The Psychology of Shame: Theory and Treatment of Shame-Based Syndromes*, edited by Patricia A. F. Stoeber. Routledge.

De Beauvoir, Simone. "One is not Born a Woman." (1981): 103-09.

Derrida, Jacques. 1981. *Positions*. University of Chicago Press.  
<https://archive.org/details/positions0000derr>.

Deveaux, Monique. "Feminism and empowerment: A critical reading of Foucault." *Feminist studies* 20, no. 2 (1994): 223-247.

Dictionaries, Oxford. *Oxford Primary Dictionary*. Oxford University Press-Children, 2024.

Dobson, James. 2012. *Dr. Dobson's Handbook of Family Advice: Encouragement and Practical Help for Your Home*. Harvest House Publishers.

Doka, Kenneth J. 1997. "Disenfranchised Grief: An Exposition and Update." In *Readings in Thanatology*, 1st ed., 275–83. Routledge.  
<https://doi.org/10.4324/9781315229829-21>.

Doka, Kennet. 1989. *Disenfranchised grief: recognizing hidden sorrow*. Lexington Books.

Doka, Kenneth J. 2002. *Disenfranchised Grief: New Directions, Challenges, and Strategies for Practice*. Champaign, Ill: Research Press.

Doka, Kenneth J. "Disenfranchised grief and non-death losses 1." In *Non-death loss and grief*, pp. 25-35. Routledge, 2019.

Dolezal, Luna. "Shame anxiety, stigma and clinical encounters." *Journal of evaluation in clinical practice* 28, no. 5 (2022): 854-860.

Douglas, Kitrina and David Carless. 2016. "A History of Autoethnographic Inquiry" In *Handbook of Autoethnography*, edited by Stacy Holman Jones, Tony E. Adams, and Carolyn Ellis. Routledge

Drossman, Douglas A. "Functional Gastrointestinal Disorders: History, Pathophysiology, Clinical Features, and Rome IV." *Gastroenterology* 150, no. 6 (2016): 1257-1269. <https://doi.org/10.1053/j.gastro.2016.02.032>.

Ehrenreich, Barbara and Deirdre English. 2011. *Complaints & disorders: The sexual politics of sickness*. The Feminist Press.

El Kissi, Yousri, Asma Ben Romdhane, Samir Hidar, Souhail Bannour, Khadija Ayoubi Idrissi, Hedi Khairi, and Bechir Ben Hadj Ali. 2013. "General Psychopathology, Anxiety, Depression and Self-Esteem in Couples Undergoing Infertility Treatment: A Comparative Study between Men and Women." *European Journal of Obstetrics & Gynecology and Reproductive Biology* 167 (2): 185–89. <https://doi.org/10.1016/j.ejogrb.2012.12.014>.

Ellingson, Laura L., and Carolyn Ellis. "Autoethnography as constructionist project." *Handbook of constructionist research* 445 (2008).

Eliot, Thomas S. "Four Quartets. 1943." *San Diego: Harvest* (1971).

Eliot, Thomas Stearns. "The Love Song of J. Alfred Prufrock." *Poetry* 6, no. 3 (1915): 130–135.

Ellis, Carolyn and Arthur Bochner. 2002. *Ethnographically Speaking: Autoethnography, Literature, and Aesthetics*. Altamira Press. <https://archive.org/details/ethnographically0000boch/page/n3/mode/2up>

Engels, Friedrich. 2004. *The Origin of the Family, Private Property and the State*. Edited by Laura Engelstein. Penguin Classics.

Epp, Eldon Jay. 1986. "Jewish-Gentile Continuity in Paul: Torah and/or Faith? (Romans 9:1–5)." *Harvard Theological Review* 79 (1–3): 80–90. <https://doi.org/10.1017/S0017816000020368>.

ESHRE Guideline Group on RPL, Ruth Bender Atik, Ole Bjarne Christiansen, Janine Elson, Astrid Marie Kolte, Sheena Lewis, Saskia Middeldorp et al. "ESHRE guideline: recurrent pregnancy loss: an update in 2022." *Human Reproduction Open* 2023, no. 1 (2023): hoad002.

Eugster, Antje, and Andrianus JJM Vingerhoets. "Psychological aspects of in vitro fertilization: a review." *Social science & medicine* 48, no. 5 (1999): 575-589.

Fauser, B. C. J. M., Tarlatzis, Fauser, Chang, Aziz, Legro, Dewailly, Franks, Balen, Bouchard, Dahlgren, Devoto, Diamanti, Dunaif, Filicori, Homburg, Ibanez, Laven, Magoffin, Nestler, Norman, Pasquali, Pugeat, Strauss, Tan, Taylor, Wild, Wild, Guzik, Ehrmann, Lobo. 2004. Revised 2003 consensus on diagnostic criteria and long-term health risks related to polycystic ovary syndrome (PCOS). *Human Reproduction (Oxford)*, 19 (1), 41–47. <https://doi.org/10.1093/humrep/deh098>

Fields, Leslie Leyland. 2008. *Parenting Is Your Highest Calling: And Eight Other Myths That Trap Us in Worry and Guilt*. WaterBrook.

