"Nobody Thinks Twice About Asking:"

Women with a Fertility Problem and Requests for Information

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Abstract

For women with a fertility problem, responding to questions about childbearing, pregnancy, and the nature of infertility is a salient issue. In this study of talking about infertility, women described their experiences in handling such requests for information. Results suggest that requests come in a variety of forms, that women attribute multiple and potentially conflicting meanings to such requests, and that requests can elicit a variety of responses. From a communication standpoint, such inquiries suggest the varied ways that conversational partners can attempt to elicit disclosive information, thus enabling or constraining the emergent nature of the interaction.

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It's frustrating in a lot of ways, because number one, it's [infertility] one of those things – and I was just talking to a friend about this – that it's probably one of the most private things in the world, but it's something that nobody thinks twice about asking.—Lisa[1]

Lisa is one of millions of women in the United States who has experienced a fertility problem. According to the 2002 National Survey of Family Growth, 7.3 million women ages 15-44 years reported a physical difficulty with getting pregnant or carrying a baby to term (Chandra, Martinez, Mosher, Abma, & Jones, 2005). RESOLVE, the national infertility organization, defines a fertility problem as a disease or condition of the reproductive system in which a woman (or couple) is unable to get pregnant after one year of trying or experiences multiple miscarriages (RESOLVE, 2007). Women and couples might experience primary infertility (i.e., problems getting pregnant the first time) or secondary infertility (i.e., problems getting pregnant after the birth of at least one child), and medical diagnoses for infertility include male factor, female factor, a combination of these factors, or unexplained infertility (van Balen, Trimbos-Kemper, & Verdurmen, 1996).

For Lisa and the other millions of women dealing with infertility, discussing this issue with others is a vital concern that has the potential to influence their access to social support, coping, and well-being (Gibson & Myers, 2002; Mindes, Ingram, Kliewer, & James, 2003). Previous research has shown that women might experience social stigma (Greil, 1991b; Miall, 1986; Whiteford & Gonzalez, 1995) and other threats to identity associated with infertility, including lifecourse disruption (Becker, 1997), challenges to the achievement of full adulthood (Exley & Letherby, 2001), and a breakdown of femininity (Abbey, 2000; Becker, 1997). Women experiencing a fertility problem have also reported psychological distress (Abbey, 2000; Greil, 1997) and strained social interactions (Remennick, 2000; Sandelowski & Jones, 1986) connected to infertility. In fact, past

research has suggested that infertility impacts men and women differentially, often playing a more central role in the lives of women (Abbey, 2000; Greil, 1997; Pasch, Dunkel-Schetter, & Christensen, 2002). Women who experience distress might disclose their fertility problem to others to vent or elicit social support. Alternatively, women who are wary of the stigma connected to infertility might conceal the fertility problem, even in the face of inquiries from others. As such, infertility provides a rich context for understanding the challenges and dilemmas involved in discussing a potentially stigmatizing condition.

Such disclosure dilemmas have been topics of perennial interest to communication scholars (e.g., Afifi, Caughlin, & Afifi, 2007; Altman & Taylor, 1973; Petronio, 2002), particularly scholars of health communication (see for example, Greene, Derlega, Yep, & Petronio, 2003 for a review of privacy and disclosure in the context of HIV). Most research about how people discuss a potentially stigmatizing health condition is centered in particular contexts, most notably HIV/AIDS (Greene et al., 2003). Infertility is distinct from this and other health-related experiences in several ways. Unlike many health conditions, the revelation of a fertility problem sometimes begins with a joyful announcement such as "We're ready to start a family" or "I'm pregnant." When a woman experiences a fertility problem after making such an announcement, she might feel compelled to explain to others why she is still childless. The connection between infertility and basic biological functions (i.e., sex, procreation), lifecourse expectations (Becker, 1997), and pronatalist assumptions (Whiteford & Gonzalez, 1995) also can influence talk in ways that are distinctive from other health contexts. For example, women have reported confessing a fertility problem to avoid the even greater stigma associated with voluntary childlessness (Greil, 1991a). Such revelations not only reveal a particular health condition but also position women as trying to fulfill the societal expectation of

motherhood. Thus, the study of privacy and disclosure in the context of infertility offers potential

contributions to communication scholarship while drawing attention to a socially significant topic.

Moreover, infertility, and reproductive health in general, offer a fascinating and informative

illustration of how notions of public and private collide. Infertility provides a situation in which what

some people consider public information (e.g., a woman or couple's decision about having children)

collides with private information (e.g., a potentially stigmatizing health condition). Indeed, previous

research suggests that childbearing and infertility often are considered public domain. In their

examination of the discourse surrounding age-related infertility, Harter and her colleagues argued

that the context "offers a unique opportunity to foreground shifting intersections between the most

private aspects of our lives (i.e., relationships with partners and kin, sexuality, and procreation) and

the public domain around us" (Harter, Kirby, Edwards, & McClanahan, 2005, p. 85). On an

interpersonal level, pregnant couples have reported receiving unsolicited disclosive advice, including

graphic details about long and difficult deliveries, even from strangers (Petronio & Jones, 2006).

Women also have reported that friends, relatives, and acquaintances routinely make requests for

information about childbearing and pregnancy (e.g., Greil, 1991a; Miall, 1986; Remennick, 2000;

Sandelowski & Jones, 1986). The scrutiny of women's childbearing decisions on a communal level

and the unsolicited advice and queries reported by women suggest that issues surrounding

childbearing and infertility are treated as public information.

The question then becomes: if infertility is treated by others as public information, how does

such a personal topic emerge in women's everyday conversations? Many studies that have examined

disclosure and avoidance paint a picture of who is told and when, reasons for revealing or concealing

information, and the potential risks and benefits of disclosure and avoidance. Although literature

examining these concepts has been helpful in discerning the dilemmas individuals face when making

disclosure decisions, particularly when it comes to disclosing or withholding potentially stigmatizing information, literature on privacy and disclosure includes comparatively few studies that uncover how personal and private topics arise in everyday conversations. In fact, Baxter and Sahlstein (2000) explicitly called for more attention to issues of dialogue in the study of privacy and disclosure. Examining inquiries as attempts to elicit disclosive information provides a partial answer to this call.

