

**NARRATIVES (IN)FERTILITY:
ORGANIZING AND EMBODIMENT IN SILENCE AND STIGMA**

by
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For the many women in the world who will experience infertility

*And also, for my mother and my grandmother,
who modeled motherhood so well for me that it became inevitable*

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ABSTRACT

Within the United States, infertility diagnoses are becoming increasingly commonplace, yet treatment often remains shrouded in stigma and silence. Consequently, for the women going through it, infertility is an isolating experience. Infertility is frequently conceived through notions of medicalization, which prompts a disembodied, scientific, ‘never give up’ discourse that often leaves women feeling disempowered and further alone. This study considers how individual narratives of infertility contributes to the organizing of a social identity of infertility, one which abuts and diverges from medicalized notions. In adopting theories related to narrative organizing, tenuous identity/identification, resilience, and social support this project engages a feminist-interpretivist framework. In doing so, this study draws upon a three-phase methodological engagement of (1) online ethnographic observations and auto-ethnographic reflections, (2) in-depth interviewing of participants narratives and networks related to (in)fertility, and (3) text mining and semantic network analysis of public discourses related to (in)fertility.

Findings from this project reveal how infertility is discursively-materiality organized to both embrace and disengage from medicalized logics. First, analysis of personal and organizational narratives illustrate how infertility is construed through competing tensions of loss, empowerment, and support. Second, identities were shown to be communicated as potentially tenuous, liminal, and/or challenged during the process of infertility as women cope with an ambiguous future; however, so too can identities be considered a source of strength and hope. Third, through conceptualizing resilience as a communicatively constructed process, this study showcases the embodied nature of resilience as it ebbs and flows throughout treatment. And fourth, in analyzing social and semantic networks this project interrogates individual and organizational discourses, building a more holistic, yet still thoroughly partial, understanding of effective supportive

communication during treatment. Through this process, this study reveals how online support groups re-center the women's body and emotions as central to the (in)fertility experience, while noting the disembodiment that occurs within health clinics.

This study advances knowledge on emergent, embodied organizing and the communicative construction of resilience through considering the intrapersonal and embodied aspects of resilience. Through conceptualizing embodied organizing and embodied resilience, this project advances theories of antenarrative, emergent organizing, and self-persuasive rhetoric. Methodologically, this study contributes to qualitative inquiry by linking crystallization methodologies with network science. Additionally, this project offers recommendations for family members, friends, and medical professionals on how to promote resilience within women receiving infertility treatment.

PREFACE

This Preface is designed to introduce readers to the values, choices, and paradigms that constitute this dissertation. Like all writing, this dissertation is constructed through a “particular view of reality and of the Self” (Richardson & St. Pierre, 2018, p. 819). In other words, this dissertation is shaped as much by the participants’ narratives and experiences, as it is by my own standpoint. As such, I rely on crystallization (Ellingson, 2009; Richardson, 2000) as a reflexive practice designed to account for my own role in constituting this dissertation. Through crystallization I locate my own authorial representation within the research process and account for the subjectivities of myself and my participants. This Preface is intended to introduce my strategies of representation on behalf of both myself, as the author, and my participants. Within this Preface, I first outline crystallization as a guiding methodological practice. Then, I shift focus to representation strategies, reviewing my metatheoretical approach to my authorial representation through the integration of reflexive, auto-ethnographic interludes and integrated pull-out boxes, which speak to community resonance¹.

Crystallization

In an effort to produce a more complex, deeper understanding of (in)fertility, this dissertation utilizes crystallization as a guiding methodology (Ellingson, 2009; Richardson, 2000). Crystallization encourages researchers to engage multiple theoretical frameworks and utilize

¹ I use the term community resonance as an alternative form of member checking (Reilly, 2013). The aim of resonance is to understand how representations and findings reverberate with participants as a means of qualitative rigor (Tracy, 2010). I draw on the notion of community to situate resonance within the specific, organized community of (in)fertility.

several different types of qualitative methods. In part, as a response to triangulation, crystallization rejects the idea of a singular, valid truth, instead it seeks to “open up [to] a more complex, in-depth, but still thoroughly partial, understanding of the issue[s]” (Tracy, 2010, p. 844). Crystallization eschews claims of a fixed, rigid, and objective truth, instead favoring truth as partial, multiple, and thoroughly subjective (Ellingson, 2009). It is through the metaphor of a crystal that we can understand truth through a variety of angles and approaches (Richardson, 2000). That is to say, just as a crystal reflects different light depending on its angle, so too does this dissertation aim to reflect various conceptions of truth.

Ellingson (2009) lays out five principles of crystallization, including: (1) a deep, thickly described, complex interpretation of the data, (2) the use of multiple qualitative methods as a means of representing different ways of knowing, (3) the incorporation of more than one genre of writing, (4) attention to the researcher’s role in the research process, and (5) a recognition of truth as “situated, partial, constructed, multiple, and enmeshed in power relations” (p. 10). Thus, crystallization moves beyond the concept of ‘thick description’ (Geertz, 1973) to consider how moments of embodiment and interaction contribute to the ongoing effort to organize and represent the Self and Others throughout the research process (Ellingson, 2009).

Crystallization pushes beyond dichotomous categories of research (e.g., qualitative versus quantitative research) and, instead, opens up a continuum of qualitative, genre-blending research. Thus, by adopting crystallization, I seek to move beyond a singular metatheoretical commitment, and instead integrate constructivist interpretations alongside post-positivist representations. In doing so, I seek to bring about a deeper understanding to both generalized themes and situated stories (Ellingson, 2009). Ultimately, crystallization informs the representational strategies that are discussed in the following section.

Representational Strategies

Questions of representation and reflexivity are at the center of qualitative research and narrative inquiry. There are various ways of engaging representation; however, for this project I integrate auto-ethnographic interludes and resonance pull-out boxes. Traditionally, qualitative research engages two forms of reflexivity: positional reflexivity, in which the author considers their own subjectivity within the research process, and textual reflexivity, which is concerned with the construction of reality (Ellingson, 2009; Macbeth, 2001). These dual and dynamic reflexive practices are at the center of my representational strategies for both myself and my participants.

Reflexive Interludes

All academic writing is attuned, to some degree, to the personal life of the researcher. Personal lives ‘erupt’ in the choices, topics, and metaphors we engage (Richardson, 2001). Richardson (1997) suggests ‘writing stories’ as a reflexive practice designed to ground the work within larger academic debates, social and cultural movements, and personal histories. Reflexivity thus demands an uncomfortable, ongoing assessment of the researcher’s role in the process (Gorelick, 1991; Scheper-Hughes, 1983). My commitments to and strategies for reflexivity are further explained in Chapter 3, however this Preface is designed to introduce and make visible my authorship, as well as to assess and analyze my own experiences auto-ethnographically (Charmaz & Mitchel, 1997; Coffey, 1999).

In an attempt to highlight the ways my own identity, values, and choices construct the research process, throughout this dissertation I integrate auto-ethnographic interludes (Ellingson, 2009). In this way, I adopt autobiographical writing as a method of inquiry, which both enhances my reflexive understanding and adds layered nuance (Richardson, 2001) and an additional source of data for this project. Coffey (1999) argues, “all ethnographic writing is to some extent

autobiographical” (p. 119), and as such these interludes contextualize my research decisions and interrogate my positionality. The interludes also serve as a means through which to reflect on my own role in the research process, they provide an insider account to the reader as to how the research was created and how it evolved over the course of the dissertation-writing experience (Coffey, 1999). These interludes are reflexive in nature and account for the ways in which my position and presence affect the conceptualization of the project as well as the data collection, analysis, and interpretation.

Atkinson and Silverman (1997) suggest that biographical narratives can be therapeutic for both the researcher and the reader, and as such the interludes are written as reflexive narratives. Fieldwork requires active engagement with identity reconstruction and has a lasting impact on the researcher’s self-identities (Coffey, 1999). Interludes are layered (Ronai, 1995), bridging the connection between social scientific knowledge and my personal experience (Ellingson, 1998). In sum, these interludes are designed to broaden the scope of accrued knowledge, to complexify the data process, and to interrogate the boundaries and contradictions inherent in a qualitative research project (Lincoln et al., 2018).

Resonance Pull-out Boxes

Central to my metatheoretical and methodological commitments was concern for participant resonance. In lieu of traditional member-checking and trustworthiness, community resonance was used to enrich the empathetic validity of the research (Reily, 2013). As an alternative form of member checking, this study engaged a hybrid combination of member check focus group (Klinger, 2005) and member synthesis of analyzed data (Birt et al., 2016) through using an online survey. As is discussed in greater detail in Chapter 3, this online survey was used as a means of checking the resonance of findings against the perspective of group members.

Participant reflections are included in pull-out boxes, which are placed alongside my analysis. Throughout Chapters 4, 5, and 6, boxes are used to provide greater nuance to findings, and, in some cases, alternative or conflicting perspectives that were not represented in the primary data collection (Linabary, 2017). To that end, these boxes are used as a means of enrichment to highlight the situatedness of knowledge, the complexities of lived experiences, and the inevitable uniqueness of each participant's story.

Interlude: Constructing a Dissertation

Two months before I began my doctorate program, when I was 25 years old, I was diagnosed with diminished ovarian reserve (DOR). A DOR diagnosis meant that I may encounter more difficulty becoming pregnant because my ovaries have a diminished number of eggs. My infertility is a direct result of the cancer treatment I received as a child, which ravaged my body in both visible and invisible ways. Weaved throughout this dissertation are reflections on my cancer journey juxtaposed against narratives of infertility; however, suffice to say, my infertility diagnosis came as a shock. I was 25 years old, on the precipice of starting my PhD program in Indiana, and desperately single.

At 25, like many of my east-coast, liberal friends, having children was the farthest thing from my mind. Even within our conservative, Catholic upbringing, none of my friends were married, or even engaged. My friends instead had spent the early half of their 20's, like me, pursuing advanced degrees in STEM and law, excelling in their careers. Occasionally we would enter late-night text conversations where we would bemoan the trivialness of legally-bound commitment in your early 20's. *Did you see that girl is engaged? Did you hear she's pregnant? I would never; I could never.* We saw marriage, never mind motherhood, as a daunting task. We were young and free and in pursuit of a future of our own design. And yet, despite all these years

of pointedly not thinking about children, after my infertility diagnosis the thought of not having children remained the singular focus of my attention. I had spent years entrenched in gossip with my friends, citing divorce statistics over cocktails, and unknowingly paraphrasing *The Feminist Mystique*. All of a sudden, however, I was confronted with the harsh reality that while I might not be ready for a child, my chances of having a child were quickly receding.

I cycled through moments of grief as I processed the potential loss of motherhood, anxiety over the vast unknowns, and anger as I reconciled cultural and religious discourses that instilled in me the idea that motherhood constitutes womanhood. I felt immense pressure to get going with my life. Whereas before the diagnosis I pictured myself with all the time in the world, after the diagnosis I became fearful that time was moving too quickly. I needed to get on a path to motherhood; I needed to find a husband, secure my career, and get pregnant. I quietly repeated these steps to myself nearly every night to quell the rising panic, a self-sustaining mantra for my future.

I began my doctorate program at Purdue two months after my initial infertility diagnosis. I used those two months, and the fifteen-hour car ride to Indiana, to carefully map a plan of imminent exit. I knew that if I wanted to have children, I would need to do it sooner rather than later, which meant I would need to find a partner. I knew that if I wanted to build a life in Massachusetts, close to my parents and my grandmother, I would need to make myself marketable, which meant I would need to publish in an emerging subdiscipline. I decided long before I set foot on Hoosier ground that I would graduate with my doctorate in three years, I would find a life partner who would father my children, and I would study sports communication.

Sports communication was the key to my professional plan. It was a quickly growing subdiscipline, and every year I saw more and more universities looking to hire sports

communication faculty. Sports communication is intra- and inter-disciplinary and allowed me to diversify my interests while, at the same time, maintain a cohesive plan of study. And importantly to my purposes, when I attended interest group and summit meetings, I witnessed a hegemonic pattern of sameness among the participants. The majority of the people studying sports communication were middle-aged, white men. I, on the other hand, was a young, pithy, white woman and I knew that, in the future, I could leverage my gender as a way to distinguish myself from other people on the job market.