Fertility Network. 2018. "Affinity." <https://fertilitynetworkuk.org/wp-content/uploads/2018/07/Affinity-for-the-Website-Summer-2018-1.pdf>

Feske, Millicent. 2012. "Rachel's Lament: The Impact of Infertility and Pregnancy Loss upon the Religious Faith of Ordinary Christians." *Journal of Pastoral Theology* 22 (1): 3-1-3–17. <https://doi.org/10.1179/jpt.2012.22.1.003>.

Flannery, Austin, ed. *Vatican Council II: Constitutions, decrees, declarations: The basic sixteen documents*. Liturgical Press, 1996.

Flyvbjerg, Bent. "Five misunderstandings about case-study research." *Qualitative inquiry* 12, no. 2 (2006): 219-245.

Foucault, Michel. 1973. *The Birth of the Clinic: An Archaeology of Medical Perception*. Translated by A. M. Sheridan. Tavistock Publications. [https://monoskop.org/images/9/92/Foucault\\_Michel\\_The\\_Birth\\_of\\_the\\_Clinic\\_1976.pdf](https://monoskop.org/images/9/92/Foucault_Michel_The_Birth_of_the_Clinic_1976.pdf)

Foucault, Michel. 1975. *Discipline and punish*. A. Sheridan, Tr., Paris, FR, Gallimard. Pantheon Books. [https://archive.org/details/disciplinepunish0000fouc\\_j5k6/page/n5/mode/2up](https://archive.org/details/disciplinepunish0000fouc_j5k6/page/n5/mode/2up)

Foucault, Michel. 1976. *The History of Sexuality, Volume 1: An Introduction*. Pantheon Books. <https://archive.org/details/foucault-the-history-of-sexuality-volume-1>

Foucault, Michel. 1988. "Technologies of the self." In *Technologies of the self: A seminar with Michel Foucault*, vol. 18.

Frank, Arthur W. 2000. "The Standpoint of Storyteller." *Qualitative Health Research* 10 (3): 354–65. <https://doi.org/10.1177/104973200129118499>.

Frank, Arthur W. 2013. *The wounded storyteller: Body, illness, and ethics*. University of Chicago Press.

Franklin, Sarah. 1997. *Embodied Progress: A Cultural Account of Assisted Conception*. Routledge.

<https://archive.org/details/embodiedprogress0000fran/page/n5/mode/2up>

Franklin, Sarah. 2010. "Can Law Facilitate Embryonic Hopes? Response." *Social & Legal Studies*, vol. 19 (4): 505–10.

Fujisawa, Daisuke, Mitsunori Miyashita, Satomi Nakajima, Masaya Ito, Motoichiro Kato, and Yoshiharu Kim. 2010. "Prevalence and Determinants of Complicated Grief in General Population." *Journal of Affective Disorders* 127 (1): 352–58.

<https://doi.org/10.1016/j.jad.2010.06.008>.

Fukuda, Keiji, Stephen E. Straus, Ian Hickie, Michael C. Sharpe, James G. Dobbins, Anthony Komaroff, and International Chronic Fatigue Syndrome Study Group. "The chronic fatigue syndrome: a comprehensive approach to its definition and study." *Annals of internal medicine* 121, no. 12 (1994): 953-959.

Gaebelein, Arno. 1939. "The Book of Psalms: A devotional and prophetic commentary." *Neptune, NJ: Loizeaux Brothers*.

[https://openlibrary.org/books/OL58658137M/The\\_Book\\_of\\_Psalms\\_a\\_Devotional\\_and\\_Prophetic\\_Commentary](https://openlibrary.org/books/OL58658137M/The_Book_of_Psalms_a_Devotional_and_Prophetic_Commentary)

Gale, Ken. "Moods, tones, flavours: Living with intensities as inquiry." *Qualitative Inquiry* 20, no. 8 (2014): 998-1004.

Gameiro, Sofia, and Amy Finnigan. 2017. "Long-Term Adjustment to Unmet Parenthood Goals Following ART: A Systematic Review and Meta-Analysis." *Human Reproduction Update* 23 (3). <https://doi.org/10.1093/humupd/dmx001>.

Gelbaya, Tarek, Neelam Potdar, Yadava Jevé and Luciano Nardo. 2014. Definition and epidemiology of unexplained infertility. *Obstetrical & gynecological survey*, 69(2), 109–115. <https://doi.org/10.1097/OGX.0000000000000043>

Gergen, Kenneth J., and Mary Gergen, eds. *Social construction: A reader*. Sage, 2003.

Gillespie, Rosemary. "Childfree and feminine: Understanding the gender identity of voluntarily childless women." *Gender & Society* 17, no. 1 (2003): 122-136. Gleicher, Norbert, and David Barad. "Unexplained infertility: does it really exist?." *Human Reproduction* 21, no. 8 (2006): 1951-1955.