A few scholars have reported on the role of inquiries in health-related situations (e.g., Agne, Thompson, & Cusella, 2000; Braithwaite, 1991; Klitzman, 1999), but the applicability of these studies is limited by their context. For instance, Agne and colleagues' (2000) study reported on disclosure of HIV in response to questions asked by health care providers during medical appointments, and Braithwaite (1991) examined inquiries about visible disabilities. These contexts are qualitatively different than the context of this study, which examined everyday interactions involving a condition that is not immediately visible to others. A few studies outside the communication discipline have reported on disclosure in the context of infertility (Miall, 1986; Remennick, 2000) and offer insight into the information management techniques women use when they are disclosing (or trying to avoid disclosing) a fertility problem. Yet, like other studies of privacy and disclosure, they generally reveal little about how the topic of infertility comes up in conversation and how the conversation progresses as women seek to reveal or conceal the fertility problem. One notable exception is Sandelowski and Jones' (1986) work, in which they argued that women with a fertility problem might feel that others demand information about their condition or their childless state, a phenomenon that the authors labeled the "impossibility of keeping certain secrets" (p. 177). However, the central concern of their study was not the conversational dynamics of privacy and disclosure. Rather, they focused largely on the inadequate social support reported by

women in their study. The present study extends work by Sandelowski and Jones (1986) by using a communication framework to investigate the phenomenon of requests for information.

One explanation for the relatively few studies on the conversational dynamics of privacy and disclosure is the difficulty involved in observing such interactions (Savin-Williams, 1998). Observing conversations that involve disclosure of highly sensitive information poses a number of practical and ethical challenges (e.g., when and how to conduct observations to avoid exerting undue pressure on participants). Moreover, observations of avoidance are often impossible (i.e., an observer might not realize when an individual has intentionally avoided disclosure of a certain topic). Thus, communication scholars have found success in using retrospective accounts of conversations to study disclosure and avoidance of potentially stigmatizing information (e.g., Greene & Faulkner, 2002; Petronio, Reeder, Hecht, & Ros-Mendoza, 1996). The goal of this paper is to expand our knowledge of the interactional dynamics involved in disclosure and avoidance by exploring how women with a fertility problem describe and interpret interactions in which people asked them for information regarding childbearing, pregnancy, and infertility. I begin by outlining the theoretical assumptions and methodological decisions that guided this project. I then report the results of in-depth interviews with 23 women and discuss the theoretical and practical implications of my findings.

Theoretical Framework

Based on relevant communication theories and research, two key theoretical assumptions informed this investigation of requests for information. First, this study assumes that talking (or not talking) about a potentially stigmatizing condition, such as a fertility problem, can reflect multiple, possibly conflicting, meanings. Second, this study assumes that disclosure and avoidance are fluid social processes in which multiple interactants enable or constrain the direction of the conversation.

Multiple Meanings of Talk

The assumption that talking about a potentially stigmatizing condition can signify multiple meanings is drawn from literature on multiple purposes and meanings in communication (Goldsmith, 2004; Goldsmith, Lindholm, & Bute, 2006; O'Keefe, 1988). Women deciding whether to reveal or conceal a fertility problem face dilemmas and decisions as they seek to balance (a) task goals that are the focus of the interaction, (b) identity goals related to portraying a desired image of the self, and (c) relational goals associated with the development and maintenance of relationships (Clark & Delia, 1979). When it comes to talking about a fertility problem, the way women talk (or avoid talk) implies something about their efforts to manage these multiple purposes. In addition, the multiple meanings framework provides a basis for understanding the varied connotations that women attribute to queries regarding childbearing, pregnancy, and infertility. Goldsmith drew on O'Keefe's work (e.g., O'Keefe, 1988, 1990) as the foundation for an approach to communication that draws our attention not only to multiple purposes but to the multiple, potentially conflicting, meanings associated with talk. According to this approach, talk is "meaningful social action" (Goldsmith, 2004, p. 50), and there are many possible meanings associated with talking about infertility, including identity and relational meanings. Moreover, Goldsmith's approach underscores how efforts to manage multiple meanings can pose dilemmas. For example, how do women handle situations in which they have a desire to reveal their fertility problem, but doing so means admitting a biological "failure," discussing a painful experience, or creating an awkward conversational moment? And how do women cope when questions from well-meaning loved ones who are curious about their plans to have children are interpreted by women as invasive, insensitive, or even threatening?

Painful Self-disclosure

The second assumption of this study views disclosure as a fluid, social process in which both interactants play a role in facilitating or inhibiting the direction of the conversation. This idea is

based on research examining painful self-disclosure (Coupland, Coupland, & Giles, 1991). Their

framework assumed that disclosure is a "complex social process" (Coupland et al., 1991, p. 108) and

focused on how both interactants enable and constrain the conversational context in which disclosure

(or avoidance) occurs. Coupland et al. argued that what information is offered voluntarily and

intentionally is not always clear when it comes to self-disclosure. More specifically, they emphasized

the ways that interactional partners can play a role in eliciting disclosive information from others and

thus guide the emergent nature of the interaction, drawing attention to how disclosive topics arise in

conversation. The current study shares the focus of the painful self-disclosure paradigm to

understand how women responded when people asked them questions related to infertility. Guided

by the multiple meanings and painful self-disclosure frameworks, this manuscript addresses the

following research questions:

> RQ1: How do women with a fertility problem describe receiving requests for information
>
> about childbearing, pregnancy, and infertility?
>
> RQ2: What meanings do women attribute to such requests?
>
> RQ3: How do women describe responding to requests for information?

Methods

Results of this study are based on interviews with 23 women who had experienced a fertility

problem and volunteered to take part in an in-depth interview focused on how they talked about (or

avoided talking about) their fertility problem with others. The following paragraphs describe the

sampling methods I employed to recruit participants, participants' characteristics, procedures for data

collection and analysis, and steps to ensure the trustworthiness of my data.

Participants

I collected data in two phases. During the first phase of data collection, I recruited

participants by placing an ad in an electronic newsletter sent to all faculty and staff at a large,

Midwestern university. The ad sought women who had experienced fertility problems in the last five

years for a study of communication about fertility problems. The initial advertisement resulted in 11

volunteers. During phase two, I placed another posting in the university's electronic newsletter and

used snowball sampling to recruit another 12 women, for a total of 23 participants. As I conducted

the second set of interviews, I noticed recurring themes consistent with the data from the first 11

interviews. I arrived at a final sample of 23 women after determining that I had a meaningful set of

cases from which I could craft robust and viable claims about recurrent ideas (also see Patton, 2002).

My final sample was relatively homogeneous in terms of social characteristics. Table 1

provides a summary of demographic information for the sample. Twenty-one of the women indicated

that they had received a medical diagnosis for their fertility problem (see Table 1 for a summary of

reported diagnoses), and all but one woman had sought some form of medical treatment for a fertility

problem (e.g., hormone injections, surgery, *in vitro* fertilization). At the time of the interview, 12 of

the 23 women had at least one child; ten of these women had given birth, and two women had

adopted. Four women were pregnant at the time of their interview, three with their first child, and

one with her second child. The remaining eight women had not given birth and were not pregnant at

the time of the interview. Three of the ten women who had given birth to a child prior to the time of

the interview had experienced or were currently experiencing secondary infertility.