Of course, once I landed in Indiana, I became overcome by an imminent feeling of dread. My infertility diagnosis felt like a ticking time bomb; it weighed heavy on my heart. *One day soon*, I thought to myself, *my period will stop being a monthly nuisance*. I was only 26, but I felt as if pre-menopause was knocking on my door, a grim reaper arrived to steal my fertility. I took fastidious care in monitoring my monthly cycle; I was Charles Darwin studying the lifespan of birds, but instead of birds I was noting the waning lifespan of my ovaries. I continued to write and publish in sports communication, but it felt increasingly inauthentic to my life. At sports communication meetings I felt even further isolated from my work. I could not casually talk statistics and sports history; I barely knew the players on my favorite baseball team. I wrote papers analyzing the National Football Leagues' (NFL) response to domestic violence and Black Lives Matter, and I felt like none of it mattered. The NFL, I knew, would never change so long as people tuned in on Sundays. My critical, feminist work did little to sway the tides of popular opinion. I wanted to help people with my scholarship, but with sports I felt as if I was merely shouting into the void.

Throughout all of this, I was spending an inordinate amount of time online, visiting various infertility support groups. It was here that I read the stories of women who had undergone multiple

rounds of in vitro fertilization (IVF), women who had spent hundreds of thousands of dollars on medication in the desperate hope of pregnancy. I read these heartbreaking narratives and I witnessed moments of hope and resilience. I became entranced by the vitality of these support groups.

It was during the fall of my second year, when I sat down with my advisor and admitted I could no longer continue studying sports communication as my major area of interest. I pulled out a faded piece of yellow construction paper on which I had mapped an overview of my dissertation project (Appendix A). In blue pen I traced connections between the theories I was committed to exploring and the D/discourses I had observed on the online support groups. I circled my potential contributions, emphasizing the gap I was filling and highlighting it all in pink. As my advisor expressed her support for my decision, I felt a heavy weight lift off my chest. I saw my well-honed plan disintegrate, I was entering unknown, unmarked territory, but at the same time I saw a renewed purpose in my scholarship. I believed that if I wrote a dissertation that was engaged and feminist, I could help others understand the terror that is infertility. I was committed to studying infertility and, more than anything, I was committed to understanding if other women were like me; I wanted to understand if other women were questioning who they were, if other women were kept awake at night by questions of purpose in a world that valorizes motherhood as the natural and assumed path for women.

I contextualize the tenor at which I arrived at this dissertation topic to illustrate the situatedness of academic work. It is my hope that through understanding my mindset as I developed this dissertation project, I can shed light on the nuanced ideas and lived experiences that swayed my collection and analysis processes. Throughout this project these interludes are interwoven to account for reflexivity, but also to add nuance to the data. As such, the interludes

follow a somewhat chronological pathway, beginning with chapter 1, where I delve deeper into the experience of receiving an (in)fertility diagnosis, to chapter 2, where I narrate the emotional magnitude of (in)fertility, and so on. Through a chronological ordering I invite you, the reader, to share in this experience, to learn from my pain, and celebrate the strength of resilience.

CHAPTER 1: INTRODUCTION

According to the Center for Disease Control and Prevention (CDC) 12% of women in the United States will have difficulty getting pregnant and/or sustaining a pregnancy. Moreover, in the United States, 7.4 million women have sought out medical services for (in)fertility². The International Committee for Monitoring Assisted Reproductive Technologies (ICMART) defines (in)fertility as “characterized by failure to establish a clinical pregnancy after 12 months of regular, unproductive sexual intercourse or due to an impairment of a person’s capacity to reproduce either as an individual or with his/her partner” (Resolve, 2019a). And yet, while research has shown that (in)fertility is often equally attributed to both male and female partners, it is typically conceived as a women’s issue (Resolve, 2019b).

(In)fertility treatments, including in vitro fertilization (IVF), oocyte cryopreservation, and intrauterine insemination (IUI) have become increasingly popular resources, yet these medical procedures also remain expensive and highly politicized. For instance, the average woman will undergo multiple cycles of IVF before pregnancy success and, with the typical IVF cycle costing anywhere from \$12,000 to \$15,000, the cost quickly accumulates. Moreover, current healthcare laws provide limited financial assistance for treatment. Only 15 states require insurance to cover (in)fertility treatment access, despite research that suggests insurance coverage helps to lower the overall cost of (in)fertility, may reduce organizational exit, and may improve organizational

² I refer to (in)fertility as a means to connote the liminal, in-between stage of treatment. As women receiving (in)fertility treatment are neither fertile, nor infertile, neither pregnant, nor nonpregnant, but rather in the in-between state of both identities this term serves useful in reminding us of the tenuous experience of (in)fertility.

commitment (Fertility I.Q., n.d.; Resolve, 2019c). In short, (in)fertility has become a big business with the brunt of physical, financial, and emotional responsibility falling on women.

(In)fertility treatment is an acutely gendered experience. While, in a heterosexual partnership, (in)fertility can be attributed to either the male or female partner, it is the female partner who is responsible for the brunt of the medical procedures, including daily monitoring of her menstrual cycles, rigid treatment regimens, and invasive surgeries (Cousineau et al., 2006). Past research (Herrmann et al., 2011; Domar et al., 1993) has positioned (in)fertility treatment as one of the most stressful experiences in a woman's life. Women undergoing treatment may experience psychological distress, loss of hope and esteem, and experience a challenge to her conception of health, wholeness, and physical integrity (Anderheim et al., 2005; Herrmann et al., 2011; Lukse & Vacc, 1999; Paul et al., 2010).

Despite the financial and emotional toll of (in)fertility treatment, medical intervention does not necessarily result in a live birth. The American Society for Reproductive Medicine notes that for a woman under the age of 38 the success that a single egg will result in a live birth is only between two and 12%. Likewise, the Society for Assisted Reproductive Technology (SART; Society for Assisted Reproductive Technology, 2020), reports that only 40% of women under the age of 35 will successfully give birth following IVF. Because of the number of uncertainties surrounding (in)fertility treatments, many women will refrain from disclosing their treatment. Furthermore, because (in)fertility is a deeply personal topic that involves financial, physical, and emotional costs, many women will avoid discussing it with friends and family members, further aggregating social isolation (Steuber & Solomon, 2011).

There are a number of reasons that may explain the recent uptick in women receiving medical treatment for (in)fertility. For example, a 2018 report by the Pew Research Center found

that women are waiting to have children longer. In fact, an increasing number of women are giving birth towards the end of their reproductive years (i.e., ages 40 to 44; Livingston, 2018). Today, the median age for a woman to become a mother is higher than years previous, due in part to declines in teenage pregnancy, the Great Recession of the late 2000s and early 2010s, higher rates of educational attainment, involvement in the labor force, and delays in marriage among women. Women having children later in life is becoming a global trend, with the 2017 United Nations World Populations Prospectus estimating that most babies in the Western world will be born to 30-somethings.

Additionally, in the last few years, a new business has emerged catering to young, millennial women looking to freeze their eggs (e.g., oocyte cryopreservation). Women who choose to undergo egg freezing will undergo the same hormone therapy and retrieval surgery as women looking to conceive. Boutique egg freezing clinics are the latest trend in (in)fertility care, offering not only short and convenient appointments but a youthful branding that is marketed towards the social media generation. In part, the rise in elective egg freezing may be due to recent changes in the regulation of egg freezing. In 2012, the American Society for Reproductive Medicine lifted their ‘experimental’ label on egg freezing allowing all women—not just cancer patients looking to preserve their fertility—access to treatment. It is estimated that 9,000 women annually will seek out oocyte cryopreservation (Regendsdorf, 2018).

This project looks to understand the narrated experiences of (in)fertility and how these narrations, in turn, produce a fuller understanding of (in)fertility as an organizing experience. Through incorporating theories of identity/identification, resilience, and social support networks,

I seek to understand how tenuous identities³ are navigated, resilience developed, and social support networks constituted during treatment. Moreover, this project draws on methodologies related to feminism and interpretivism as a means of understanding how situated, individual experiences can nonetheless contribute to a more holistic portrayal of (in)fertility. Thus, I first briefly explain the medical protocol for the most common, but also the most extensive, (in)fertility treatment: in-vitro fertilization (IVF). Next, I situate my proposal within current research on (in)fertility, before overviewing the organizational schema of this project.

Treating (In)fertility

As previously introduced, the three most common (in)fertility treatments are in vitro fertilization (IVF), oocyte cryopreservation, and intrauterine insemination (IUI). However, in order to fully understand why (in)fertility is such a traumatic experience, it is important to understand the basics of the treatment protocol. Specifically, this study focuses on women who are undergoing IVF treatment because it is considered the most expensive and extensive of the available medical procedures. However, as noted, other women, like myself, who are undergoing oocyte cryopreservation (e.g., preserving eggs through freezing) will also go through a round of IVF medications before retrieval.

During IVF, an egg (or ideally multiple eggs) are removed from a woman's ovaries and fertilized with sperm in a laboratory. Once the egg is fertilized into an embryo it is then returned to the woman's womb in the hopes that it will grow and develop into a healthy fetus. However,

³ As is explained in Chapter 2, this research considers different forms of identity tensions, including multiple identities, stigmatized, identities, and liminal identities. However, particular attention is paid to liminality as an overarching form of identity tension, thus the phrase liminality and tenuous identities are used interchangeably throughout this dissertation project.

this process is not straightforward. When a woman decides to undergo IVF, usually after she fails to conceive for 12 months of unprotected sexual intercourse (or 6 months if the woman is over 35), she will begin by suppressing her natural menstrual cycle. This first step typically involves two weeks of continued daily injections. During this stage of IVF, a woman will boost her egg supply through taking a follicle stimulating hormone (FSH), colloquially referred to within the (in)fertility community as ‘stim shots.’ FSH is a daily self-administered injection that is taken for 10 to 12 days. The FSH shot can range in cost, but typically averages about \$100 per shot, totaling \$1,000 to \$1,200. The goal of FSH is to increase the number of eggs the ovaries produce and thus the chances of retrieving and fertilizing more eggs. As IVF is so rarely successful, the more eggs available the more chances of pregnancy success. Throughout the FSH phase of IVF the woman is returning to her doctor’s clinic daily for ultrasound scans and blood tests to monitor how many eggs she has produced.

After two weeks of stim shots, the woman is prepped for her retrieval. During the retrieval the patient is sedated, and the eggs are retrieved in about 15 to 20 minutes. The eggs are then fertilized with sperm and, after 16 to 20 hours, the lab is able to check if any have successfully fertilized. The fertilized egg will continue to grow in the lab for 6 days. It is after this time that the egg may receive genetic testing, which not only allows the parents to learn the sex and genetic makeup of the embryo, but so too assesses the chances of the embryo’s ability to survive in the womb. Usually the best one or two embryos are chosen to transfer, and the rest are frozen for later use. When embryos (or eggs if the patient is undergoing oocyte cryopreservation) are stored for later use, the patient must pay an annual storage fee ranging anywhere from \$500 to over \$1,000. The final stage of the IVF cycle involves the embryo transfer which is less extensive than the egg

retrieval. It can take two weeks for a woman to discover if she is pregnant, a time period many women cite as immensely stressful.

Studying (In)fertility

Health crises, like (in)fertility, are often assumed to be objective, evidence-based, and impartial. Researchers in public health, in particular, have noted that (in)fertility is a growing health problem that requires national attention for the prevention, detection, and management of (in)fertility (Macaluso et al., 2010). Public health scholars have noted that an (in)fertility diagnosis can cause heightened emotional stress, as well as financial and physical burdens that result in a lower quality of life (Fidler & Bernstein, 1999; Macaluso et al., 2010). And while there has been a call within public health research to understand the communicative elements of (in)fertility, public health researchers generally treat communication as a linear dissemination process, rather than as a dynamic dialogical process that is constantly in flux (Macaluso et al., 2010). Approaching (in)fertility from a communication standpoint allows us to understand how experiences of (in)fertility are created through communicative interaction between the patient, her doctor, her support system, and other sources of influence.

Through studying (in)fertility from a communicative perspective, this study also adds to an interdisciplinary conversation investigating the relationship between (in)fertility and a woman's identity. It is well documented that an (in)fertility diagnosis wreaks havoc on a woman's emotional state, however much of the foundational research on this topic was developed prior to the expansion of medical treatment for an (in)fertility diagnosis. Much of the research is focused on the emotional tension and resilience enacted by couples who are trying and failing to conceive, but do not have access to treatment. For example, Taymor and Bresnick (1978) note that the intense, emotionally charged 'crisis of infertility' can cause tension in every area of the couple's

relationship. Past research has found that individuals and couples diagnosed with (in)fertility will often undergo a patterned emotional response, beginning with surprise and moving to grief, anger, isolation, denial, and finally acceptance (Rosenfeld & Mitchell, 1979). Conceptions of the emotional response to an (in)fertility diagnosis may change, with recent medical advancements made in the last 20 years.