Glazer, Nathan. 1997. *We are all multiculturalists now*. Harvard University Press. <https://archive.org/details/weareallmulticul0000glaz/page/n5/mode/2up>

Gleicher, Norbert and David Barad. 2006. "Unexplained Infertility: Does It Really Exist?" *Human Reproduction (Oxford)* 21 (8): 1951–55. <https://doi.org/10.1093/humrep/del135>.

Goffman, Erving. 1963. *Stigma: Notes on the Management of Spoiled Identity*. Prentice-Hall.

Greil, Arthur. 1999. "Infertility and psychological distress: a critical review of the literature". *Social science & medicine (1982)*, 45(11): 1679–1704. [https://doi.org/10.1016/s0277-9536\(97\)00102-0](https://doi.org/10.1016/s0277-9536(97)00102-0)

Greil, Arthur. 2002. "Infertile bodies: medicalization, metaphor, and agency." In *Infertility around the Globe: New Thinking on Childlessness, Gender, and Reproductive Technologies: A View from the Social Sciences*, edited by Marcia Inhorn and Frank van Balen. University of California Press.

Greil, Arthur and Julia McQuillan. 2010. "'Trying' times: Medicalization, intent, and ambiguity in the definition of infertility." *Medical Anthropology Quarterly* 24 (2): 137-156. <https://doi.org/10.1111/j.1548-1387.2010.01094.x>.

Greil, Arthur, Kathleen Slauson-Blevins, and Julia McQuillan. 2010. "The Experience of Infertility: A Review of Recent Literature." *Sociology of health & illness* 32 (1): 140-162. <https://doi.org/10.1111/j.1467-9566.2009.01213.x>.

Gupta, Jyotsna Agnihotri and Annemiek Richters. 2008. "Embodied Subjects and Fragmented Objects: Women's Bodies, Assisted Reproduction Technologies and the Right to Self-Determination." *Journal of Bioethical Inquiry*, vol. 5 (4): 239–49, <https://doi.org/10.1007/s11673-008-9112-7>.

Guzick, David, Michael Sullivan, David Adamson, Marcelle Cedars, Richard Falk, Edwin Peterson, and Michael Steinkampf. 1998. "Efficacy of Treatment for Unexplained Infertility." *Fertility and Sterility* 70 (2): 207–13. [https://doi.org/10.1016/S0015-0282\(98\)00177-0](https://doi.org/10.1016/S0015-0282(98)00177-0).

Hacking, Ian. *The social construction of what?*. Harvard university press, 1999.

Hale, Matthew. *Daily Entries from the 17th Century London Diary*. Unpublished manuscript, 17th century.

Hart, Valerie. 2002. "Infertility and the Role of Psychotherapy." *Issues in Mental Health Nursing* 23 (1): 31–41. <https://doi.org/10.1080/01612840252825464>.

Hartwig, Mervyn, and Jamie Morgan. 2012. *Critical Realism and Spirituality*. Routledge. <https://doi.org/10.4324/9780203878293>.

- Harris, Darcy and Judith C Daniluk. 2010. "The Experience of Spontaneous Pregnancy Loss for Infertile Women Who Have Conceived through Assisted Reproduction Technology." *Human Reproduction (Oxford)* 25 (3): 714–20. <https://doi.org/10.1093/humrep/dep445>.
- Harris, Darcy. 2017. "Grief and Loss in Infertility." *Grief Matters* 20 (2): 32–36. <https://search.informit.org/doi/10.3316/informit.278078481683829>.
- Harris, Darcy L. "Supporting people through living losses." In *Non-Death Loss and Grief*, pp. 311-323. Routledge, 2019.
- Harris, Darcy. 2021. "Compassion-Focused Grief Therapy." *British Journal of Guidance & Counselling* 49 (6): 780–90. <https://doi.org/10.1080/03069885.2021.1960948>.
- Haskell, Stephen Nelson. 1999. *Bible Handbook*. Review and Herald Pub Assoc.
- Heidegger, Martin. 1962. *Being and Time*. Translated by John Macquarrie and Edward Robinson. Harper & Row, 1962.
- Herrera, Florencia. 2020. "'I Did Everything Humanly Possible': The Process of Making Reproductive Decisions in the Context of Assisted Reproduction in Chile." *Tapuya : Latin American Science, Technology and Society* 3 (1): 377–95. <https://doi.org/10.1080/25729861.2020.1794667>.
- Holman Jones, Stacy. 2016. "Living Bodies of Thought: The 'Critical' in Critical Autoethnography." *Qualitative Inquiry* 22 (4): 228–37. <https://doi.org/10.1177/1077800415622509>.
- Holman Jones, Stacy, Tony E. Adams, and Carolyn Ellis. 2016. *Handbook of autoethnography*. Routledge.
- Hurwitz, Nancy. 1989. "The Psychological Aspects of In-Vitro Fertilization". *Pre- and Peri-natal Psychology Journal* 4 (1): 43-50. <http://search.proquest.com/docview/198717431?accountid=36557>
- Inhorn, Marcia Claire, and Frank van Balen. 2002. *Infertility around the Globe: New Thinking on Childlessness, Gender, and Reproductive Technologies*. University of California Press.
- Inhorn, Marcia and Pasquale Patrizio. 2015. "Infertility around the globe: new thinking on gender, reproductive technologies and global movements in the 21st century." *Human reproduction update* 21 (4): 411-26. doi:10.1093/humupd/dmv016.