Data Collection

After receiving Institutional Review Board approval for the project, I interviewed each

woman during an in-depth session, focusing on her experiences with talking about her fertility

problem. I conducted interviews at a location of participants' choice. In one case, I interviewed a

woman in her office at work, per her request. In all other cases, women accepted my offer to interview them in a private office on campus. Although my inability to witness actual conversations could be viewed as a limitation, asking women about past conversations is an appropriate method for several reasons. First, the use of interviews is particularly appropriate in studies of highly sensitive topics for which ethical considerations might inhibit researchers from directly observing or recording conversations (see, for example, Keeley, 2004). Although taking part in an interview about a sensitive topic could be painful for participants, this method is less intrusive than other methods, such as observation, and can offer benefits (e.g., catharsis) for participants (McCracken, 1988). Interviews also allow scholars to ask questions about whether and how people avoid discussing certain topics, a phenomenon that cannot readily be observed. In-depth interviews provided me with opportunities to ask about the full range of interactions in which a participant took part, including those conversations in which she made the decision not to disclose a fertility problem. Finally, the use of interviews is appropriate in cases where researchers want to explore how people make disclosure decisions and attribute meaning to social interaction (Baxter & Sahlstein, 2000).

I followed the same procedures in both phases of interviewing. At the beginning of the interview, each woman completed a short questionnaire that gathered demographic information and particulars regarding the fertility problem. The interview guide included a series of open-ended questions designed to investigate (a) to whom women had disclosed, (b) the factors women considered when deciding whether to disclose, (c) the details of women's disclosure interactions, (d) whether women planned disclosures, (e) the responses women received when they disclosed, and (f) women's perceptions of the interactions. Although the protocol did not include questions specifically addressing requests for information, 21 of the 23 women I interviewed discussed their experience with receiving such requests. Twenty of the women who talked about this phenomenon

spontaneously mentioned such incidents during the interview session (i.e., with the exception of one case, I did not explicitly ask participants to describe request for information. Women brought up the topic of their own accord. In only one case did I ask a woman how she handled such questions.).

Interviews lasted between 45 and 90 minutes (the average length of an interview was around 60 minutes) and were tape recorded and transcribed verbatim[2]. I double-checked each transcript against the original recording to ensure accuracy for purposes of data analysis. I also recorded detailed field notes shortly after completing each interview to note initial impressions, remark on methodological issues (e.g., the wording of questions), and make theoretical notes.

Data Analysis

Data analysis in qualitative research is an iterative process, beginning with data collection (Strauss & Corbin, 1990). As I talked with women, I made notes of recurring themes and ideas. I then conducted several rounds of analysis using the transcribed interviews. I first completed an initial read-through of each interview transcript to gain a holistic sense of the data (also see Keeley, 2004). Based on my field notes and an initial review of the transcripts, I noticed several instances in which women commented on people asking them personal questions related to childbearing and infertility. I read each transcript again to identify specific cases in which women described requests for information. During the next stage of analysis, I focused my attention on these particular excerpts. For each interaction, I determined (a) how topics related to childbearing and infertility arose, (b) how the topic was discussed (or not), and (c) the meanings women attributed to talking or not talking. I used constant comparison (Glaser & Strauss, 1967) to create categories describing the nature of the requests, the meanings attributed to talking or not, and responses to requests.

Throughout this project, I took mindful steps to ensure the trustworthiness of my data (Lincoln & Guba, 1985). I produced an extensive audit trail (Lincoln & Guba, 1985) that includes

"detailed records of methods and decisions taken before and during the research process" (Farley & McLafferty, 2003, p. 163). I recorded field notes after each interview and wrote detailed research memos to document each stage of data analysis. These documents and the interview transcripts provide a picture of the methodological and theoretical decisions guiding my study. Another researcher could follow the "decision trail" that I followed (Farley & McLafferty, 2003, p. 163).

Finally, as Taylor and Bogdan (1998) noted, "findings do not exist independent of the consciousness of the observer" (p. 160). My own theoretical sensibilities and positionality drew me to the meanings women attributed to their interactions. At the same I also sought to find and report a representation of women's experiences with fertility problems that would be recognizable to the study participants (Cotterill, 1992). Thus, I engaged in critical self-reflection (Taylor & Bogdan, 1998) throughout each stage of data collection and analysis (e.g., I recorded personal reactions and theoretical impressions in my field notes and research memos) to ensure that my own assumptions and interpretations were informing but not clouding my understanding of women's recollections. These procedures are consistent with my concern for giving voice to the experiences of my participants while still recognizing that data analysis should be systematic in nature (e.g., following a set of procedures such as constant comparison; Strauss & Corbin, 1990). Based on these processes and sensibilities, I offer a viable and plausible interpretation of women's experiences with requests for information while recognizing that these findings lie within my own "theoretical perspective, stock of cultural knowledge, and particular vantage point" (Taylor & Bogdan, 1998, p. 160).

Results

Handling requests for information was a prominent feature of the infertility experience for the women in this sample. The following sections describe the various forms requests for information

can take, the multiple, and sometimes conflicting, meanings attributed to requests for information, and women's responses to these requests.

Descriptions of Requests for Information

Women described situations in which various others made requests for information related to the fertility problem. Some of these individuals knew about the woman's experience with infertility while others did not. Women described conversations in which people asked them direct questions about their plans to have children, inquired as to whether they were currently pregnant, or asked pointed questions such as whether a woman received "help" in achieving pregnancy, who was to blame for the fertility problem, why a woman chose not to pursue a particular treatment, or whether a woman had considered adoption. In each of these interactions, others' attempts to elicit information prompted women to make a decision about whether and how to respond to a request for information (e.g., should I reveal my fertility problem? should I share details regarding treatment and adoption decisions?), suggesting the role recipients of information play in eliciting disclosive information. I identified two sub-categories of recipient requests for information: (a) requests from strangers and new acquaintances and (b) questions from a woman's social network.

Requests from strangers and new acquaintances. Requests for information about childbearing were sometimes embedded in the ritual exchange of demographic information motivated by a first-time meeting (e.g., "Are you married? Do you have kids? Where do you work?").Women described such exchanges as sometimes progressing from innocuous inquiries to more pointed, personal questions and unsolicited comments (e.g., "Why don't you have children?" "You better get started."). Cheryl, whose husband had recently started a new job, said that she found it difficult to account for her childlessness when meeting her husband's new colleagues: "I'm meeting a lot of people, and the question always comes up, 'Do you have children? Well, you guys

have been married for awhile, how come?'" Deborah described a conversation with a woman she met at a professional conference:

> She said, "Oh, do you have children?" And she wouldn't get off the topic. I said, "No, we
> don't have children." "Oh, really? Oh, well..." And she just kept either asking "why not?" or
> just going on. And finally, I just stopped and I looked at her and I said, "You know, we've
> been unable to conceive." And she was like, "Oh, my God."

In these examples, and others like them, women found themselves having to decide whether to reveal intimate details of their lives and a potentially stigmatizing condition to people they had just met.