Through a communicative approach, this project also looks to understand how resilience is crafted and enacted for women undergoing treatment. Resilience has been a topic of concern for researchers because, regardless of treatment options, an (in)fertility diagnosis may often lead to feelings of immense grief, which can be difficult to overcome. Seibel and Taymor (1982) cite four reasons for why individuals are unable to overcome the grief of (in)fertility. First, the negative emotions of (in)fertility may, in part, be caused by the lack of physical loss, which causes couples to feel as if they have no right to grieve. Second, even though (in)fertility treatment is becoming increasingly common, many people may still consider the loss ‘socially unspeakable,’ thus alienating patients from their social network. Relatedly, third, couples may lack the ability to mobilize social support, thereby missing an important source of comfort. And finally, as previously noted, IVF is often filled with ambiguities and uncertainties as it typically requires multiple rounds of treatments.

One way for individuals and couples to overcome the enormous emotional strain of (in)fertility is through enacting resilience. Research in psychiatry (Yu et al., 2013), medicine (Herrmann et al., 2011), and family therapy (Ridenour et al., 2009) have all sought to understand the benefits of resilience for couples undergoing (in)fertility, yet few researchers have explicitly traced the communicative constitution of resilience and how resilience may aid in maintaining identities. Often, past research on (in)fertility has sought to treat resilience as an outcome of stress,

rather than as a process of recovery. When resilience is treated as an outcome it is often measured as a variable, which is then moderated by available resources (i.e., Friborg et al., 2003; Wickes et al., 2015). However, this project adopts a social constructionist and communicative approach to resilience through which resilience is considered a process, which can be enacted over time. It is through understanding the communicative construction of resilience that other women can learn and model resilience during their own treatment cycles.

Importantly too, my conceptualization of resilience, and more broadly the experience of (in)fertility, is grounded within a qualitative, feminist-interpretivist framework. Much of the past research on (in)fertility has sought to identify negative outcomes caused by stress. For example, Zucker (1999) found that reproductive-related stress was mediated by the woman's emotional response and orientation towards motherhood. Other post-positivist oriented models have been created to study (in)fertility, including: the close-relationship model (Higgins, 1990), self-regulation model (Benyamini et al., 2004), the relational model of development (Gibson & Myers, 2000), the family/medical systems model (McDaniel et al., 1992), and attachment and social support model (Amir et al., 1999). While these models all provide important insight into the experience of (in)fertility, few consider (in)fertility from a communication perspective. By understanding the experience of (in)fertility communicatively, we are able to connect the descriptions women provide of their experiences to the larger, macro-level discourse (i.e., discourses emanating from cultural, religious, or biomedical ideologies, normative practices and assumptions, and/or governmental policies) which permeates public perceptions of (in)fertility.

Communication researchers have begun to explore the varied ways in which discourses on (in)fertility function as persuasion⁴. In tracing the rhetorical evolution of the term (in)fertility, Jensen (2015) notes the shift from perceptions of childless women as “barren” to “sterile.” Historically, the barren metaphor was used to locate individual responsibility for pregnancy (or lack thereof) to the individual women. So-called barren women were often believed to hold maternal sin, and thus portrayed in medical texts of the time as unruly others. By the early nineteenth century, with the development of medical interventions for (in)fertility, the barren metaphor was exchanged for one that described childless women as sterile. Developing alongside the industrial revolution of the West, the sterile metaphor framed the female body as a machine in need of repair. It was because of this discursive change that responsibility for pregnancy was taken away from the women and instead placed within the medical community. In recognizing the varied ways in which (in)fertility has functioned as a persuasive tool, this project looks to build on Jensen’s (2015) theorizing through examining the use of these metaphors within the context of the way women narrate their (in)fertility experience.

A narrative approach to studying (in)fertility has contributed to the development of post-positivist models. Researchers (Sandelowski et al., 1990) have sought to model the explanatory phases couples undergo in order to resolve the liminal identity paradox of (in)fertility. Liminality is the state of in-betweennesses when an individual is transitioning between two identities, yet occupies neither (Turner, 1967). The liminal identity becomes paradoxical when the identity

⁴ While Jensen (2015) does not explicitly adopt the language of Putnam and Fairhurst (2004) in her examination of discourses related to (in)fertility, her analysis does privilege an analysis of the *Discourse* of (in)fertility. That is to say, Jensen (2015) looks to understand rhetorical conceptions of (in)fertility through tracing the historical lineage of the term through biomedical texts.

transition begins and the individual occupies both identities, while simultaneously occupying neither (Greco & Stenner, 2007). And yet this explanatory model offered by Sandelowski, Holditch-Davis, and Harris (1990) focuses exclusively on couples who look to adoption, instead of the use of assisted reproductive technologies. As will be explained in greater detail in Chapter 2, this study seeks to understand how women navigate the paradox of liminality through a communicative framework, where explanation is recognized as a communicative act that can give way to sense-making.

Importantly, this project adopts a communicative approach to understanding narratives of (in)fertility within the culture of the United States. Because (in)fertility is a global problem, researchers have explored the narration of (in)fertility in diverse cultural contexts. Researchers in Australia (Kirkman, 2001, 2003), India (Riessman, 2002, 2005), Egypt (Inhorn, 2003, 2012) and Ireland (Allison, 2009, 2010a, 2010b, 2011; McDonnell, 1999) have all sought to better understand how culture shapes the (in)fertility experience. These narratives showcase both the unique ways in which culture orients (in)fertility as well as how notions of (in)fertility can transcend culture. (In)fertility, for example, is uniquely experienced by women living in the developing world, where rates of (in)fertility are higher yet access to treatments is more difficult (Inhorn, 2003). Likewise, in Ireland, the social stigma and silence of (in)fertility is reproduced in large part because of the influence of the country's religious history, reproductive politics, and cultural idiom of choice (Allison, 2011).

Thus, in focusing on the United States and Canada, this project seeks to illuminate the ways in which (in)fertility is experienced within a specific national cultural context. Past researchers have noted that the United States presents a unique cultural context in which to examine health issues. The dominant language within the U.S. is one of rugged individualism and personal

responsibility, where individuals are expected to be disciplined, hardworking, and self-determined (Dorfman, Wallack, & Woodruff, 2005). This cultural ideology may present itself in a number of ways for women experiencing (in)fertility. For example, some women may feel pressure to continue treatment until its successful (Whiteford & Gonzales, 1994). However, this rugged individualism may also contribute to the culture of silencing around (in)fertility.

While the cause(s) of silencing may be uniquely attributed to specific cultural norms (i.e., Ireland's history), many researchers have found that the silencing of (in)fertility is common throughout nations. The silencing of (in)fertility may contribute to a fractured identity. Kirkman (2001), for example, used narrative analysis as a means to understand how women presented a coherent life story when an (in)fertility diagnosis wreaked havoc on their sense of selves. In her research Kirkman (2001) identified that women often feel they must present different identities in the public versus private spheres in order to navigate the stigma associated with (in)fertility. My research looks to build on the psychological studies of Kirkman (2001, 2003) by orienting identity and identification as communicative based, where identity is expressed through language and discourse.

Much of the research on (in)fertility in the United States highlights the persuasive role of gender norms in shaping (in)fertility experiences. Young women in the United States may be particularly prone to 'anticipated infertility' because of gender norms that link womanhood to motherhood as well as cultural anxieties surrounding fear of aging, reproduction, and risk (Martin, 2010). 'Anticipated infertility,' may lead healthy women, who show no signs of reproductive risk to preemptively freeze their eggs.

Other researchers have sought to understand narratives of (in)fertility on a societal level. Franklin (1990), for example, identified dominant frames of discourse which constitute the major

frame of reference for women undergoing (in)fertility treatment. These frames include a juxtaposing of ‘desperate victims of childlessness’ against ‘happy couples’ who have produced a ‘miracle baby.’ It is these types of frames that serve as an “emergent narrative” (Franklin, 1995, p. 330) for women experiencing (in)fertility to draw on by undermining the popular conception of the ‘naturalness’ of procreation. Instead these narratives emphasize the complex, but nonetheless miraculous way in which assisted reproductive technologies can lead to conception. Franklin (1995) suggests that the growing awareness of assisted reproductive technologies, like IVF, have allowed for more public acceptance of the varied ways in which women conceive.

Like many of the other foundational pieces of research on (in)fertility, Franklin’s (1990, 1995) research is grounded in a sociological perspective, which approaches understanding (in)fertility through an analysis of social patterns and behaviors. Sociologists have drawn on narrative research as a method for understanding the structural and political barriers inhibiting women of low socioeconomic status from gaining treatment (Bell, 2010). It is important to note, that while (in)fertility treatment is an expensive procedure, some states, like Massachusetts, have mandated insurance coverage; and yet many women of low socioeconomic status still are unable to receive treatment (Jain & Hornstein, 2005).

Conversely, in approaching (in)fertility from a communicative perspective, this project privileges understanding the *discourse* and *Discourse* of (in)fertility (Putnam & Fairhurst, 2004). The *discourse*, or the everyday talk of the participants, might provide insight into the ways the larger *Discourses* of ideology, assumptions, and power-knowledge relations are culturally standardized. It is through analyzing the *discourse/Discourse* that a communicative approach allows us to examine how communication produces behavior and shapes knowledge. By examining the *discourse/Discourse* in juxtaposition we are more apt to highlight the “competing

and conflicting” discourses that augment selective, hegemonic narratives, while marginalizing others (Mumby, 1997, p. 20). As discussed in Chapter 3, my metatheoretical assumptions privilege a view of communication that is closely linked to the production and (re)production of knowledge as emanating from social interaction.

Overview of Chapters

This dissertation seeks to understand the narrated experience of (in)fertility through a focus on identity/identification, resilience, and social support. Through an explicit adoption of a feminist-interpretivist metatheory, this dissertation seeks to add to the current understanding of how (in)fertility is experienced and build upon the multi-level organizing discourses of (in)fertility.

The remainder of this dissertation is composed of six chapters. In Chapter 2, I introduce my theoretical frameworks and organizing context: narrative, identity/identification, resilience, and social support networks. In Chapter 3, I review my meta-theoretical and methodological engagement and outline my methods of inquiry. Methodologically this study calls on three forms of qualitative data—in-depth interviews, online and auto-ethnographies, and text mining and semantic network analysis—as a means to more fully understand (in)fertility. In Chapters 4, 5, and 6, I analyze dominant findings related to the three areas of theoretical interest. In particular, Chapter 4 addresses moments of loss through examining narratives related to lost and liminal identities, failed resilience, and social isolation. In juxtaposition to Chapter 4, Chapter 5 highlights narratives of hope, drawing on narratives of positive identification, successful resilience, and social support. In Chapter 6, I dive further into in-person and online social support, tracing the evolution of social networks and integrating results from the semantic network analysis in order to portray dominant patterns of discourse within online support groups. And finally, in Chapter 7, I

summarize findings and discuss the study's theoretical, methodological, and practical contributions.

Interlude: Situating the Self

The first time it comes up, I'm sitting on the examination bed, in a sterile room, in the Dana-Farber Cancer Institute, in Boston. The locals refer to this area of Boston, where all the major hospitals are, as 'Hospital Hill.' Here lies a towering landscape of hospitals cluttered together within four blocks.

Before I leave my studio apartment for the appointment, I take careful care in doing my makeup, adding a slight curl to my hair, and putting on a simple sundress. I am hoping to meet a handsome, single doctor in a coffee shop or on the subway, or even in the waiting room; I'm not particularly concerned with the logistics of our meet-cute, so long as it happens. I am 25 years old, and I really want to marry a medical doctor. I am already daydreaming about being a *doctor's wife*, while also being a doctor in my own right. I take the long route to the hospital, the one that has me conveniently walking by the Harvard Medical School. It's a sunny, July day and people are sitting outside, on the grass studying. I walk a bit slower, hoping one of those medical students might look up from his textbook on neurosurgery or pediatric oncology, and see me in my dress and think, *Oh, there is my wife*.

My nurse practitioner, Amanda, who has been my nurse practitioner for 20 years, sits across from me on one of those swivel stools that doctors use to quickly scurry across a patient's room. I am a cancer survivor, and Amanda is my case manager. Every year, or whenever my health insurance supports it, I return to Dana-Farber for a physical. I call these annual physicals 'cancer check-in's' because they are intended to check that my status as cancer-free is still intact. At every cancer check in Amanda reviews my case history.