Jackson, Alecia Youngblood, and Lisa A Mazzei. 2009. *Voice in Qualitative Inquiry: Challenging Conventional, Interpretive, and Critical Conceptions in Qualitative Research*. London: Routledge. <https://doi.org/10.4324/9780203891889>.

Jamieson, Kathleen Hall. *Eloquence in an electronic age: The transformation of political speechmaking*. Oxford University Press, 1988.

Jason, Leonard A., Madison Sunnquist, Abigail Brown, Julia L. Newton, Elin Bolle Strand, and Suzanne D. Vernon. "Chronic fatigue syndrome versus systemic exertion intolerance disease." *Fatigue: biomedicine, health & behavior* 3, no. 3 (2015): 127-141.

Jeremiah, David. *Forward Bible Study Guide: Discovering God's Presence and Purpose in Your Tomorrow*. Harper Christian Resources, 2021.

Johansson, Marianne, and Marie Berg. "Women's experiences of childlessness 2 years after the end of in vitro fertilization treatment." *Scandinavian Journal of Caring Sciences* 19, no. 1 (2005): 58-63.

Johnson, Wesley. "'It's a good diagnosis' Storying Unexplained Infertility." *Journal of Autoethnography* 2, no. 3 (2021): 306-316.

Kamath, Mohan and Siladitya Bhattacharya. 2012. "Demographics of Infertility and Management of Unexplained Infertility." *Best Practice & Research. Clinical Obstetrics & Gynaecology* 26 (6): 729–38. <https://doi.org/10.1016/j.bpobgyn.2012.08.001>.

Kashyap, Soumya and Priyanka Tripathi. 2025. "'Are You Pregnant? If Not, Why Not?': Artificial Reproductive Technology and the Trauma of Infertility." *Medical Humanities* 51 (1): 102–11. <https://doi.org/10.1136/medhum-2023-012690>.

Kluger-Bell, Kim. 2000. *Unspeakable losses: healing from miscarriage, abortion, and other pregnancy loss*. Harper Collins Publishers.  
<https://archive.org/details/unspeakablelosse00klug/page/n3/mode/2up>

Kirkegaard, Signe, Nanna Maria Uldall Torp, Stig Andersen, and Stine Linding Andersen. "Endometriosis, polycystic ovary syndrome, and the thyroid: a review." *Endocrine connections* 13, no. 2 (2024).

Knight, Paula. *The facts of life*. Myriad Editions, 2017.

Kovacs, Gab, ed. *The subfertility handbook: a clinician's guide*. Cambridge University Press, 2010.

Lebovitz, Oshrit, Jigal Haas, Kaitlyn E James, Daniel S Seidman, Raoul Orvieto, and Ariel Hourvitz. 2018. "The Expected Cumulative Incidence of Live Birth for Patients

Starting IVF Treatment at Age 41 Years or Older." *Reproductive Biomedicine Online* 37 (5): 533–41. <https://doi.org/10.1016/j.rbmo.2018.08.014>.

Letherby, Gayle. "Other than mother and mothers as others: The experience of motherhood and non-motherhood in relation to 'infertility' and 'involuntary childlessness'." In *Women's studies international forum*, vol. 22, no. 3, pp. 359-372. Pergamon, 1999.

Letherby, Gayle. 2002. "Challenging Dominant Discourses: Identity and Change and the Experience of 'infertility' and 'Involuntary Childlessness.'" *Journal of Gender Studies* 11 (3): 277–88. <https://doi.org/10.1080/0958923022000021241>.

Letherby, Gayle. "'Infertility' and 'involuntary childlessness': Losses, ambivalences and resolutions." In *Understanding Reproductive Loss*, pp. 9-21. Routledge, 2016.

Lee, Christina, and Pauline Slade. 1996. "Miscarriage as a traumatic event: a review of the literature and new implications for intervention." *Journal of psychosomatic research* 40 (3): 235-244. DOI: 10.1016/0022-3999(95)00579-x

Lehmann-Haupt, Rachel. 2023. *Reconceptions: Modern Relationships, Reproductive Science, and the Unfolding Future of Family*. BenBella Books.

Loftus, Jeni, and Angie L. Andriot. "'That's what makes a woman': Infertility and coping with a failed life course transition." *Sociological Spectrum* 32, no. 3 (2012): 226-243.

Lorde, Audre. 2017. *Your silence will not protect you*. Silver Press.

Lupton, Deborah. "The Woman in the Body: A Cultural Analysis of Reproduction." In *Foucault, Health and Medicine*, edited by Paul Alan and Robin B. 94–110. London: Routledge, 1997.