Questions from the social network. Women also described situations in which people they already knew asked them direct questions about their family planning decisions (e.g., "When will you have kids?" "Why don't you have kids?" "Are you pregnant?" "When are you going to have another child?"). Even women who had already given birth to one child described receiving requests for information related to their childbearing decisions. Stacy, who was struggling to get pregnant with her second child at the time of the interview, said, "And I can't tell you how many people have asked me, 'When are you going to have another one? You don't want [son's name] to be an only child, do you?'" Such questions put Stacy in a situation where she had to decide whether to reveal her fertility problem to others.

Cara, like other women in the sample, regularly dealt with requests for information from a coworker. She explained, "And every time I go down there [past her coworker's desk], she has some comment about, 'Are you pregnant yet?'" In Cara's case, her coworker was unaware of the fertility problem, but women also received inquiries even from people who knew about their struggles with infertility. Sometimes these questions prompted women to divulge additional details regarding their situation. Kelly, for example, recalled attending a baby shower for a pregnant relative. At the shower,

her father-in-law, who knew about her efforts to get pregnant, approached Kelly and asked, "So when are we going to have one of these for you?" Kelly responded by saying "You know what? We just found out yesterday this last [*in vitro* fertilization] cycle didn't work."

Women also recalled situations in which people asked questions about the nature of the fertility problem, such as the medical origin of the problem. Christy's contraction of a sexually-transmitted disease (STD) from her husband caused scarring in her fallopian tubes and made pregnancy extremely difficult to achieve. She often received questions about her medical condition, inquiries as to whether or not she would try to get pregnant again after an ectopic pregnancy, and queries regarding her decision to adopt a child rather than seek medical intervention. She explained:

> You know, a conversation would start out very general: "What happened?" "Oh, this is what happened." "Oh, well, what causes a tubal pregnancy?" "Well..." And I would be choosy on who I would go into this much detail with, so I would say, good friends, I would say, go this far. 'Well, my tubes are blocked." "Well, how do you get blocked tubes?" Well, that's where I would kind of draw the line, because I know what caused mine, and I wasn't really willing to discuss that at the time... And so I had to determine, oh, God, who do I want to tell that this was caused by that? But I just thought, you know, I would never ask somebody, I think I would draw the line at, "Oh, I'm sorry." I don't think I would say, "Well, what caused you to be infertile?" [chuckles] or "Why would you have scarred tubes?"

Christy's explanation illustrates how a string of inquiries can become progressively more invasive. Not only did these elicitations oblige her to decide whether to reveal her inability to get pregnant, she also had to make decisions about how much intimate detail to share about her unique situation.

Although the majority of the interactions featured direct requests (i.e., inquiries) for information, some women interpreted indirect or off-record comments (Brown & Levinson, 1987)

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from close others as solicitations. Cara's mother-in-law regularly made such comments: "If we're at a store, she would hold up little clothes and say, 'Hey, what do you think? Boy or girl?' and I'm like, 'Don't know. Don't *have* any.'" Cara interpreted such comments as her in-laws searching for information about whether Cara and her husband would have children. Cara said, "And I was probably pretty harsh, but fairly insulted that they're digging and prying, and not just asking, giving us the opportunity to say, 'You know, we're trying, but give us space.'" Cara's interpretation makes it clear that she viewed these statements as indirect ways of seeking information, and such utterances created scenarios in which Cara had to decide how to respond.

In summary, requests for information came from various others and took diverse forms (e.g., ranging from "Why don't you have kids?" to "Why can't you get pregnant?"). The characteristic that these conversations share is a potential recipient's attempt to elicit disclosive information.

Multiple Meanings of Asking

For the women in this study, handling requests for information, and, for those in a potentially supportive role, deciding whether to inquire about fertility-related issues, is a complicated and fragile enterprise because of the numerous meanings that can be attributed to these requests. Inquiries were described by some women as a sign of caring and an opportunity to discuss the fertility problem. However, inquiries also can be interpreted as insensitive, a threat to identity, an invasion of privacy, and a reflection of larger societal beliefs about the motherhood mandate. These contradictions in meaning make inquiring about infertility, pregnancy, and childbearing a delicate dilemma and pose challenges to managing identity and relationships.

Asking can be interpreted as caring and a chance to talk. Some women described situations in which inquiries related to their fertility problem were expected or even welcome, especially in situations involving close others. These instances illustrate how asking can mean caring and a chance

to talk. Erica, for instance, was not bothered when her grandmother asked about her fertility problem and discussed the issue with her on an ongoing basis. Erica commented that she enjoyed these conversations with her grandmother and preferred it when people inquired about her efforts to get pregnant so that she did not have to find ways to insinuate the topic in everyday conversation. Other women agreed that broaching the topic of infertility can create awkward conversational moments, and responding to questions sometimes eased the burden of deciding how to disclose the fertility problem and related aspects. In some cases, the failure of particular friends and relatives to ask about the fertility problem was interpreted by women as a lack of caring. Kelly commented:

> With friends that knew we were doing infertility treatments that never said, "How are you?"
> or "How are things going?" or asked, "How are the infertility treatments going?" to me it
> seemed like they didn't care, they didn't acknowledge that huge chunk of my life right then.

As these examples make clear, requests for information about a fertility problem can be interpreted as an expression of caring and concern that gives women an opportunity to talk about their situation.

Asking can be interpreted as insensitive. Although asking can sometimes mean a sign of caring, several examples shared by women in this study illustrate how asking can be interpreted as insensitive, especially when specific others ask particular questions or ask questions in a certain way. Barbara, for example, had entrusted a close friend with information about her fertility problem, yet described feeling hurt and betrayed when her friend asked Barbara if she was pregnant yet. Barbara explained, "I was just like, I was flabbergasted. I thought, how am I in this situation right now? It was a terrible feeling…She should've known not to ask me." Even though Barbara had already disclosed her fertility problem to this close friend, she still expected her to be sensitive in making inquiries about pregnancy. Julie indicated that a casual friend's blunt inquiry about whether she or

her husband was physically infertile would have been better tolerated if the friend had asked the question in a different, more sensitive way:

> And so she just said to me, "So is it you or is it him?" Just in that tone of voice, like who's got the problem. And I said, "Well, I guess it's me." And I was really, really offended by the way she asked that. So I just think it was really, really insensitive of her to ask it like that, you know? Not just to say, "Well, did the tests show anything? How did it go?"

Julie explicitly commented on *how* her friend asked, indicating that if she had asked in an indirect way (e.g., "Did the tests show anything?"), Julie might have been less offended by her question.