“So,” she says, “you had stage three Wilms Tumor in your right kidney. It was removed. You had a combination of chemotherapy and radiation.”

“Yes,” I say. I’ve heard it all before.

“Well,” Amanda continues on, “I want to check your AMH levels because there is a chance, with how young you were, and where your cancer was located, that your cancer treatment may have affected your fertility.”

AMH, I later learn, is a hormone used to detect the number of eggs remaining in a woman’s ovaries. Women are born with all the eggs they will ever have, but because of my cancer treatment—which involved sending radiation laser beams into a two-year old body—some of those eggs are gone.

I’m quiet for a moment; I’m not sure what to say. I am 25 years old, and I am single enough that moments before I was scheming a plan to meet a doctor on my way home. I am not ready for children, and I am also not ready for someone to tell me I might never be able to have children.

Amanda attempts to reassure me, “There are a lot of options these days. You don’t even need sperm anymore to freeze eggs.”

I nod, and Amanda fills out the order for a blood test to measure my AMH.

A few weeks later the results come back, Amanda calls me and says that while the results do not look promising, the AMH is often swayed by one’s menstrual cycle; she suggests we test it again, just to be sure.

Six months later, we test it again; my levels have dropped. Amanda refers me to a fertility specialist, and I start down the long, winding road of IVF.

The third time my AMH is tested, I am sitting in the office of a reproductive endocrinologist (RE), a fertility specialist. It is May, eleven months later, and I have just completed the first year of my PhD. The RE sits on one side of the desk, my mother and I on the opposite. I anxiously twist my fingers together as I attempt to control the rising panic in my mind. The doctor pulls up a PowerPoint slideshow to describe the process of fertility treatment and the causes of infertility.

“I like to use this PowerPoint when I give presentations to students, but there is one slide I want to highlight for you,” she says, as she awkwardly rotates her desktop computer to face me. My mom and I lean to the right, and I think of all those times a student comes to my office, sits across the desk from me when protesting a grade. The student sits on the other side of my desk, and I pull up their essay on my laptop, awkwardly positioning the screen between us, allowing the student to see the assignment from my perspective, for them to understand my reasoning for giving them a poor grade. It feels a bit like that, as if my doctor is urging me to see my infertility diagnosis from her medical perspective, and not, as I have been doing, from a wholly emotional mindset.

The slideshow ends and the doctor turns her gaze to me and says, “There are a lot of options beyond IVF and a lot of ways to make a family. There is egg donation and embryo adoption—adoption of any kind. There are a lot of options and people are successful in many ways.”

I avoid eye contact with my mom as I process this information. Almost a year has passed since that hot July afternoon in Boston, when I received my initial AMH test, and I have been hoping things might have changed, that my results might improve. AMH results are highly dependent on your menstrual cycle, or at least that is what Amanda has told me, so, up until this moment, I optimistically preserved my hope. I think to myself; *it is too soon to be considering adoption, we don't even know if I'm officially infertile, right? Right?* I am 26 years old; I am not

looking to become pregnant, but already it feels like the hope to have biological children has been taken away from me. Her words, which my mother later suggests might have been an attempt at optimism, fractured my hope.

I share these two stories, spaced eleven months apart, to not only illustrate the experience of receiving an infertility diagnosis, but to localize the theories I sought to understand through this research project. In the next chapter I map the theoretical foundations of this dissertation; however, these theories were as much selected for their larger relevance to research on (in)fertility, as they were for their bearing on my own experiences.

In receiving an (in)fertility diagnosis, I encountered moments of ambiguity, endured feelings of loss, and questioned my sense of self. During Spring break, for example, sitting on a bus from the airport to my parent's house, the RE's office calls to tell me that my insurance will not cover the RE's visit I had scheduled for later that week. Without insurance, I would need to either pay \$500 or cancel the appointment. I felt trapped. It had been nearly seven months since my initial AMH testing and I was desperate to find a concrete answer. Amanda had warned me that AMH results vary, and that without the inspection by a RE she could not make any concrete judgements on the state of my fertility. I wanted so desperately to have an answer because, if I was infertile, I knew I would need to act soon to preserve my remaining eggs.

But I was a first-year doctoral student and \$500 was a lot of money to spend on a consultation. I could not justify that expense. I broke down. Sitting on the bus, twenty minutes from my home, I started sobbing. I cried on the phone to the doctor's office, as I tried to explain that I was a graduate student, I was low-income, and I had no other options. "What am I supposed to do?" I cried. They were empathetic, but unyielding on the other end of the phone. Next, I called

my mom and cried to her, loudly. I am not a cute crier, I cry with my whole body, and on that bus, sitting alone, I could not stop the swell of tears that ran down my face. I tried desperately to get ahold of myself, I had no tissues and I was still 20 minutes from home, but I could not quell the rising panic in my mind; *when would I ever get answers?*

But emotions and identity are complex and transgressive. Despite my desire for an answer, during those eleven months, I took solace in the idea that maybe I was not infertile, maybe the test was wrong. Without a second opinion, without a second AMH test, I embraced the liminality of my diagnosis. Even sitting in the office of my RE, as she talked through the medical aspects of infertility and I clutched my hands in trepidation, I nonetheless remained stubbornly persistent in my belief that maybe this would not happen. During those eleven months, when I wavered between hope, despair, and confusion, I embraced the liminality as a source of resilience. And so, in mapping my research onto that faded piece of yellow paper, I took careful care to connect resilience to liminality (Appendix A). Even though I am not a post-positivist, and I eschew claims of causality, I unconsciously drew a directional line linking liminality to resilience, as if to emphasize that fragmented identities may not be negative, but rather they may represent a resilient act of self-preservation, an act of preserving against the reality of the situation.

CHAPTER 2: LITERATURE REVIEW

By integrating theories of and empirical work in narrative inquiry, identity/identification, resilience, and social support networks this project attempts to explore how women experiencing (in)fertility develop resilience during treatment, and how resilience is crafted through social support networks. To begin, I review narrative inquiry, paying particular attention to the ways in which personal narratives can be used to understand the organizing experience of a health crisis. It is through an overarching appreciation for personal narratives gathered through participant interviews and aggregated through text mining, that I hope to explore how identity/identification tensions, resilience, and social support networks are constituted as distinguished aspects of the (in)fertility experience. Second, I address theories related to identity/identification. Further highlighting the organizational nature of (in)fertility, I adopt Social Identity Theory (SIT) as the predominant means through which to explore how social interactions and communicative behaviors influence a woman's identity during treatment. Third, I review theories of resilience, with particular attention paid to how resilience functions as a communicative process. Fourth, I conclude with a review of social support network constructs. It is through an analysis of these constructs that I look to understand the relationship between a participant's social support network and her ability to remain resilient in the face of the emotional, physical, and social burdens of (in)fertility.

Narrative Inquiry

A key concern of this dissertation project is the ways in which narratives can be used to more fully understand the (in)fertility experience. Narrative inquiry has served as a popular theoretical framework for health communication researchers interested in understanding health

behaviors and experiences (Hinyard & Kreuter, 2007). Narrative inquiry assumes that, on a most basic level, humans communicate information through storytelling, by relying on identifiable plot points (i.e., beginning, middle, and end), characters, scenes, and conflicts to inform, guide, teach, and inspire (Chase, 2018). Narratives can include fictional and nonfictional stories as well as stories that relate to firsthand experiences, secondhand retellings, and culturally shared descriptions (Schank & Berman, 2002). Narratives are used not only on the interpersonal level, but so too by social and political institutions. In short, narratives are how we learn about the world around us (Woodstock, 2002).

Central to the narrative perspective is an appreciation for the uniqueness of the storyteller. From a theoretical standpoint, narratives provide insight into “socially situated interactions that are embedded in interpersonal, cultural, institutional, and historical contexts” (Chase, 2018, p. 547). Through a focus on intentionality, motives, and the meaningful connections people make, narrative inquiry serves to highlight taken-for-granted assumptions (Sools, 2012).

Organizing through Narratives

It is through narrative inquiry that I explore how narratives contribute to individual women organizing around a shared, social identity. The idea of organizing is deeply rooted within a constitutive approach to communication, which recognizes communication as the predominant means through which organizations are created, designed, and sustained (Putnam & Nicotera, 2009). The conception of organizations as sustained through communication disrupts the notion of organizations as stable entities, instead privileging a notion of organizations as ongoing, interactive, and precarious (Ashcraft et al., 2009). Ultimately, a constitutive approach to understanding organizing recognizes how jointly shared experiences can contribute a collective

sensemaking that is then “(re)produced, (re)incarnated, and (re)embodied” through individual interactions (Cooren et al., 2011, p. 1158).

This study, therefore, looks to examine how the individual narratives can contribute to the organizing of (in)fertility as a shared, social identity. The concept of social identity is further explored in this chapter however, it is through narratives that we can recognize how individuals undergoing the same health crisis may develop the social identity of (in)fertility patients. Narratives have been shown to be a source of organizing for individuals experiencing the same health condition. Ellingson (2017) illustrates how narratives of cancer survivorship—especially those that stem from nonprofit and advocacy groups—contribute to the grand narrative on what it means to be a cancer survivor. These narratives can serve as empowering and inspiring invitations to build a social collective. Health stories can serve as narrative resources that assist individuals and communities in generating resources, including empathy and support.

These narratives serve as a resource around which cancer survivors can organize, and yet they may also problematically exclude those who do not clearly fit within the scope of the narrative. For example, in Barbara Ehrenreich’s (2001) renegade essay she introduces the “Cancer Industrial Complex” (p. 52), through which corporations capitalize and commercialize narratives of breast cancer survivorship. It is through this commercialization that breast cancer narratives not only serve to normalize cancer but so too present a perversely positive, if not enviable, experience. King (2008) found that many women diagnosed with breast cancer feel irritated by these narratives, which exclude patients who do not remain aggressively optimistic about their treatment protocol. This project seeks to explore how similar discourses surrounding (in)fertility affect the patient’s identity, and ultimately her ability to stay resilient during treatment.

Self-narratives, or the stories we tell about ourselves, are key means through which we reconstruct our identities during life transitions and tense identity moments. In their research on employees' identity during work role transitions, Herminia and Barbulescu (2010) found that self-narrative analysis could provide important evidence into how workers transition between old and new identity roles. As Herminia and Barbulescu (2010) argue, narrative stories can help to "articulate provisional selves, link the past and future into a harmonious, continuous sense of self, and enlist others to lend social reality to the desired changes" (p. 138). In short, narrative inquiry allows researchers to understand how participants communicate their identity negotiation process. For women undergoing (in)fertility treatment, this identity negotiation may be a central component of their treatment process, therefore I next introduce the theoretical contributions of identity/identification.

Identity and Identification

Central to my concern for the lived experiences of women suffering through (in)fertility lies a concern for the social identities and identification process of (in)fertility treatment. Identity can be examined at multiple levels and through various lenses, but social identity theory (SIT) posits that identity is built through identification with others in the social world. Ashforth and Mael (1989) define identification as the "perception of oneness with or belongingness to some human aggregate" (p. 135). Thus, it is through the identification process that social identities are formed. While identities can provide a stable and coherent sense of self, they are typically understood as under constant negotiation as roles and experiences change or challenge our self-conception (Alvesson et al., 2008). Because of the fragmented perspective of identity, SIT understands identities as patterned and regular, but also as temporary, context-sensitive, and evolving (Ashforth, 1998; Gioia et al., 2000).

Social identity is the sense of self people gain through their membership in social groups (e.g., family, work, community) (Tajfel, 1978; Tajfel & Turner, 2004). Tajfel and Turner (2004) define groups as “a collection of individuals who perceive themselves to be members of the same social category, share some emotional involvements in the common definition of themselves, and achieve some degree of consensus about the evaluation of their group and of their membership to it” (p.59).

Inherent within the SIT approach are three key assumptions. First, SIT assumes that people generally strive to achieve or maintain a positive sense of self. Second, SIT is most often defined in terms of an individual’s group membership. And third, when a social identity is salient, individuals will strive to maintain a positive social identity by differentiating their own group (i.e., the in-group, such as women undergoing (in)fertility treatment) from other groups (i.e., out-group, such as women who are able to conceive spontaneously) (Tajfel & Turner, 2004). Thus, individuals will strive to maintain or construct a positive comparison of their group to other groups because members gain self-esteem through their group. Self-esteem, on a most basic level, is understood in relation to how outsiders perceive the group (Cooley, 2004).