Lyons, D., and LCP DC. "Response to Gonstead chiropractic care in a 27-year-old athletic female with a 5-year history of infertility." *J. Vertebral Subluxation Res* (2003): 1-3.

Magnuson, Kenneth T. "Marriage, procreation and infertility: Reflections on Genesis." *Southern Baptist Journal of Theology* 4, no. 1 (2000): 26–42.

Martucci, Jessica, Ronit Y. Stahl, and Joris Vandendriessche. "One Religion, Two Paths: Making Sense of US and Belgian Catholic Hospitals' Approaches to IVF." *Journal of Religious History* 46, no. 3 (2022): 552-579.

Maté, Gabor. 2011. *When the body says no: Understanding the stress-disease connection*. John Wiley & Sons.

- Mate, Gabor, and Attila Torok. 2020. "Elimination of Stress Factors by Continuous Embryo Culture and Its Influence on in Vitro Fertilization Outcomes." *Reproductive Biology* 20 (4): 512–19. <https://doi.org/10.1016/j.repbio.2020.08.004>.
- Mazzei, Lisa and Alecia Jackson. 2012. "Complicating Voice in a Refusal to 'Let Participants Speak for Themselves.'" *Qualitative Inquiry* 18 (9): 745–51. <https://doi.org/10.1177/1077800412453017>.
- Mazzei, Lisa A, Rebecca Coleman, and Jessica Ringrose. 2013. "Desire Undone: Productions of Privilege, Power and Voice." In *Deleuze and Research Methodologies*, 96–110. United Kingdom: Edinburgh University Press.
- McBain, Tristan D, and Patricia Reeves. 2019. "Women's Experience of Infertility and Disenfranchised Grief." *The Family Journal (Alexandria, Va.)* 27 (2): 156–66. <https://doi.org/10.1177/1066480719833418>.
- McCarthy, M. Patrice. 2008. "Women's Lived Experience of Infertility After Unsuccessful Medical Intervention." *Journal of Midwifery & Women's Health* 53 (4): 319–24. <https://doi.org/10.1016/j.jmwh.2007.11.004>.
- McLeod, Carolyn. 2002. *Self-trust and reproductive autonomy*. MIT Press.
- McNutt, Bryan, and Oksana Yakushko. 2013. "Disenfranchised Grief Among Lesbian and Gay Bereaved Individuals." *Journal of LGBT Issues in Counseling* 7 (1): 87–116. <https://doi.org/10.1080/15538605.2013.758345>.
- Martucci, Jessica, Ronit Stahl, and Joris Vandendriessche. 2022. "One Religion, Two Paths: Making Sense of US and Belgian Catholic Hospitals' Approaches to IVF." *Journal of Religious History* 46 (3): 552–79. <https://doi.org/10.1111/1467-9809.12878>.
- Meyer, Michaela DE. "The Cost of Winning the Pregnancy Lottery: An Autoethnographic Account of How My Life Was Consumed by Secondary Infertility." *Journal of Autoethnography* 3, no. 4 (2022): 544-56
- Milton, John. 1667. *Paradise Lost*. Edited by Gordon Teskey. New York: W. W. Norton, 2005.
- Motry, Hubert Louis. 1920. *The concept of mortal sin in early Christianity*. No. 15. Catholic University of America.
- Muck, Terry C. "God's Silence: Psalm 28." *The Asbury Journal* 67, no. 2 2012: 2.

Muharam, R, Ririn Rahmala Febri, Kevin Ardito Prabowo, Arleni Bustami, Indra G Mansur, and Han J Moshage. 2021. "Increased Levels of CD107a and Intracellular Cytokines in IL-2 Stimulated PBMCs from Endometriosis Patients." *International Journal of Inflammation* 2021. <https://doi.org/10.1155/2021/5760959>.

Murdock, George Peter. 1950. "Family Stability in Non-European Cultures." *The Annals of the American Academy of Political and Social Science* 272 (1): 195–201. <https://doi.org/10.1177/000271625027200125>.

Nathanson, Donald. 1992. *Shame and Pride: Affect, Sex, and the Birth of the Self*. W.W. Norton & Company.

Neff, Kristin. 2011. Self-compassion, self-esteem, and well-being. *Social and Personality Psychology Compass*, 5(1): 1–12. <https://doi.org/10.1111/j.1751-9004.2010.00330.x>

Nouwen, Henri. 1979. *The Wounded Healer: Ministry in Contemporary Society*. Doubleday and Company. <https://archive.org/details/woundedhealermin0000nouw/page/n5/mode/2up>

O'Brien, Thomas G. 2010. *Stigma: The Mark of the Human Condition*. New York: Routledge.

Obama, Michelle. 2018. *Becoming*. Crown Publishing Group.

Olshansky, Simon. "Chronic sorrow: A response to having a mentally defective child." *Social casework* 43, no. 4 (1962): 190-193.

Orloff, Judith. 2021. *The Power of Surrender: Let Go and Energize Your Relationships, Success, and Well-Being*. Hay House UK.

Pelias, Ronald. 2004. *A methodology of the heart: Evoking academic and daily life*. Rowman Altamira.