Asking can be interpreted as a threat to identity. Women also reported feeling that questions from both intimates and non-intimates endangered valued aspects of their identity. Susan felt that her mother's constant inquiries about having a second child not only came across as pushy but also implied that Susan was selfish for not giving her son a sibling and her mother another grandchild. Cheryl sensed that questions from both acquaintances and family members altercasted her as someone who did not want children and described a situation in which one of her husband's colleagues asked, "Don't you *want* children?" Andrea elaborated on how questions directly asking a woman whether she is pregnant should never be posed in the first place:

> I remember after my laparoscopy, I was still very bloated because they pump you full of gas. And I went back to work, and I was wearing baggier clothes because my regular pants didn't fit yet. And one of the janitors asked me if I was pregnant. It's like the last thing you want to hear. Even just as a woman…you never ask if somebody's pregnant.

Andrea's story indicates how such a question can be threatening to a woman's body image because it implies that she looks pregnant even if she's not. For Andrea, this query was doubly insulting because it also highlighted her inability to get pregnant.

Asking can be interpreted as an invasion of privacy. Many women in this study described situations in which asking means an invasion of privacy. Several women expressed disbelief at others' willingness to ask "personal" and "private" questions about childbearing, pregnancy, and infertility. Explicit questions from non-intimate others were interpreted as particularly invasive. Even so, women also described some questions from intimates as "nosy" or "rude." Sharon's interaction with a coworker who blatantly asked her if she had help conceiving was framed as invasive:

> He was real direct about it. And as I said, I thought really nosy. And ordinarily, I would say to somebody, "Sure, I got help." But his directness and nosiness was too much for me. If he just said, "My girlfriend and I, wife and I, we're trying for a baby," whatever, I don't know, I would've given him every gory detail about every needle that I used.

Although Sharon described this inquiry as "nosy" and "direct," her narrative also suggests that even requests from a non-intimate other, such as a coworker, might be tolerated and even acceptable if they are worded in a sensitive way or if the person explains a sensible reason for asking such a personal question (e.g., he and his partner are having fertility problems and want advice).

Asking can be interpreted as a reflection of pronatalist beliefs. Finally, women suggested that requests for information are tied to larger societal views, indicating that asking can reflect pronatalist beliefs. Inquiries about childbearing, pregnancy, and infertility, particularly when directed to women, reflect and reinscribe a societal expectation about women's roles as mothers. Cara expressed this sentiment in her interview. In a clearly sarcastic voice, she explained, "That's what you ask women, and especially if they just got married. That is a woman's job in life, and if you're not getting pregnant, then by God, what's wrong with you?" Because motherhood is an expected part of adult life for women in Western societies, people feel that it is acceptable to ask women questions about childbearing and pregnancy. Indeed, the motherhood imperative for women has been documented by

various scholars who argue that we live in an unquestionably pronatalist society in which infertility

can put a woman's identity in peril and lead to social sanctioning (Gonzalez, 2000; Miall, 1994;

Whiteford & Gonzalez, 1995). Sandelowski and Jones (1986) noted that while discussion of intimate

topics, especially with strangers or acquaintances, is often forbidden, the topic of childbearing,

though intensely private, does not appear to be subject to this taboo.

Several women also suggested that solicitations regarding childbearing and pregnancy reflect

broader assumptions about the expected lifecourse. In other words, the questions people ask reflect

the belief that having children is "an expected step in life" and that "there's an accepted lifecourse

involved." Scholars have suggested that infertility can, indeed, amount to a disrupted lifecourse for

those who experience it (Becker, 1997; Exley & Letherby, 2001). Requests for information related to

this issue indicate that others take note of this disruption and ask questions accordingly.

Responses to Requests for Information

Women responded to requests for information in a variety of ways. In certain cases, women

lied or provided an account or vague reply when people inquired about having children or about

infertility. In other cases, women disclosed the fertility problem or divulged additional details about

their situation. The way women responded to inquiries suggests three noteworthy implications for

communication scholars. First, women's recollections of these interactions suggest that both

interactants play roles as individuals negotiate conversations involving privacy, avoidance, and

disclosure. In every case, another's inquiry prompted women to decide how to respond. In addition,

examining responses to requests for information sheds light on women's efforts to manage multiple

purposes in the face of others' attempts to elicit disclosive information. Finally, analyzing women's

responses draws attention to the relationship between how a topic arises in conversation, the

meanings attributed to talk, and whether and how a particular topic is discussed.

Evasive responses. In many cases, women gave equivocal responses that allowed them to answer a question about childbearing or infertility without actually revealing the fertility problem. Kelly, for example, regularly gave vague but "true" responses that allowed her to avoid revealing her infertility when she received questions about her plans to have children (e.g., responding to a question about when she would have children by saying "In God's time"). Women also reported using humor or sarcasm as a shield that allowed them to respond to queries without disclosing the fertility problem. Andrea, for instance, would "lighten" the situation by joking that she already had two dogs at home when people inquired about her plans to have children. Cara recalled a particular interaction with a woman at work who asked her if she was pregnant yet:

> And so I just stopped, I breathed, and I said, "Mom?" And she laughed her butt off. She
>
> thought that was really funny and she's like, "Oh, I'm sorry. Does your mom ask that?" I'm
>
> like, "No, my mom actually doesn't ask that." And she got a little bit of hint of the sarcasm.

Such messages involved answering queries in a manner that enabled deflection of the topic and avoidance of a revelation. Other women were quite forthright in the interview about their decisions to "omit the truth" in the face of inquiries. Sharon reported frankly denying the fact that she had undergone treatment for infertility when asked rather bluntly by a coworker if she had "help" conceiving. Anna chose not to disclose her fertility problem to a former roommate and instead created excuses for not having children, such as being busy at work or moving into a new home.

Indirect disclosures. Women also recalled instances in which they hinted to others that they had a fertility problem by giving vague or indirect answers to questions. When people asked Amber whether she and her husband had children she would sometimes say, "No we don't. We tried." Notice that while this response is open to interpretation, the recipient might conclude that a woman has experienced infertility. Several women commented on their intentional choice to divulge their

fertility problem in a discreetly suggestive way, leaving the listener to draw his/her own conclusions. Stacy explained that she handled questions about having a second child by saying, "We're trying." She explained how this phrase allowed her to disclose her fertility problem indirectly:

> People say, "When are you going to have it?" and it's like, "We're trying. We'd like to have baby number two. We're trying. Just don't know if it's going to happen." I say, "Don't know if it's going to happen." *And I think that they can conclude from that."* [emphasis added]

Notice how Stacy's final comment suggests that the recipient can conclude from her indirect response that she is having trouble getting pregnant.

Revelations. Sometimes women chose to reveal the fertility problem in response to inquiries. The decision to reveal a fertility problem in the face of inquiries can be framed in terms of women's efforts to balance multiple purposes. In some situations, revealing a potentially stigmatizing condition, like infertility, allowed women to preserve other valued identities. Lisa, for instance, described a situation in which someone not only asked her explicitly about her childbearing plans, but also labeled her as selfish for not wanting to have more than one child (Lisa successfully conceived and gave birth to a son after undergoing treatment for infertility):

> [The person asked Lisa] "When are you going to have another one?" "Well, I'm probably not going to." She goes, "Well, that's just mean." And finally I looked at her and I said, "You know what? I had to give myself shots in the stomach. [Son's name] is a blessing, and he's going to be an only child." She was like, "Oh. Okay."