Individuals may seek to reconcile their personal identity with the social identity of their group. Because of the complex, fragmented, and occasionally contradictory nature of social identities, Alvesson, Ashcraft, and Thomas (2008) introduce the concept of ‘identity work,’ which they describe as “the ongoing mental activity that an individual undertakes in constructing an understanding of self that is coherent, distinct, and positively valued” (p. 15). Research into identity work is concerned with the self-narratives individuals tell about themselves as they recall memories, cultural resources, and desires in an attempt to communicate a more coherent identity (Knights & Willmott, 1989; Sveningsson & Alvesson, 2003).

Identity work also allows individuals to make sense of the world around them. SIT argues that identity serves as a major resource for how individuals make sense of the world (Gephart, 1996; Weick, 1995). As Ashforth and Mael (1989) contend, social identities not only provide answers to *who* one is, but also *where* one is, and *what* is expected of them. Sense-making is fundamentally a communicative process through which researchers have been able to uncover how social identities are constructed for new members (Alvesson et al., 2008; Boyle & Parry, 2007).

While SIT is often considered a socio-cognitive process, communication researchers (Scott, 2007) have begun to explore the ways in which social identities are communicatively developed. Scott, Corman, and Cheney (1998) argue that central to the production, expression, and maintenance of social identities is social interaction; and it is through social interaction that identities are expressed discursively and differences between identity groups are developed (Kuhn & Nelson, 2002).

Understanding identity through narrative inquiry offers the ability to reconcile identity with the cultural, ancestral, and mythic conceptions of fertility. As Jensen (2016) highlights, (in)fertility is often located within an individual woman's agency to choose and yet, women also receive a cultural message of their "duty" to bring forth a child (p. 38). As social identity theory highlights, these societal messages on roles and statuses are reinforced through interaction and communication with others.

A narrative approach can help shed light on the rhetorical influences of identification. Through an analysis of narratives, Kirkman (2003) found that women who have used assisted reproductive technologies but have failed to produce a child are likely to mourn the lost identity that connects their womanhood to motherhood. Moreover, these women may often be forced to

reconstitute, and thus redefine, their identity as a woman in a society that privileges the view of all women as mothers (Kirkman, 2003).

Identities and Health

Identities, and moreover the groups that foster identification with identities, can serve as instrumental resources in overcoming health problems. When social relationships are neither conflicting nor ambiguous, perceived as neither overwhelming nor burdensome, but rather based on cooperation, trust, and support, research (Sani, 2011) suggests that those relationships can be positively linked to good health and well-being. Sani (2011) considers social relationships as closely linked to groups (i.e., families, schools, teams, organizations, communities), arguing that the extent to which one identifies with the group will, in part, determine the curing benefits the group offers.

Groups are conceived as an outcome of social identification. As SIT argues, the group will emerge when people perceive themselves as sharing a sense of identification with other members of the same social category (Turner, 1982). Individuals are more likely to offer help or assistance to a person when that person is a member of their in-group (Levine et al., 2005).

Social identity groups can provide a framework through which to instill positive health behaviors in individuals. Past research (Osyeran et al., 2007) has found that individuals engage in health behaviors that are consistent with the normative behavior and beliefs of their group. Engagement with these behaviors can be identity-affirming (Osyeran et al., 2007; Tarrant et al., 2011), thus assisting in a stronger identification with the group. Of course, groups can also promote negative health behaviors. Even if a group encourages positive health behaviors (i.e., exercising, visiting the doctor), the same group may also encourage behaviors that undermine health (i.e., excessive alcohol consumption).

Identity Tensions

Communication researchers have added to the complexity of SIT by acknowledging that individuals may embody multiple, competing identities. Of course, by comparing the difference of identification levels across groups, this perspective fundamentally alters “the common treatment of social identities as already coherent, ready-made or virtually self-evident objects or templates of affiliation” (Alvesson et al., 2008, p.14). Identities, for example, may be called forth and activated by different roles, activities, or settings (Ashforth & Mael, 1989). Moreover, past research (Bullis & Bach, 1989; Dutton & Dukerich, 1991) has consistently found that experiencing new events can alter previously stable identities. Communication researchers recognize that identities are situated within certain activities (Scott et al., 1998; Scott & Stephens, 2009). That is to say that an individuals’ identity may be called forth, or made more salient, when interacting with others who share that social identity. Likewise, an individuals’ identity is situated within their own lived experiences, which may influence their ability to identify with certain identities (Stephens & Dailey, 2012). Recognizing that identities may be fluid adds to a “growing trend in communication-based identity scholarship”, wherein identities are understood as “situated, changing, and even fleeting” (Stephens & Dailey, 2012, p. 413).

Accepting this fluid understanding of identities as tenuous and situated also allows us to understand the many competing tensions placed on identities during the identification process. The project focuses on three types of identity tensions: the management of multiple identities; stigmatized identities; and, liminal identities, as potential tensions experienced by women receiving (in)fertility treatment.

A central argument of SIT is that identities are multilayered, allowing individuals to move between their personal and collective selves depending on the social interaction in which the individual is involved. Accepting this situated nature of identities has encouraged researchers to

develop multiple theories in order to explore how individuals negotiate the boundaries of managing multiple identities, yet communication researchers tend to focus on the importance of salient identities. During times of identity stress, where individuals are attempting to negotiate multiple identities, social interaction can serve to call forth and make specific identities more salient than others (Hogg & Terry, 2001). This argument suggests that communication is the primary means through which individuals choose to identify with one identity over another (Hogg & Reid, 2006; Scott, 1997).

Many researchers have highlighted the assortment of identities used to describe (in)fertility patients. Letherby (2002b) suggests that these various nomenclatures may present a “profound shock to some individual’s sense of self,” which can result in a challenge to the woman’s identity (p. 279). For example, women will often choose between the identity of ‘infertile,’ which emphasizes a biological condition, or the ‘involuntarily childless’ identity, which suggests a social experience connected to motherhood (Letherby, 2002b). Women experiencing fertility problems are forced to negotiate between these two identities as they seek to understand their diagnoses in relation to their self-concept.

Likewise, it is important to consider how (in)fertility patients negotiate multiple identities by analyzing which identities are made more salient. Daly (1988) stresses that the salience of the parenthood identity will determine the course of action an (in)fertility patient pursues (i.e., continued IVF treatment, egg or sperm donation, or adoption) in order to fulfill their identity desire. That said, research (McQuillan et al., 2003) has challenged the assumption that fertility impairment necessarily equates to childlessness, suggesting that (in)fertility is an identity on a continuum of childlessness that spans across experiences. It is important to remember that not all fertility patients are childless, in fact, the National Infertility Association, Resolve, estimates that secondary

(in)fertility accounts of 30% of all (in)fertility cases (Resolve, 2019d). Women may therefore have a choice for which identity to adopt, choosing that which best describes her self-concept as it relates to the social experience of (in)fertility treatment.

A second potential source of identity tensions for (in)fertility patients is the effects of a stigmatized identity. Stigma is defined as the relationship between an attribute (i.e., the inability to naturally conceive children) and discrimination based on an identity stereotype (Goffman, 1963). Stigmas are social constructs, which are most often attached to cultural beliefs that reproduce negative stereotypes; however, stigmas are highly contingent on social, economic, and political power (Link & Phelan, 2011). Moreover, stigmas require daily identity management to avoid stigma-based identity threats. Past research (Dahnke, 1982; Miller & Kaiser, 2001) suggests that stigmas can lead to negative outcomes, including devalued social identities, prejudices, stereotypes, and other forms of discrimination. One possible way stigma-based identity threats can be managed is through social buffers, such as surrounding oneself with in-group members (Meisenbach, 2010).

The development of stigmas may, in part, be due to the communication of stigma messages. Stigma messages are those which communicate a degree of responsibility or blame on the person experiencing the stigmatized illness for their membership in the stigma group (Smith, 2007). A number of researchers have highlighted the social pressures women feel to have children, especially those societal expectations that suggest women should be able to bear children naturally (Jensen, 2016). For example, (in)fertility patients often feel a high degree of guilt or grief as a result of cultural norms and governmental policies that encourage a ‘pro-birth’ rhetoric (i.e., income tax reduction; Whiteford & Gonzales, 1994).

Women who experience a stigma associated with (in)fertility may experience a number of ill-effects, including anger, depression, frustrations, feelings of loss of relationships, and a negative

self-image (Whiteford & Gonzales, 1995). Likewise, stigmatized identities may encourage individuals to remain silent about their health condition. Meisenbach (2010) theorizes that while individuals may accept their stigmatized identity, they may remain passively silent and thus refrain from telling others about the diagnosis unless asked. Individuals may also avoid the stigma identity through secrecy and social withdrawal (Markowitz, 1998).

Stigmas are closely related to group membership, and individuals who have a stigmatized identity may be forced out of the group if the stigma is perceived to lower the group's perceived esteem. Past research (Neuberg et al., 2000) has argued that "people [stigmatize] those individuals whose characteristics and actions are seen as threatening or hindering the effective functioning of their group" (p. 34). Group members may feel the stigmatized individual threatens resources and interferes with group norms (Neuberg et al., 2000). Because Tajfel and Turner (2004) suggest that group membership is closely linked to self-definition, if group members feel the group is viewed negatively, then the group members may consequently experience a negative sense of self (Cohen & Garcia, 2005).

While (in)fertility is becoming an increasingly common diagnosis, for many women it continues to remain a stigmatized disease. Research (Jensen, 2016) has highlighted the social pressure women feel to have children, especially the social expectation that women should bear children naturally and without medical intervention. In fact, the rhetoric surrounding natural conception has become so pervasive that many women experiencing (in)fertility prefer the term "spontaneous conception" in order to diminish the normalized assumption that natural conception is standard. For example, cultural and religious expectations (Bharadwaj, 2003; Whiteford & Gonzales, 1994) have been identified as sources of stigma for women, because they communicate that married women are failing to fulfill a cultural norm. For many women the pressure and grief

associated with not having children is so strong that they may feel an inability to proceed with their lives as normal (Griel, 1991). Pfeffer and Woollett (1983) argue that once a woman finds herself “involuntarily childless, all other identifying markers are washed away,” further amplifying her stigmatized condition (p. 82).

News coverage and ethical debates surrounding the science of assisted reproductive technologies have also contributed to the perception of (in)fertility as a stigma. Especially in the 1990’s and early 2000’s, during the height of IVF’s development, rhetoric surrounding ‘mad scientists,’ ‘designer babies,’ and, ‘savior siblings’ (Bryld, 2001; Lemonick, 1999; Murray, 2014) contributed to growing cultural fears of women who sought out medical assistance for infertility. Because IVF allows parent(s) to know the sex of their baby prior to implantation, public controversy arose surrounding the parent(s) ability to ‘pick and choose’ their child’s gender. Of course, IVF is so rarely successful that these debates do not accurately reflect the true experience of receiving treatment.

Finally, an important consideration of this dissertation is the influence of liminal identities during (in)fertility treatment. Liminality is the state of in-betweenness and ambiguity a person feels when transitioning between two identities, yet occupying neither (Beech, 2011; Turner, 1967). The transition from one identity to another is often marked by rituals and normative behaviors (Turner, 1967). The first phase of the liminal ritual is marked by a ‘triggering event.’ Woods and Carlyle (2002) found that the participants often describe the liminal experience as ‘hitting rock bottom,’ suggesting the triggering event can be catastrophic or emotionally traumatic. Turner (1974, 1967) suggests that after the triggering event, individuals will often be required to adopt certain rules of conduct, often performed at specific places or during a specific period of time. The transition from childhood to adulthood, for example, is often described as a ‘rite of passage,’ where

certain cultural events (i.e., Bar and Bat Mitzvahs, debutante balls, graduations) are used to mark the beginning of the transitional stage (van Gannep, 1960).

Like the triggering event, liminality is often guided by symbolic rituals. Dentice and Dietert (2015) illuminate the ritualized nature of liminality through their study of transgender individuals, finding that certain events, including changing their name, cutting or growing their hair, or taking hormone therapy, functioned as ritualized acts that served to mark the change in gender. However, this process can also be fraught with feelings of failure, shame, rejection, and ostracization (Lucal, 1999; Tigert, 2001). The liminal transition often signifies a separation from one's everyday routine. Unfortunately, separation from routine can further encourage social withdrawal (Atkinson & Robson, 2012). The development of new social groups, though, may offer necessary emotional support for individuals who can hear and learn from others' successful stories of transition (Dentice & Dietert, 2015).