Pfeffer, N. and Woollett, A. 1983. *The Experience of Infertility*. London: Virago.

Pollock, Della. 2006. "Performance trouble". In *The SAGE handbook of performance studies*, edited by D. Soyini Madison and Judith Hamera. SAGE Publications.

Porges, Stephen W. "The polyvagal theory: new insights into adaptive reactions of the autonomic nervous system." *Cleveland Clinic journal of medicine* 76, no. Suppl 2 (2009): S86.

Porges, Stephen W. *The pocket guide to the polyvagal theory: The transformative power of feeling safe*. WW Norton & Co, 2017.

Putowski, LT, WJ Schillings, CM Lee, EP Reddy, and JA Jakowicki. 2004. "Human Follicle-Stimulating Hormone Receptor (FSH-R) Promoter/Enhancer Activity Is Inhibited by Transcriptional Factors, from the Upstream Stimulating Factors Family, via E-Box and Newly Identified Initiator Element (Inr) in FSH-R Non-Expressing Cells." *Gynecological Endocrinology* 19 (1): 9–17. <https://doi.org/10.1080/09513590410001725503>.

Radford, Marie L., and Gary P. Radford. "Power, knowledge, and fear: Feminism, Foucault, and the stereotype of the female librarian." *The Library Quarterly* 67, no. 3 (1997): 250-266.

Rajagopal, Rohini S. *What's a Lemon Squeezer Doing in My Vagina?: A Memoir of Infertility*. Penguin Random House India Private Limited, 2021.

Raphael-Leff, Joan. 2012. "The Baby Makers: Conscious and Unconscious Psychological Reactions to Infertility and 'Baby-Making'-an in-Depth Single Case Study." In *The Maternal Lineage: Identification, Desire, and Transgenerational Issues*, 205–30. <https://doi.org/10.4324/9780203078341>.

Raphael-Leff, Joan. 2020. "Dark Wombs and Broken Pledges." *Studies in the Maternal*, doi:10.16995/SIM.275.

Raymond, Janice G. *Women as wombs: Reproductive technologies and the battle over women's freedom*. Spinifex Press, 1995.

Reed-Danahay, D. (2017). Bourdieu and Critical Autoethnography: Implications for Research, Writing, and Teaching. *International Journal of Multicultural Education*, 144- 154.

R.E.M. 1991. "Losing My Religion." On Out of Time. Warner Bros. Records.

Richardson, Joseph Gibbons, William Henry Ford, and Cornelius C. Vanderbeck. 1905. *Medicology, or, Home encyclopedia of health: a complete family guide: abounding in practical household information on the structure and functions of the human body, the laws of hygiene, diet... home administration of medicines: ten books-one volume*. <https://wellcomecollection.org/works/ya9qj252>

Richie, Cristina. 2018. "The Augustinian Perspective on the Transmission of Original Sin and Assisted Reproductive Technologies." *Religious Studies and Theology* 37 (1): 79–91. <https://doi.org/10.1558/rsth.31054>.

Rilke, Rainer Maria. *Ahead of all parting: The selected poetry and prose of Rainer Maria Rilke*. Modern Library, 1995.

Rogers, C. 1961. On Becoming a person. "A Therapist's View of Psychotherapy." London: Constable and Co.

Rhodes, Ron. *Reasoning from the Scriptures with Catholics*. Harvest House Publishers, 2000.

Rogers, Peter, Barrie J Milne, and Alan O Trounson. 1986. "A Model to Show Human Uterine Receptivity and Embryo Viability Following Ovarian Stimulation for in Vitro Fertilization." *Journal of In Vitro Fertilization and Embryo Transfer* 3 (2): 93–98.

<https://doi.org/10.1007/BF01139353>.

Richie, Cristina. "The Augustinian Perspective on the Transmission of Original Sin and Assisted Reproductive Technologies." *Religious Studies and Theology* 37, no. 1 (2018): 79–91.

Roos, Susan. *Chronic sorrow: A living loss*. Routledge, 2014.

Ryan, Maura. 1995. "The New Reproductive Technologies: Defying God's Dominion?" *The Journal of Medicine and Philosophy* 20 (4): 419–38.

<https://doi.org/10.1093/jmp/20.4.419>.

Schenker, Joseph. 1992. "Religious Views Regarding Treatment of Infertility by Assisted Reproductive Technologies." *Journal of Assisted Reproduction and Genetics* 9 (1): 3–8. <https://doi.org/10.1007/BF01204106>.

Schenker, Joseph, John Sciarra, Andrea Genazzani, Liselotte Mettler, and Martin H Birkhaeuser. 2021. "Human Reproduction: Religious Perspectives." In *Clinical Management of Infertility*. Springer International Publishing.

[https://doi.org/10.1007/978-3-030-71838-1\\_1](https://doi.org/10.1007/978-3-030-71838-1_1).

Selye, Hans. "The Evolution of the Stress Concept: The originator of the concept traces its development from the discovery in 1936 of the alarm reaction to modern therapeutic applications of syntoxic and catatotoxic hormones." *American scientist* 61, no. 6 (1973): 692-699.