This narrative suggests that Lisa revealed her fertility problem, in part, to salvage her identity (i.e., "I'm not mean. I had trouble getting pregnant"). Some women described responding to requests for information in particular ways to "shut people up" or "tell them off" in an indirect manner. Deborah's terse response of "We've been unable to conceive" for instance, was intended to let an

acquaintance who asked her why she didn't have children know that her question was improper. In these cases, women might choose to sacrifice identity and relational goals to altercast an asker as rude or inappropriate. Linda did this in response to a coworker who on multiple occasions asked her when she was going to have children: "When that lady, who was very well-meaning, had said something, I had said very curtly to her, 'You know, some people don't have an easy time getting pregnant,' and that really shut her up." In this example, Linda risked coming across as rude in order to make it clear that her coworker's question was unacceptable.

The decision not to reveal a fertility problem or not to altercast the asker as rude can also be a means of balancing multiple purposes. Some women indicated that they resisted the urge to give a biting or sarcastic retort in order to preserve identities and relationships. Andrea explained:

There's definitely times when people ask the question, and I want to be like, "No, we can't." And I know it would be extremely awkward for them, and I know it would be such an awkward situation. But part of me thinks, maybe if I did that to enough people, people would stop asking people…A lot of times, you are in a social situation, or starting a new job, for example. You don't want to just immediately start offending your boss, your coworkers, you know what I mean? Creating that kind of atmosphere. So you don't want to be the bitter, angry, you know, like super-feminist infertility lady, you know what I mean? But it's definitely tempting sometimes to do that.

Even though she generally found requests invasive and annoying, Andrea resisted the temptation to blatantly teach people a lesson about asking such personal questions. Her final comment in this excerpt indicates her need to preserve valued identities and relationships. Depending on the situation, both revealing and concealing a fertility problem can be a means of doing so.

Discussion and Implications

To date, virtually no published research has explored the experience of talking about a fertility problem from a perspective informed by communication theory and research. Using a communication-oriented framework, the present study offers an in-depth examination of requests for information about infertility and reveals the numerous challenges associated with handling inquiries.

Theoretical Implications

The results of this study offer compelling evidence of the role of inquiries in the conversational co-construction of disclosure and topic avoidance and highlight how the multiple meanings assigned to inquiries can guide responses to these questions. The study of requests for information also draws our attention to tensions between public and private in everyday talk.

Disclosure and topic avoidance are communication phenomena that are jointly constituted in everyday interactions (Coupland et al. 1991). Thus, both interactants (not just the potential discloser) play a role in enabling or constraining the direction of the conversation (e.g., whether and how certain information will be revealed). When people ask questions with the potential to elicit disclosive information (e.g., why don't you have kids?), we see clear illustrations in which disclosure and avoidance are not necessarily the result of a simple decision to talk about a topic or intentionally avoid talk. Rather, the direction of the conversation is guided both by the question posed and the recipient's response (also see Goldsmith, 2004). Although some scholars have framed questions about childbearing, pregnancy, and fertility as "coercive social exchanges," in which women are "forced" to disclose their infertility (Sandelowski & Jones, 1986), this characterization of inquiries does not adequately acknowledge the varied and nuanced meanings that women might attribute to questions and the numerous ways that women can and do respond to such requests. Instead of framing these interactions as *forcing women to disclose*, it is more accurate to point out, as the present study does, that certain types of interactions are more likely to *compel women to make a*

decision about whether and how to talk about infertility (e.g., when women receive requests for information). Certain inquiries undoubtedly threaten control over information about fertility, but, as the participants in my sample indicated, women can and do make thoughtful decisions about whether and how to disclose a fertility problem, even in the face of inquiries. The present study also suggests that inquiries might be acceptable or even expected in some situations (e.g., when inquiries come from certain relational partners or are worded in a certain way). Although women in the present study described uncomfortable, and even painful, interactions similar to those described in previous research, others described questions as providing an appropriate conversational moment to discuss infertility, and described talking about infertility as a chance to vent and elicit support.

Considering requests for information suggests a potential relationship between how a sensitive topic comes up in conversation, how talk about that topic is interpreted, and how these two factors influence whether and how the topic gets discussed. For instance, when women receive questions related to fertility that they interpret as insensitive, they might respond with an indirect disclosure, a lie, or a terse comment meant to teach the asker a lesson. On the other hand, some meanings of asking might lead women to directly disclose a fertility problem. If a woman interprets a query about why she doesn't have children as a threat to her identity, she might reveal her fertility problem to preserve an identity as someone who wants children. The idea that how a topic arises is related to what talk means and how a topic is discussed warrants further investigation.

Coupland et al. (1991) also discussed elicitations of disclosive information in their study of painful self-disclosure and claimed that elicitations, particularly those made in a direct manner, "invite, and to an extent require, *predictably* painful disclosure on particular topics" (p. 81; emphasis added). In contrast, the present study suggests that askers who make general inquiries about whether people have children yet or why they don't have children probably don't realize that they could be

inviting troubles-telling in the form of a painful disclosure. In fact, when comparing and contrasting requests for information across various health-related contexts, including HIV and visible disability, it is useful to consider the potential for a shift in the framing of the conversation. During a medical appointment (Agne et al., 2000) or a conversation involving safer sex practices (Klitzman, 1999), queries about a person's HIV status can be recognized as an expected part of the frame. Likewise, people with visible disabilities might expect questions about their disability during early interactions with others (Braithewaite, 1991), and requesting information from a person with a visible disability would be unlikely to result in an unexpected disclosure about the existence of that disability (i.e., because the condition is readily apparent). What makes the infertility context distinctive from these other situations is the potential for a shift in frame when an unanticipated revelation is made in response to a recipient request for information. Consider, for instance, scenarios in which the asker is operating under the assumption that s/he is engaging in the ritual exchange of demographics during an initial encounter, or situations in which the asker is teasing a friend or acquaintance about when she will have a child. Depending on a woman's response in such interactions, the frame can shift quickly from small talk or joking to an awkward interaction or a serious conversation that involves the revelation of a potentially stigmatizing condition and the discussion of a painful experience. The potential for this shift in frame is another example of how talk about sensitive topics is co-constructed moment-by-moment.