More recent research into liminality has modified Turner's original conception by considering the transition not as an abrupt change, but rather as a gradual integration of a new identity. This slower transition is especially prevalent in research on identity/identification online. For example, Madge and O'Connor (2005) investigated how new mothers participated in online communities in order to discursively 'try out' different versions of motherhood. Likewise, research has explored how physical spaces can serve as liminal spaces of blurred boundaries. Prison visiting rooms, for instance, are liminal spaces where boundaries between the inside world of the 'total institution' and outside world of freedom meet, where, for example, visitors and prisoners congregate (Moran, 2013). Moreover, these visiting rooms can be considered both static and repetitive while also temporary and transient, further challenging the conception of liminality as an abrupt transformation.

Within research on health, liminality is often experienced when individuals receive negative or inconclusive test results. For example, women who receive ambiguous pap smear results (i.e., neither health nor disease is confirmed), often experience a distorted sense of self (Forss et al., 2004). Liminality is experienced when women go from expecting a confirmation of health to receiving ambiguous news. This unexpected ambiguity wreaks havoc on a woman's self-perception (Forss et al., 2004).

Because negotiating multiple identities, stigmatized identities, and liminality can all contribute to feelings of shame, guilt, and social ostracization, resilience is considered as a second theoretical framework through which to more fully understand the narrated experience of (in)fertility.

Resilience

(In)fertility experiences have been known to demand a high degree of resilience (Herman et al., 2011; Ridenour et al., 2009; Yu et al., 2013). For example, the (In)fertility Resilience Model (IRM) suggests that the interconnectedness between individuals, couples, and external factors (i.e., environmental influences; medical prognosis; treatment duration; interpersonal and familiar social support; and, cultural and religious influences) can be used to evaluate and promote resilience in couples undergoing (in)fertility treatment (Ridenour et al., 2009). Past research on (in)fertility has centered on understanding the process of how resilience is formed through either an analysis of the protective psychological factors (Herman et al., 2011) and coping strategies (Sexton et al., 2010) and their relationship to the patient's well-being and quality of life. However, by adopting a communicative approach to resilience this dissertation project seeks to understand how resilience is fostered through discourse.

My understanding of resilience builds on three definitions, which together construct a clearer picture of the non-linear resilience process women may undergo during (in)fertility treatment. I begin with the definition introduced by Vanhove, Herian, Perez, Harms, and Lester (2016), in which resilience is conceived not solely as the ability to bounce back after a stressful or traumatic experience, but moreover as “sustained functioning . . . in the face of comparably mundane stressors that exist on a day to day basis” (p. 15). Because (in)fertility treatments are an experience that can last years (Forrest & Gilbert, 1992), conceiving resilience as a method of sustained functioning serves to provide greater insight into the prolonged, day-to-day endurance of treatment. The Vanhove et al., (2016) definition also highlights my conception of resilience as a process, rather than an outcome, which can ebb and flow depending on the vulnerability and protective factors available. However, it would be unfair to frame (in)fertility as a “comparably mundane stressor” because as research shows (Herman et al., 2011), (in)fertility treatment is a time filled with heightened physical and emotional stress.

To address the gaps in the Vanhove et al., (2016) definition, I also incorporate Buzzanell’s (2018) definition of resilience, wherein resilience is defined as the ability to “foster productive change during and after losses, setbacks, disasters, and other obstacles” (p. 14). Buzzanell’s (2018) definition places greater emphasis on the losses, setbacks, and constant medical obstacles that women undergoing (in)fertility treatment endure. Certainly, (in)fertility is an experience fraught with setbacks, losses, and consistent financial, emotional, and communicative obstacles. For example, past research (Allison, 2011) suggests that women undergoing (in)fertility treatment will remain silent about their treatment, and consequently feel more isolated and alone (Hinton et al., 2010). Moreover, Buzzanell’s (2018) use of the phrase “productive change” emphasizes the potential acts that women may take to create and sustain resilience. In short, this definition

provides women with agency during a treatment cycle where they may feel they lack none. As I will later discuss, much of the research on resilience is coordinated around communicative acts, like seeking social or informational support, therefore through investigating what communicative changes women adopt we can better understand how communication aids in the constitution of resilience.

However, neither of these two definitions explicitly situate resilience as a communicative experience, nor as one that is closely linked to identity/identification. Therefore, in understanding resilience as fundamentally a communicative phenomenon, I also adopt Agarwal and Buzzanell's (2015) perspective, wherein resilience is constructed by and through communication. With this specific emphasis on communication, resilience is conceptualized as a social construct, something that is "created, sustained, and enhanced" (Afifi, 2018, p. 7) through discursive and material factors (Buzzanell, 2010).

Agarwal and Buzzanell (2015) posit that resilience is communicatively crafted through stories that "foster productive narratives, identities, and networks" (p. 411). Buzzanell (2010, 2018) also provides a framework for understanding the key communicative processes that are triggered by a loss or setback. It is during the loss or setback where individuals attempt to adapt or transform their experience through resilience. These five communication processes include: crafting a new normal; affirming or anchoring important identities; using and/or maintaining communication networks; employing alternative logics; and, foregrounding productive logics.

In understanding resilience as a communicative process, rather than as a trait, I hope to present ways in which resilience can be viewed as empowering, instead of deficit-based. Further, viewing resilience as a process conforms to this project's feminist-interpretivist meta-theoretical lens, by recognizing that people will enact the process differently depending on their unique

circumstances. However, a process perspective also allows us to understand how resilience can be modeled, changed, and learned from over time.

My interest lies specifically with the third communication process outlined by Buzzanell (2010/2018): affirming and/or anchoring important identities during difficult times. Identity anchors aid in providing stability by offering a “relatively enduring cluster of identity discourses upon which individuals and their familiar, collegial, and/or community members rely when explaining who they are for themselves and in relations to others” (Buzzanell, 2010, p. 4). Identity anchors are thought to be an important aspect of constructing and maintaining resilience (Agarwal & Buzzanell, 2015; Villagran et al., 2013). Buzzanell and Turner (2003) explain that identity anchors can be beneficial to overcoming experiences fraught with uncertainty. Identity anchors serve to emphasize and redefine other key identity roles the individual holds to align with their needs in that specific context and time. In part, this research examines identity anchors as a potential source of resilience for women undergoing (in)fertility treatment.

It is through Buzzanell’s (2010/2018) perspective that resilience is understood as a means of fostering and promoting stable identities when identities are otherwise tenuous. However, my dissertation builds on Buzzanell’s (2010/2018) work on the relationship between identity and resilience through the integration of theories pertaining to social support networks.

Social Network Constructs

Individuals may often turn to family or friends to help them cope with the stress of infertility. Past research (Birditt & Antonucci, 2007; Felmlee & Sprecher, 2000) has found that when (in)fertility patients turn to network members, particularly friends, they will experience increased marital satisfaction and higher personal well-being. However, while it would behoove individuals to turn to friends and family members when navigating infertility, there are a number

of potential negative consequences that prevent women from discussing their (in)fertility treatment with others. Reproduction, for instance, is a deeply personal topic and individuals may consider the medical, financial, or emotional details of treatment too sensitive to disclose to friends and family (Steuber & Solomon, 2011). Understanding the composition of social networks, therefore, is incredibly important to understanding the holistic experience of women undergoing (in)fertility treatment.

Past research on the relationship between (in)fertility and social networks has focused on stigma, communication efficiency, and closeness as moderating the choice to disclose a health diagnosis to social network members (Steuber & Solomon, 2011). Additionally, perceived social support and positive coping has been found to promote resilience and positive psychological changes (Yu et al., 2014). However, less research has sought to understand how network constructs, including social support and social capital, are communicated to women at the individual level and how these constructs, in turn, promote resilience.

Personal (ego-centered) networks provide a useful framework for understanding the structural characteristics of three core network constructs: social networks, social support, and social capital. Conceptually, these three constructs have been studied in the context of one another, however they are operationalized differently, allowing for a more holistic understanding of how an individual develops resources through their personal network (Borgatti et al., 1998). Additionally, there has been recent attention paid to how these three constructs work together to promote a positive well-being (Lee et al., 2018; Zhu et al., 2013) and resilience (Doerfel et al., 2013).

Social Networks

The theory related to social networks was developed by sociologists as a method to describe the structures of relational ties between individuals (e.g., Burt & Minor, 1983; Marsden & Lin, 1982; Wasserman & Faust, 1994). These relational ties are typically used for the transfer of resources, including money, material goods, emotional support, and information (Visser & Mirabile, 2004). However, by privileging a network perspective, social network analysis seeks to understand not only the characteristics of individuals in the system, but so too the relational system in which actors are embedded. In other words, a networks perspective encourages examination of how resources flow between actors at the micro, meso, and macro levels.

Personal networks are most frequently studied through a structural approach, which includes network range and network composition. An individual's interpersonal environment has network range in so much as she is able to connect with other actors (i.e., alters) (Burt, 1983). Range can include a number of measurements, such as size, density, homogeneity, dispersion, span, reachability, and anchorage (Marsden, 1987). On the other hand, network composition is concerned with the level of diversity among alters in a social network (Marsden, 1987, 1990). Particularly, network composition considers the type of alter (i.e., friend, family member, co-worker, consultant, group member, or doctor) and how the type of alter influences the other network constructs of social support and social capital.

Understanding the structural properties of an individual's social network can shed light on the individual's well-being (Lin & Ensel, 1989). For example, when individuals have a dense personal network in which they are highly connected and involved, research suggest that these individuals will have higher emotional well-being (Acock & Hurlbert, 1993) and report stronger feelings of belongingness (Lee et al., 2018; Lin, 1999). Moreover, past research (Cohen, 2004) suggests that individuals gain a positive sense of social identity and security through their

interpersonal ties. Thus, in understanding the form and content of an individuals' social network, researchers will be better able to gauge how a woman remains resilient during the stress of (in)fertility treatment.

Social Support

A second network construct frequently considered is the role of social support. Researchers have long sought to understand the role of social support within health communities. Perceptions of social support, for example, can positively influence the physical and mental health of patients (Cohen & Syme, 1985). Additionally, health communities which provide empathy as a form of social support, can be critical for enhancing a patient's compliance with treatment protocol and can quicken the pace of healing (Nambisan, 2011).

Particularly for women experiencing infertility, social support can be incredibly important. Research suggests that social support networks online (Malik & Coulson, 2008a) and offline promote resilience and positive coping for women (Yu, et al., 2014) and men (Malik & Coulson, 2008b) undergoing (in)fertility treatment. Social support may, for example, help lower distress in women facing (in)fertility (Dunkel-Schetter & Stanton, 1991), however, some forms of social support—especially from family and community members with children—may present a source of strain (Ridenour et al., 2009). In a community sample of (in)fertile women, social support was found to diverge between a woman's desired amount of support and the amount of support she received from spouses, friends and family members, medical professionals, and online groups (High & Steuber, 2014).

There are, of course, different forms of support. Xu and Burleson's (2001) typology of social support includes informational, emotional, esteem, network, and tangible support. Informational support includes providing factual information or advice, which can include

recommending a doctor or medical resources. Emotional support involves expressions of solidarity and empathy and is often considered “one of the most, if not the most, desired types of support provided by close relationship partners” (Burleson, 2003, p. 2). Esteem support is most often coded as that which enhances an individual’s self-worth through messages that emphasize respect and promote confidence. Network support is closely linked to network range, with support developing as an individual’s social network recommends new contacts. And finally, tangible support is the type of support that provides practical assistance, which could include money, assistance with house chores, or driving women to appointments.

Research on resilience suggests that individuals undergoing stress will be more likely to focus on provisional support, rather than mobilized support. In other words, individuals will call on social support as a means of ‘getting by,’ rather than ‘getting ahead’ (Elliott et al., 2010). For women suffering through the prolonged treatment, this form of social support may be most useful for understanding how resilience is crafted.

Social Capital

The third network construct analyzed through the study of ego networks is social capital. Social capital is conceptualized as “the consequences of investment in and cultivation of social relationships, [which allow] an individual access to resources that would otherwise be unavailable to him or her” (Glover et al., 2005, p. 87). Social capital aids in the coordination and cooperation of resources between people (Woolcock, 2001). Social capital is dependent both on personal characteristics of the ego (i.e., age, gender, education, and/or occupation) and environmental contexts (i.e., location, disruptions to routines, and/or natural disasters) (Lee, Sadri, Ukkursuri, Clawson & Seipel, 2019).