Serour, Gamal Ibrahim and Ahmed G Serour. 2017. "Ethical Issues in Infertility." *Best Practice & Research. Clinical Obstetrics & Gynaecology* 43, 21–31.

<https://doi.org/10.1016/j.bpobgyn.2017.02.008>.

Shapiro, Constance Hoenk. "Therapy with infertile heterosexual couples: It's not about gender—or is it?" *Clinical Social Work Journal* 37, no. 2 (2009): 140-149.

- Shaw, Jennifer. 2012. "The Birth of the Clinic and the Advent of Reproduction: Pregnancy, Pathology and the Medical Gaze in Modernity." *Body & Society*, 18(2), 110-138. <https://doi.org/10.1177/1357034X10394666>
- Shear, M. Katherine. 2015. "Clinical Practice. Complicated Grief." *The New England Journal of Medicine* 372 (2): 153–60. <https://doi.org/10.1056/NEJMcp1315618>.
- Simopoulou, Zoi. "In Search of a Space." In *Young Children's Existential Encounters*, pp. 3-12. Cham: Springer International Publishing, 2019.
- Simopoulou, Zoi, and Amy Chandler. "Provoked perplexity in live methods." *Qualitative Research* 24, no. 4 (2024): 1021-1041.
- Snyder, C. R., Thuy Tran, L. L. Schroeder, K. M. Pulvers, J. Adams, and L. Laub. "Teaching the hope recipe: Setting goals, finding pathways to those goals, and getting motivated." *National Education Service* (2000): 46–50.
- Speedy, Jane. "Magical realist pathways into and under the psychotherapeutic imaginary." *British Journal of Guidance & Counselling* 39, no. 5 (2011): 425-438.
- Spry, Tami. "A "performative-I" copresence: Embodying the ethnographic turn in performance and the performative turn in ethnography." *Text and Performance Quarterly* 26, no. 4 (2006): 339-346.
- Steinberg, Deborah. 1990. "The Depersonalisation of Women through the Administration of 'In Vitro Fertilisation'". In: *The New Reproductive Technologies. Explorations in Sociology*, edited by Maureen McNeil, Ian Varcoe, Steven Yearley. British Sociological Association conference volume series. Palgrave Macmillan, London. [https://doi.org/10.1007/978-1-349-20548-6\\_4](https://doi.org/10.1007/978-1-349-20548-6_4)
- Slater, Suzanne. 1999. *The lesbian family life cycle*. University of Illinois Press.
- Tamas, Sophie. 2011. *Life after leaving: The remains of spousal abuse*. Routledge.
- Templeton, Allan and Gillian C. Penney. 1982. "The Incidence, Characteristics, and Prognosis of Patients Whose Infertility Is Unexplained." *Fertility and Sterility*, vol. 37 (2): 175–82, [https://doi.org/10.1016/S0015-0282\(16\)46035-8](https://doi.org/10.1016/S0015-0282(16)46035-8).
- The Holy Bible: King James Version. Cambridge: Cambridge University Press, 1769.
- Throsby, Karen. 2004. *When IVF Fails*. Springer.  
<https://link.springer.com/book/10.1057/9780230505704>
- Toadvine, Jennifer. 2015. *Our story too: Giving voice to lesbian couples' experience with infertility*. Widener University.

Van Balen, Frank. "ONE Introduction Interpreting Infertility: A View from the Social Sciences Frank van Balen and Marcia C. Inhorn." *Infertility around the globe: New thinking on childlessness, gender, and reproductive technologies* (2002): 3.

Venkatesan, Sathyaraj, and Chinmay Murali. "Childless? Childfree? Neither, Just ME": pronatalism and (m) otherhood in Paula Knight's *The Facts of Life*." *Journal of Graphic Novels and Comics* (2021).

Wang, Ning, Ziyuan Chen, Xiangshen Guo, Hao Cheng, Pengfei Wang, Tianqi Wang, Linlin Wang, Dilichati Tash, Peng Ren, Baoli Zhu, Dawei Guan, Guohua Zhang, Rui Zhao. 2021. "Sudden Death Due to Severe Ovarian Hyperstimulation Syndrome: An Autopsy-Centric Case Report." *The American Journal of Forensic Medicine and Pathology* 42 (1): 88–91.  
<https://doi.org/10.1097/PAF.0000000000000601>.

Ward, Jean. 2017. "Images of the child and childhood in Elizabeth Jennings' poetic world." *Beyond Philology: An International Journal of Linguistics, Literary Studies and English Language Teaching* 14/3.  
<https://www.semanticscholar.org/paper/Images-of-the-child-and-childhood-in-Elizabeth-Ward/76f8e6926a47e918b5b10eff0a0bd21a0e504508>

Watkins, Kathryn and Tracy D Baldo. 2004. "The Infertility Experience: Biopsychosocial Effects and Suggestions for Counselors." *Journal of Counseling and Development* 82 (4): 394–402. <https://doi.org/10.1002/j.1556-6678.2004.tb00326.x>.