Queries about childbearing, pregnancy, and infertility also offer convincing illustrations of how notions of what is public information (e.g., whether a woman or couple will have children) and what is personal, private, and sensitive information (e.g., a painful struggle to get pregnant) can collide. Although talking about fertility-related topics often implies or explicitly includes discussion of intensely personal issues, including sexual intercourse, martial relationships, and bodily functions,

the stories from women in the present study suggest that even strangers and acquaintances show little hesitation in asking about women's plans to have children. Moreover, examination of these requests provides an opportunity to link micro-level discourse to macro-level societal expectations of women and heterosexual couples. The requests for information received by women in this study can be understood as reflections of societal-level assumptions about motherhood and the expected lifecourse. At their extreme, requests for information about childbearing and pregnancy can be construed as a form of social control designed to sanction those who are not proceeding along an expected lifecourse. At the very least, a poststructural feminist perspective (Weedon, 1987) would argue that such discourse reflects Western notions of the expected lifecourse, heterosexism, and pronatalism by treating issues related to childbearing and family formation as public information.

Practical Implications

Women's accounts of handling requests for information suggest several practical implications for those coping with infertility and those in supportive roles (also see Bute, 2008). For women and couples experiencing a fertility problem, expecting these questions and deciding how to handle them can be useful. Several of the women I talked to indicated that they eventually found comfortable ways to offer a standard response to seemingly endless inquiries (e.g., replying with "No, but we'd like to have kids someday," when asked if they had children). Although women like Lisa, whose narrative served as the opening for this manuscript, might wish that inquiries about childbearing, pregnancy, and fertility would cease, expecting such questions to disappear from our cultural repertoire is probably unrealistic. Some women and couples also might find it helpful to note that inquiries can pave the way when they wish to initiate talk about infertility in conversations.

For supportive others, and even strangers and acquaintances, women's experiences suggest that it would be wise to "think twice" before asking potentially invasive questions. Although

innocuous inquiries about whether people have children are an accepted component of ritual

exchanges, asking why a woman does not have children or pressing a couple to start having children

soon might be crossing a line that could shift the frame of the conversation and make the situation

awkward for everyone involved. For those in the inner circle who know about the fertility problem,

metacommunicating about whether and how to ask questions could be a useful strategy. Reflections

from participants in my study suggest that having a conversation with close others to clarify

preferences might be another way to ease the burden for everyone involved (e.g., recall Barbara who

wished that her friend had not asked whether she pregnant).

Limitations and Directions for Future Research

Like any project, the results of this study are necessarily partial and thus offer numerous

opportunities for future research. Additional studies could refine the findings presented here by

including a more diverse sample (e.g., women from a variety of socioeconomic backgrounds). How

might women from other backgrounds, such as those without access to the same health care

resources and information as the women in my sample, interpret and cope with requests for

information in ways that are similar to and different from the findings reported here? Future research

could also include interviews with men to explore their experiences. Most studies on the effects of

infertility have focused on the experience of couples or of women, but very few studies have focused

solely on the voices of men (Sherrod, 2006). Finally, future research could build on the practical

implications of this study by including a more extensive investigation directly addressing the tensions

of providing social support in the infertility context. Like previous research (Goldsmith et al., 2006),

the current study suggests that providing social support in health–related contexts poses problematic

dilemmas. How can potentially supportive others manage the conflicting meanings associated with

requests for information? In other words, how can they ask questions in a manner that expresses concern and caring without coming across as nosy or invasive?

<div align="center">Summary</div>

For women with a fertility problem, handling requests for information is a salient, recurring, and often frustrating aspect of the infertility experience. Using a communication framework to investigate this phenomenon draws attention to the dilemmatic nature of such requests and the challenges women and various relational partners face as they negotiate the interactional dynamics involved in the discussion of a potentially stigmatizing condition.

References

Abbey, A. (2000). Adjusting to infertility. In J. H. Harvey & E. D. Miller (Eds.), *Loss and trauma: General and close relationship perspectives* (pp. 331-341). Philadelphia: Brunner-Routledge.

Afifi, T. D., Caughlin, J. P., & Afifi, W. A. (2007). The dark side (and light side) of avoidance and secrets. In B. H. Spitzberg & W. R. Cupach (Eds.), *The dark side of interpersonal communication* (2nd ed., pp. 61-92). Mahwah, NJ: Erlbaum.

Agne, R. R., Thompson, T. L., & Cusella, L. P. (2000). Stigma in the line of face: Self-disclosure of patients' HIV status to health care providers. *Journal of Applied Communication Research, 28*, 235-261.

Altman, I., & Taylor, D. A. (1973). *Social penetration: The development of interpersonal relationships*. New York: Holt, Rinehart, &Winston.

Baxter, L. A., & Sahlstein, E. M. (2000). Some possible directions for future research. In S. Petronio (Ed.), *Balancing the secrets of private disclosures* (pp. 289-302). Mahwah, NJ: Erlbaum.

Becker, G. (1997). *Disrupted lives: How people create meaning in a chaotic world*. Berkley, CA: University of California Press.

Braithwaite, D. O. (1991). "Just how much did that wheelchair cost?" Management of privacy boundaries by persons with disabilities. *Western Journal of Speech Communication, 55*, 254-274.

Brown, P., & Levinson, S. C. (1987). *Politeness: Some universals in language usage*. Cambridge: Cambridge University Press.

Bute, J.J. (2008, March) "So, are you pregnant?" Handling those unwanted questions with grace. *American Fertility Association Connections Newsletter*.

Chandra, A., Martinez, G., Mosher, W., Abma, J., & Jones, J. (2005). *Fertility, family planning, and reproductive health of U.S. women: Data from the 2002 National Survey of Family Growth.* National Center for Health Statistics.

Clark, R. A., & Delia, J. G. (1979). *Topoi* and rhetorical competence. *The Quarterly Journal of Speech, 65*, 187-206.

Cotterill, P. (1992). Interviewing women: Issues of friendship, vulnerability, and power. *Women's Studies International Forum, 15*, 593-606.

Coupland, N., Coupland, J., & Giles, H. (1991). *Language, society, and the elderly: Discourse, identity, and ageing*. Oxford, UK: Blackwell.

Exley, C., & Letherby, G. (2001). Managing a disrupted lifecourse: Issues of identity and emotion work. *Health, 5*, 112-132.

Farley, A., & McLafferty, E. (2003). An introduction to qualitative research concepts for nurses. *Professional Nurse, 19*, 159-163.

Gibson, D. M., & Myers, J. E. (2002). The effect of social coping resources and growth-fostering relationships on infertility stress in women. *Journal of Mental Health Counseling, 24*, 68-80.

Goldsmith, D. J. (2004). *Communicating social support*. Cambridge: Cambridge University Press.

Goldsmith, D.J., Lindholm, K.A., & Bute, J.J., (2006). Dilemmas of talking about lifestyle changes among couples coping with a cardiac event. *Social Science and Medicine, 63,* 2079-2090.

Gonzalez, L. O. (2000). Infertility as a transformational process: A framework for psychotherapeutic support of infertile women. *Issues in Mental Health Nursing, 21*, 619-633.

Glaser, B. G., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine.