An individual's access to social capital can be particularly fragile during stressful life events, which may encourage individuals to seek social capital elsewhere. Bridging refers to connections that are built through a far-ranging network, which allows individuals access to external opportunities. Bridging includes weak ties, which provide egos access to diverse social groups and new resources. On the other hand, bonding refers to the social capital emanating from strong ties that are rooted in a cohesive community, where trust and intimacy are high (Putnam, 2001). Bonding includes strong ties, especially within a homogeneous group (Beaudoin, 2009). Both forms of social capital—bridging and bonding—can contribute to positive well-being (Lee et al., 2018) as well provide important sources of emotional and informational support (Lin, 2001).

However, there is some debate that despite the number of benefits social capital produces, it can also produce negative health outcomes. Portes and Landolt (1996) suggest that social capital can contribute to individuals feeling a high degree of pressure to conform to group expectations, leading to feelings of ostracization if they do not conform. Likewise, these group norms can contribute to individuals feeling overwhelmed by obligations. For example, women experiencing (in)fertility may experience high degrees of guilt or grief because of cultural or religious expectations that they should be able to bear children (Jensen, 2016).

Present Study

Through integrating theories related to narrative organizing, identity/identification tensions, resilience, and social support networks this study contributes to an interdisciplinary conversation on how women experience (in)fertility treatment. Recognizing that (in)fertility may result in a fractured sense of self, this study focuses on resilience as a means to overcome tenuous identities and social support networks as a source of fostering resilience. Resilience is crafted communicatively through attention to narratives and networks (Buzzanell, 2010/2018). Thus,

through linking these theories interdependently (Figure 1), I present a deeper, more complex, yet recognizably partial, understanding of the lived, embodied experience of (in)fertility.

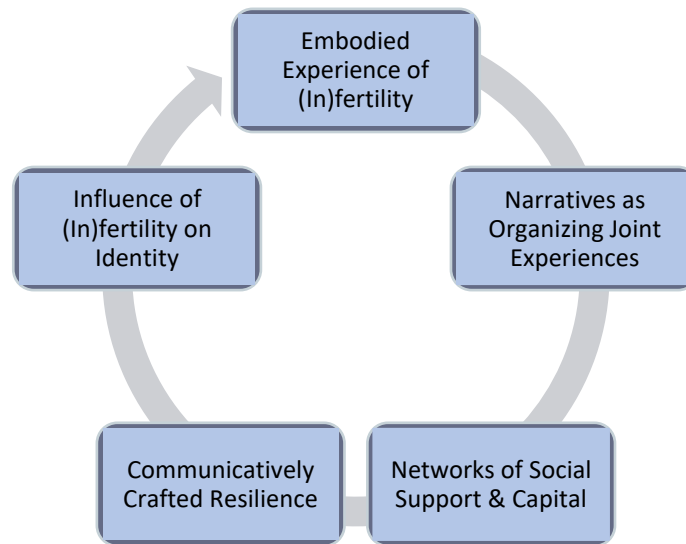


Figure 1. : Theoretical Interdependence

As is discussed in Chapter 3, the methodological and theoretical composition of this study is attuned to the individual experiences of (in)fertility. Where past research has sought to draw generalizations, crystallization prompts us to consider the value of individual stories and experiences as drawing to a more in-depth representation of the (in)fertility experience. In particular, recognizing that across disciplines scholars, practitioners, and patients echo that (in)fertility demands resilience, this project is particularly attuned to modeling resilience through consideration of narrative, networks, and identities. Through the guiding frameworks of identity/identification, resilience, and social support, this study examines the following research questions:

RQ1: How do personal narratives of (in)fertility contribute to the organizing of the (in)fertility identity?

RQ2: How are tenuous identities communicated during (in)fertility?

RQ3: How is resilience developed during (in)fertility?

RQ4: How do the social network constructs interactively contribute to resilience?

RQ4a: How does social support evolve over the course of a woman's (in)fertility treatment?

Interlude: Anger

During the summer between the first and second year of my doctoral program, I become increasingly stressed. I am on edge, easily irritated by even the most mundane of occurrences. In the Walmart parking lot, for example, rushing home after a quick pit-stop to pick up cookie dough for our weekly Shabbat, I honk and swerve around a group of pedestrians loitering in the parking lot. I take their slow, meandering walk to their car as a personal offense. "I have places to be!" I furiously mutter under my breath. Later that night I have a panic attack in bed; *I put people in danger*, I cry to myself. I pray for forgiveness, patience, and answers.

Later that month, on my 27th birthday, I post a blog post, publicly sharing the news of my (in)fertility. It has been one year since that initial AMH test, four months since the confirmation test, and while I know I need to freeze my eggs, I also know that I cannot afford to. I am stuck and I am confused; do I really spend all of my savings on fertility treatment? Is that financially advisable for the peace of mind and partial assurances for my future? On my blog I try to explain this mounting panic:

My graduate student health care, the plan that I will hold for the remainder of my 20's, doesn't allow me to explore fertility options. It doesn't even allow me to get a test that would provide the peace of mind I'm desperate to receive. A test that would simply say, *Hey, it's ok to wait and deal with this fertility stuff until after you have a Dr. in front of your name.*

I have given up my 20's to become a PhD, but I keep asking myself: at what cost? It's obvious my institution doesn't care about my well-being, or they would offer a more comprehensive plan. After all, who needs fertility assistance more than

graduate students, the majority of whom are at the peak-to-end of their fertile years?

I am angry with the system, with my reality, with the hand that I have been dealt and that anger warps its way into every crevice of my life.

Two days later, on a hot July afternoon, I am sitting in a graduate seminar, irritation brewing under my skin. In following the plan I established at the start of my PhD program, I take extra summer courses in hopes of graduating early. Just as I arrived with a plan for ensuring success in my PhD, I enter the summer semester with equally stringent goals. I view each course and each assignment as building blocks for my future. Before the summer semester begins, I spend an afternoon carefully pouring over syllabi, connecting the theories and methods we would learn to my upcoming preliminary exams. I want to ensure that the courses are worthwhile and that they will serve me in my pursuits. I am focused, but I am also overburdened by feelings of anxiety and dread as I try to process my fertility in light of my recent birthday. I am 27 and as each month passes, I am reminded of my lessening egg count. Treatment feels increasingly essential but inaccessible.

And so, as these feelings converge—of overwhelming pressure and focus—I become ever more petulant. It all comes to a head in seminar where, once again, I notice the class conversation veer off track. “I am so tired of this,” I text my friend, “every day the conversation goes off topic and the professor tries to keep us grounded in the theory, but when it’s off topic I learn nothing. It is excruciatingly obvious that no one has done the reading, so they’re just making uninformed arguments that are grounded in nothing but their own thoughts. What’s even the point? How is this helping anyone learn anything?” I am so depressed by the mix of fertility woes and graduate pressures that I let loose, chastising my classmates for their continued disregard for the theory at

hand. “Your arguments don’t make sense!” I say, “What are you even talking about? How does this relate to research methods *at all*?” It becomes quickly apparent, by the awkward silences and shifting eye contact, that I have overstepped and offended. I walk out of class quickly, stuffing my books into my bag as I dial my mom. I cry on the phone, with shallow breathing and a rapid heart rate that characterize my panic attacks. I try to process my feelings, as I attempt to understand what happened. This moment stays with me for years, a representation of the Irish temperament written into my DNA converging with the extreme stress, unending fears, and mounting pressures of my personal and professional lives.

(In)fertility pervades every experience; it is the silent, ever-present character in the background. The grief, anxiety, and anger that many women carry with them throughout (in)fertility is coupled only by a lack of social understanding (Fassnio et al., 2002). That summer I published to my blog because I needed people to understand what I was experiencing, but I also struggled to find the right words. *How do I make people understand what this is like without appearing wholly narcissistic*, I ask myself? On the one hand, I was angry at the system that had routinely denied me fertility coverage. Even though I could draw a straight causal connection between my (in)fertility and cancer, health insurance did not seem to recognize late-term cancer effects as real.

On the other hand, my anger was warped by omnipotent fear. That summer, for example, as I drive home with my mom after a visit with my grandmother at her assisted living facility, I share my deepest anxieties. “If I don’t have children,” I whisper to her, afraid that speaking it any louder might render my words reality, “who will take care of me if I’m like Grammie?” My grandmother has advanced Alzheimer’s, she needs constant supervision and my mom retains

power of attorney, advocating on her behalf to doctors, resident supervisors, and case workers. If my grandma runs out of toilet paper, it is my mom that places the order on Amazon. If my grandma must see a cardiologist for her heart palpitations, my mom is the one who schedules the appointment, reviews her existing medications with the doctor, and keeps my grandma calm throughout it all. I see and admire the work my mom does on my grandmother's behalf, but I selfishly begin to worry that if I do not have children then there will be no one to look after me in my old age. My mom nods, sharing that she has occasionally had similar fears for me.

I always envisioned myself as a mother. In many ways my entire life has been structured around becoming a mother. As a young girl, I loved the 'realistic' babies that cried when needing a diaper change. I fantasized about having a daughter to name after my great-grandmother, Elsie, or maybe my great-great-great-great grandmother, Sophie. As a teenager, in our pre-confirmation classes at church, the priest told us that we had two vocational options: the religious calling of the nuns, or the calling of motherhood. At 16, when I overheard my dad tell my Great Aunt Billie that he thought I would become a nun, I knew he was wrong; I wanted to have a child instead.

Calling is often considered in the context of vocation and career (Berkelaar & Buzzanell, 2015). Even when considered alongside motherhood, calling is frequently framed as a choice between the two (Schermer Sellers, Thomas, Batts, & Ostman, 2005). Motherhood, and the potential to attain it, is so deeply embedded within our cultural and religious discourses that rarely do we question or doubt our own abilities. Losing the potential for that identity, losing the hopes I had built around the motherhood experience, was devastating. During the nearly two years that I attempted to secure funding for fertility preservation, I was continually wrought by panic attacks as I envisioned a life without a child.

Throughout all of this, even after I underwent fertility preservation, I continue to ask myself that same question, the question that plagued me during the summer of anger and vitriol: *How do I make people understand what this is like without appearing wholly narcissistic?* And then a global pandemic happened and suddenly I had an analogous crisis, experienced by everyone, that could perfectly encapsulate the feelings of grief, uncertainty, and ambiguity that plague (in)fertility.

In regard to the panic and anxiety surrounding COVID-19, Damon Linker (2020), a columnist for the magazine and website *The Week*, wrote this about passage of time in the midst of static uncertainty:

Human beings live their lives in time. Our sense of ourselves in the present is always in part a function of our remembrance and constant reinterpretation of our past along with our projection of future possibilities. *We live for* the person we hope to become. *We look forward to* who we will be a month or a year or a decade or more from now—and we commemorate the transitions from present to future with rites of passage celebrated in public with loved ones and friends. This makes us *futural* creates. [Emphasis as appears in original text]

During COVID-19, as our lives are disrupted, graduations cancelled, weddings delayed, and funerals abandoned, we are forced to renegotiate our plans. In the midst of COVID-19 every person is forced to put off plans, cancel ceremonies and rites of passage. Even as I write this, and restrictions around COVID-19 begin to wane, and the world slowly creeps back to “normal,” we also are all aware that it will likely come back, that this is merely a moment of quiet reprieve. COVID-19 is reaped with uncertainty and stagnant time; (in)fertility is like that too. (In)fertility is built around competing tensions of mourning a lost identity and hoping beyond hope for success. (In)fertility is a waiting game as months and years pass without success. There is no finite answer in (in)fertility and until success is achieved it is difficult to identify a finite ending.

CHAPTER 3: METHODOLOGY

In adopting theories related to narrative organizing, tenuous identity/identification, resilience, and social support this project engages a feminist-interpretivist framework. In doing so, this project draws on multiple qualitative methods through a three-phase methodological engagement of (1) online ethnographic observations and auto-ethnographic reflections, (2) in-depth interviewing of participants narratives and networks related to (in)fertility, and (3) text mining and semantic network analysis of public discourses related to (in)fertility. Adopting a mix of qualitative methodologies allows for a more holistic, nuanced understanding of how identities are negotiated, resilience enacted, and support fostered during (in)fertility treatment. To begin, I review my meta-theoretical underpinnings as providing both a context for and a source of tension within my methodological approach. Next, I review the procedures for each phase of the methodology, which provides an in-depth examination of the unique, lived experiences of (in)fertility. And finally, I join these three phases of qualitative data together, to construct a multi-level understanding of (in)fertility.

Metatheoretical Underpinnings

In order to fully understand the methodological approach to this dissertation project, I review my epistemological assumptions on the study of communication and the significance of practicing reflexivity. To do so I begin by defining my conception of communication. Next, I position my research within the broader metatheoretical conversation by integrating interpretivist-feminist research. Finally, I use these assumptions to ground my research practice as inherently reflexive and feminist.