Whelan, Joseph and Nikos F Vlahos. 2000. "The Ovarian Hyperstimulation Syndrome." *Fertility and Sterility* 73 (5): 883–96. [https://doi.org/10.1016/S0015-0282\(00\)00491-X](https://doi.org/10.1016/S0015-0282(00)00491-X).

Whiteford, Linda M, and Lois Gonzalez. 1995. "Stigma: The Hidden Burden of Infertility." *Social Science & Medicine* (1982) 40 (1): 27–36.  
[https://doi.org/10.1016/0277-9536\(94\)00124-C](https://doi.org/10.1016/0277-9536(94)00124-C).

Willcocks, L. "Foucault, power/knowledge and information systems: Reconstructing the present." *Social theory and philosophy for information systems* (2004): 238-296.

Winnicott, Donald Woods. 2012. "Primary maternal preoccupation." In *The maternal lineage: Identification, desire and transgenerational issues*, edited by Paola Mariotti. Routledge/Taylor & Francis Group.

World Health Organization. (2018). Infertility definitions and terminology [sexual and reproductive health]. Retrieved January 7, 2018, from the World Wide Web: [www.who.int/reproductive-health/topics/infertility/definitions](http://www.who.int/reproductive-health/topics/infertility/definitions)

World Health Organisation. *WHO laboratory manual for the examination of human semen and sperm-cervical mucus interaction*. Cambridge university press, 1999.

Wyatt, Jonathan, and Ken Gale. "Writing to it: Creative engagements with writing practice in and with the not yet known in today's academy." *International Journal of Qualitative Studies in Education* 31, no. 2 (2018): 119-129.

Wyatt, Jonathan. "Frank and the gift, or the untold told: Provocations for autoethnography and therapy." In *Handbook of autoethnography*, pp. 79-88. Routledge, 2021.

Wyatt, Jonathan. 2021. Pandemic, Therapy, and a Meditation on How: A Creative-Relational Inquiry. *Qualitative Inquiry*, 28(5): 562-565.  
<https://doi.org/10.1177/10778004211063616>

Zegers-Hochschild, F, G.D Adamson, J de Mouzon, O Ishihara, R Mansour, K Nygren, E Sullivan, and S van der Poel. 2009. "The International Committee for Monitoring Assisted Reproductive Technology (ICMART) and the World Health Organization (WHO) Revised Glossary on ART Terminology, 2009." *Human Reproduction (Oxford)* 24 (11): 2683–87. <https://doi.org/10.1093/humrep/dep343>.

## Appendices

## Appendix 1



### CONSENT FORM

Dear .....,

As you know, as well as a psychotherapist working solely with all aspects of fertility issues, I am also a PhD researcher at the University of Edinburgh inquiring into the experience of 'unexplained infertility' (UI) from insiders' perspectives. This means I will use my own lived experiences in connection with my field of knowledge within counselling and psychotherapy.

The purpose of my study is to contribute to a gap in research regarding the emotional experiences of unexplained infertility (UI). Thus, investigating the lack of attention given to the emotional aspect of fertility impairment. My aim: to give voice to the, often, silent experience of the patient/sufferer of UI.

I believe bringing some examples from my counselling practice would strengthen this research. Hence, I am inviting you to agree to having your experiences of unexplained infertility (UI) drawn upon as part of my thesis.

What I mean by 'drawing on your experiences' is: I am asking your permission to use examples or extracts from my notes taken during our therapy sessions together. An example might be, my using something that you told me had been said to you either inside or outside of the reproductive medical environment that impacted you.

If this were to happen, I am highly aware that this would mean bringing your vulnerabilities from our counselling sessions to the pages of my project, albeit keeping your identity confidential and using a pseudonym if necessary, so that it would not be possible to recognise you. Therefore, anything that I might use in my thesis relating to you would be handled with great care, respect, and compassion as happens generally in our therapeutic relationship.

If you are happy with this I am asking if you are willing to sign this consent form, having agreed that I may use examples from our sessions together that would inform my research.

Please do ask me any questions you may have, and we can discuss at an appropriate time that we will arrange separately or after a suitable therapy session. Additionally, I would like to offer you a copy of my completed thesis to read if you so wished.

If you decide not to agree to this, then I will not draw from our sessions in my research, and it will have no impact whatsoever on our therapeutic relationship going forward.

My Best Wishes,

Client Name(s): \_\_\_\_\_

Please initial box  
(or tick box, if online)

1. I confirm that I have read and understood the information above and am happy to proceed in consenting to you, Marie, using examples from our sessions together to inform your PhD thesis
2. I have been given the opportunity to consider the information provided, ask questions, and have had these questions answered to my satisfaction

Name of person giving consent

Date

Signature

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of person taking consent

Date

Signature

Marie Meechan

## In Therapy with Marie

A space to know that you are not alone  
A space to honour grief. A space to find hope.

Supporting individuals, couples, families, and workshop groups navigate all that is entailed in living with and working through fertility issues

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