Greene, K., Derlega, V. J., Yep, G. A., & Petronio, S. (2003). *Privacy and disclosure of HIV in interpersonal relationships*. Mahwah, NJ: Erlbaum.

Greene, K., & Faulkner, S. L. (2002). Expected versus actual responses to disclosure in relationships of HIV-positive African American adolescent females. *Communication Studies, 53*, 297-317.

Greil, A. L. (1991a). *Not yet pregnant: Infertile couples in contemporary America*. New Brunswick: Rutgers University Press.

Greil, A. L. (1991b). A secret stigma: The analogy between infertility and chronic illness and disability. *Advances in Medical Sociology, 2*, 17-38.

Greil, A. L. (1997). Infertility and psychological distress: A critical review of the literature. *Social Science and Medicine, 45*, 1679-1704.

Harter, L. M., Kirby, E. L., Edwards, A., & McClanahan, A. (2005). Time, technology, and meritocracy: The disciplining of women's bodies in narrative constructions of age-related infertility. In L. M. Harter, P. M. Japp & C. S. Beck (Eds.), *Narratives, health, and healing* (pp. 83-105). Mahwah, NJ: Erlbaum.

Keeley, M. P. (2004). Final conversations: Survivors' memorable messages concerning religious faith and spirituality. *Health Communication, 16*, 87-104.

Klitzman, R. L. (1999). Self-disclosure of HIV status to sexual partners: A qualitative study of issues faced by gay men. *Journal of the Gay and Lesbian Medical Association, 3*, 39-49.

Lincoln, Y., & Guba, E. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.

McCracken, G. (1988). *The long interview*. Newbury Park, CA: Sage.

Miall, C. E. (1986). The stigma of involuntary childlessness. *Social Problems, 33*, 268-282.

Miall, C. E. (1994). Community constructs of involuntary childlessness: Sympathy, stigma, and social support. *Canadian Review of Sociology and Anthropology, 31*, 392-421.

Mindes, E. J., Ingram, K. M., Kliewer, W., & James, C. A. (2003). Longitudinal analyses of the relationship between unsupportive social interactions and psychological adjustment among women with fertility problems. *Social Science and Medicine, 56*, 2165-2180.

O'Keefe, B. J. (1988). The logic of message design: Individual differences in reasoning about communication. *Communication Monographs, 55*, 80-103.

O'Keefe, B. J. (1990). The logic of regulative communication: Understanding the rationality of message designs. In J. P. Dillard (Ed.), *Seeking compliance: The production of interpersonal influence messages* (pp. 87-104). Scottsdale, AZ: Gorsuch Scarisbrick.

Pasch, L., Dunkel-Schetter, C., & Christensen, A. (2002). Differences between husbands' and wives' approach to infertility affect martial communication and adjustment. *Fertility and Sterility, 77*, 1241-1247.

Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.

Petronio, S. (2002). *Boundaries of privacy: Dialectics of disclosure*. Albany, NY: State University of New York Press.

Petronio, S., & Jones, S. M. (2006). When "friendly advice" become a privacy dilemma for pregnant couples: Applying communication privacy management theory. In L. H. Turner & R. West (Eds.), *The family communication sourcebook* (pp. 201-218). Thousand Oaks, CA: Sage.

Petronio, S., Reeder, H. M., Hecht, M. L., & Ros-Mendoza, T. M. t. (1996). Disclosure of sexual abuse by children and adolescents. *Journal of Applied Communication Research, 24*, 181-199.

Remennick, L. (2000). Childless in the land of imperative motherhood: Stigma and coping among infertile Israeli women. *Sex Roles, 43*, 821-841.

RESOLVE. (2007). What is infertility? Retrieved March 21, 2007, from http://www.resolve.org

Sandelowski, M., & Jones, L. C. (1986). Social exchanges of infertile women. *Issues in Mental Health Nursing, 8*, 173-189.

Savin-Williams, R. C. (1998). The disclosure to families of same-sex attractions by lesbian, gay, and bisexual youths. *Journal of Research on Adolescence, 8*, 49-68.

Sherrod, R. A. (2006). Male infertility: The element of disguise. *Journal of Psychosocial Nursing & Mental Health Services, 44*(10), 30-37.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage.

Taylor, S. J., & Bogdan, R. (1998). *Introduction to qualitative research methods: A guidebook and resource* (3rd ed.). New York: John Wiley & Sons.

van Balen, F., Trimbos-Kemper, T. C. M., & Verdurmen, J. (1996). Perception of diagnosis and openness of patients about infertility. *Patient Education and Counseling, 28*, 247-252.

Weedon, C. (1987). Feminist practice and poststructural theory. New York: Basil Blackwell.

Whiteford, L. M., & Gonzalez, L. (1995). Stigma: The hidden burden of infertility. *Social Science and Medicine, 40*, 27-36.

Note

[1] Pseudonyms are used to protect women's identities.

[2] I did not include the total number of transcript and field note pages produced during data collection. Although I understand that reporting these numbers can provide clarity for some readers, reporting the total number of transcript pages tells the reader nothing about the quality of the interviews or the information gleaned from the interactions. For instance, it's possible to conduct a lengthy interview in which a participant discusses information that is completely irrelevant to the project because the interviewer is unskilled or the interview questions are poorly worded. Moreover, the total number of pages produced is somewhat arbitrary; the final number depends on line spacing, margin size, font style, and so on. It would be possible to create a greater number of transcript pages simply by using a bigger font or wider margins. I hope that readers will understand my decision not to include this information.

Table 1

Participant Characteristics (*n* = 23)

Age	28 to 48 years (*M* = 36.36, *SD* = 4.99),
Marital Status	All participants were married.
Race/ethnicity	Twenty of the women described themselves as Caucasian or white, one described herself as Jewish, one described herself as European, and one described herself as Hispanic.
Education	Fifteen women had graduate degrees, six had completed college, and two had completed some college.
Occupation	The women were employed in a variety of occupations, and a majority of the women who volunteered for the study were employed by the university in some capacity. Occupations associated with the university included professor, researcher, administrative assistant, and librarian. Other community-based professions represented in the sample included teacher, accountant, and graphic designer.
Diagnoses	The most frequently reported diagnosis was polycystic ovarian syndrome (*n* = 11), followed by unexplained infertility (*n* = 3), age-related infertility (*n* = 2), endometriosis (*n* = 2), and progesterone or thyroid problems (*n* = 2). Additional diagnoses included acidic cervical fluid, anti-ovarian antibodies, anovulation, scarred fallopian

tubes, and low ovarian reserve; each of these conditions was reported only once. Some women reported multiple diagnoses; for instance, one woman reported her diagnosis as a combination of polycystic ovarian syndrome, endometriosis, and anti-ovarian antibodies.

Of the two women who indicated that they had not received an official medical diagnosis for a fertility problem, one had experienced a miscarriage eventually attributed to a luteal phase defect, and one reported that her infertility was unexplained.