My conception of communication is grounded in a dialogical perspective. A dialogic approach to communication recognizes the power of communication to construct the social world (Bakhtin, 1986; Baxter, 2007). This perspective grants us the ability to view communication as fundamentally a social process, which works to produce and (re)produce knowledge while also functioning as a means of control (Craig, 1999). As Baxter (2007) argues, a dialogical perspective emphasizes the competing discourses that privilege some ideologies, while at the same time marginalizing the voice of others. This perspective of communication is especially useful for this dissertation, which highlights how women experiencing a silenced, stigmatized health condition navigate the prevailing discourse on what it means to be a woman and a mother.

Because of the emphasis a dialogical perspective places on communication as an epistemological process, central to my meta-theoretical approach lies a concern for the knowledge production process. Throughout my understanding of communication lies an epistemological assumption that knowledge is localized, fragmented, and plural. It is through social interaction that knowledge is developed (Blumer, 1966; Gergen, 1985). Knowledge is developed within historical and cultural contexts that are progressively and reflexively (re)produced (Carey, 1988; Philipsen, 1975). Throughout the explanation of my meta-theoretical underpinnings, I rely on the epistemological assumption that knowledge is situated within individual standpoints and is thus produced through the interaction of the researcher and the researched. This assumption is further explored through my adoption and integration of interpretivist, critical-feminist, and reflexive research.

As an interpretivist-feminist researcher, my interpretivist approaches to research are grounded within three key assumptions. First, I believe that knowledge is situated within individual standpoints. That is to say, I recognize that individual experiences are unique and situated within

the individual's own lived experiences (Allen, 2005; Gergen, 1985). It is through this belief that I recognize that people gain meaning through participation in the social world. Second, I acknowledge that knowledge is co-produced through the interaction of the researcher and the researched (Cheney & Tompkins, 1988; Phillipsen 1975). And third, my research is grounded in understanding, rather than predicting, a communicative phenomenon.

Thus, I consider knowledge as situated (Haraway, 1988). Drawing from a lineage of feminist scholarship, situated knowledge is indebted drawn from standpoint theory (Hartstock, 1987). Developed out of a Marxist philosophy, standpoint theory suggests that through understanding the experiences of the oppressed, we can make visible the power relations at play to render them monitories. Standpoint theory is especially attuned to the power-knowledge relations embedded within material and immaterial structures (Hartstock, 1987, 1998). Haraway (1988) pushes us beyond dichotomous categorizing however, to consider knowledge as situated through claims of embodied objectivity, wherein knowledge is multidimensional, partial, and limited.

In line with this project's commitment to exploring and problematizing identities as diverse and fragmented, standpoint theory and situated knowledges recognizes that individuals hold multiple identities, and those identities are shaped by and through social interaction (Schegloff, 1997). Social interactions, like communication, are the key method through which individuals (re)produce knowledge (Blumer, 1966; Burr, 1995). Situated knowledge builds on standpoint theory, considering knowledge as socially situated. Through this perspective, marginalized standpoints and experiences offer distinct benefits for scholarship and lay research.

I also integrate postmodern theory. Postmodernism prompts us to reconsider reality as plural, fragmented, and constructed through a range of experiences beyond gender (Allen & Baber,

1992; Hawkesworth, 1989). A postmodern feminist approach seeks to deconstruct, challenge, and expose taken-for-granted beliefs that are assumed to be natural (Hare-Mustin & Marece, 1988; Scott, 1990). In short, postmodern feminism views knowledge as socially constructed and situated, however this risks the perception of knowledge as relative and personal (Allen, 2011; Allen & Baber, 1992).

The postmodern epistemological approach to interpretivist-feminist research rejects the assumption that there is one ‘reality’ to discover. Instead, feminist researchers recognize that difference begets difference, but that through difference we are able to recognize important commonalities women share (Di Stepheno, 1990; Letherby, 2002a). Additionally, feminist researchers approach knowledge as a material product, “something that is specific to time and place and person . . . rooted in the ‘point of view’ of particular knowledge producers” (Stanley, 1997, p. 204). Stanley and Wise (1993) call for a “morally responsible epistemology” wherein the researcher recognizes “the objects” of research as human subjects (p. 200).

Additionally, postmodern feminist epistemologies are conceived as partial, fragmented, and sensitive to issues of power, sameness, and difference. Feminism offers an “epistemological shift away from androcentric, boundary-specific methods that enforce traditional binaries [i.e., rational over emotional, authoritative voices over voices of the oppressed, public over private]” by instead privileging “thought as rational and emotional with both multiple views and truths” (Farrow & Cook, 1991; Collins, 1989; Crawley, 2012, p. 151). Ultimately, because postmodern epistemologies recognize that knowledge is situated within the research context and produced through the relationship of the subject and the researcher, I next review two ways—embodiment and emotions—in which feminist epistemologies are engaged in this research context.

A key tension undergirding feminist research is the role of the body and the ways in which research is an embodied practice. Through adopting an embodied practice in interpretivist research, researchers are able to connect theory to epistemology. It is therefore through embodiment that we recognize that the researcher's body is not separate from the inquiry, but rather that the body serves to continually mediate interactions with other humans and nonhumans (Weiss, 1999). Feminist researchers accept that the body does not have a materiality separate from discourse, but rather it is through discourse that the body is performed. This performance, in turn, discursively constructs norms through which all other bodies are judged (Ellingson, 2006). Thus, bodies serve an important function in upholding specific, contextual histories and powers.

Through adopting a feminist metatheoretical perspective and privileging knowledge as situated, I value emotions as an embodied knowledge construction. Thus, while post-positivist research has often sought to minimize the body and silence the researcher's emotions in favor of a perceived rationality, rationality is actually considered to be interwoven with emotions (Denzin, 1997; Ellingson, 2017a; Johnson, 1987). Emotions provide valuable insight into knowledge construction processes and can provide an important linkage between the private and social self (Ellis, 1991). Emotions allow us to more fully evaluate our experiences and provide a deeper understanding of the social world (Jagger, 1989). The perspective gained through the linkage of emotions and rationality is the 'embodied objectivity' of feminist research. Embodied objectivity gives way to, and is built from, the 'extreme localization' of situated knowledge (Haraway, 1988). That is to say, it is only through partial, emotional perspectives that we can come to know objectivity (Haraway, 1988).

As the researcher, recognizing and analyzing the influence of the body and emotions are a reflexive process. Bodies do not merely influence the knowledge construction process, but rather

they influence, constitute, and enrich meaning making (Ellingson, 2017a; Harding, 1991). As a white, heterosexual, middle-class, cis-gendered woman my embodied experiences of the social world necessarily guide this research, but so too are they shaped by the shared embodied identity of (in)fertility, which I share with my participants. In consideration of this project's metatheoretical commitments to interpretivism, this research is co-constructed with the participants (Charmaz, 2006). Emotions saturate the research process, allowing for the development and maintenance of a relationship with my participants (Ellingson, 2017a). Thus, when emotions are displayed, when tears are shed, or nervous laughter abounds in the interviews, these emotions are embraced with empathetic vigor. For this reason, I am continually attuned to the reflexive nature of this project.

Reflexivity

In accordance with this project's feminist-interpretivist approaches, reflexivity is a central tension undergirding this dissertation. Reflexivity serves as a way to critically examine epistemological and methodological choices through considering, among other things, the privilege and power structures that affect both the researcher and the researched. It is through reflexivity that my epistemological orientation, and thus my interpretation of the data, is made evident.

Through reflexivity I engage in an "explicit, self-aware, meta-analysis of the research process" (Finlay, 2002, p. 531), wherein the epistemological and ontological assumptions of the research are examined and made clear to the reader. Reflexivity, closely linked to the ethical dimensions of any feminist research practice, allows the researcher to be "self-critical, yet compassionate" as they examine their role in the research process (Medved & Turner, 2011).

Feminist researchers may be more likely than others to investigate emotionally affective topics, especially those with which they hold a personal connection. Feminist methodologies

embrace the personal experiences of researchers as legitimate sources of knowledge (Jagger, 1989). Thus, because of the attention paid to the epistemological foundations of embodiment and emotions, my personal identity plays a significant role in how I connect my meta-theoretical leanings to my understanding of (in)fertility. For this reason, I look to continually practice reflexivity at every stage of this project.

There is debate on how much a researcher should share their social identities (e.g., gender, race, sexuality) with those of their participants (McDonald, 2013). Some researchers (Rooke, 2009; Rhodes, 1994) argue that through matching the social identities of their participants, the researchers may have more effective communication with participants, and, in turn, participants may be more likely to disclose their life experiences⁵. This is especially true for those social identities, like (in)fertility, that remain physically invisible, only accessible through disclosure and discourse (Adams, 2011). Ultimately, the complexity of reflexive identification has led some researchers (Sherman, 2002) to argue that sharing of social identities is less important than having a stake in the well-being of participants.

⁵ In my recruitment letter to participants I highlight that I was diagnosed with (in)fertility and would be undergoing (in)fertility treatment to preserve my fertility. I believed in admitting my own status as an (in)fertility patient my participants would trust when I promised empathy during the interview process. On my recruitment flyer I wrote, “My interest in infertility comes from a personal interest—I was diagnosed with a low AMH when I was 26 years old, thanks in large part to a childhood cancer diagnosis. I say this because I want you to know that my interest is personal, and the interviews will always come from a place of empathy and a desire to listen to people’s experiences. I’m interested in recruiting participants through this group because I have used this group as a resource over the last few months as I prepare for freezing my eggs this summer.”

Valuing well-being speaks to the ethical demands of feminist research. Reflexivity serves an important role in framing the ethical bounds of this project. Because this project adopts feminist epistemological and methodological principles ethical dimensions are recognized at every phase of the research process, from topic selection, to theoretical framework, through data collection and analysis. Ethical considerations can highlight the ways in which epistemology emanates through power structures and/or through emotions (Rose, 1994). It is through considering the ethical elements of this feminist research project that I choose to highlight my own personal experiences (Porter, 1999). Likewise, I adopt a care-based approach that emphasizes the emotions that naturally arise through researching such a deeply personal, embodied experience.

Auto-Ethnographic Interludes

I incorporate auto-ethnographic interludes both as an account of reflexivity and also as an additional form of data. These interludes not only serve as a means to critically examine my research practices, but so too situate my experiences alongside those of my participants. For example, while my participants and I will both undergo the exhaustive treatment of in vitro fertilization (IVF), we exist at radically different standpoints. Where my participants are actively trying to achieve the motherhood identity, I am trying to preserve my fertility in the hopes of becoming a mother many years from now. These embodied categories of difference (McDonald, 2013) allow me to understand the physical, embodied toll of IVF and the emotional toll of an (in)fertility diagnosis, without fully encapsulating the unique, situated experience of presently yearning for motherhood. In this way, the embodied difference between my participants highlights the way in which social identity categories are shaped by role, culture, and group membership (Brewer & Garner, 2004; Twine, 2000).

This project draws on a social constructionist epistemology as a means to interrogate and narrate my own experiences. I analyze these auto-ethnographies in order to consider how meaning is generated (Ellingson & Ellis, 2008). The interludes allow me to write, analyze, and theorize about my own experiences (Denzin & Lincoln, 2005). Letherby (2002a) argues that through including autobiographical accounts in her writing, respondents and readers are able to compare her motivations, experiences, and views with those expressed by her participants. Self-consciousness serves to emphasize that the author is constructing, rather than discovering, the knowledge (Letherby, 2002b; Mykhalovskiy, 1996, Stanley, 1993). Thus, through including auto-ethnographies in this dissertation, I imbue Charmaz's (2016) conception of 'methodological self-conscious,' wherein I make my tacit individualism evident, dissect the structural contexts, language, and power arrangements inherent in my meaning-making processes and lived experiences in order to develop a more fruitful, nuanced understanding of my own narratives, identities, and resilience processes at play.

Auto-ethnography blends well with this project's situated knowledge and postmodern methodologies because it considers multivocality as a central resource. Auto-ethnography is well suited to explore the varied standpoints of the embodied experiences and emotions of (in)fertility. Epistemically, auto-ethnography benefits from dual epistemic sources of everyday and academic knowledge, recognizing that members and academics offer equally important contributions to knowledge (Crawley, 2012). Crawley (2012) argues that auto-ethnography lies at the intersection of the humanities and social sciences, and this methodological hybridity is well suited to providing insights into embodied experiences.

Because of the many different forms of epistemology evoked through auto-ethnography, it serves as an important method in feminist research. Burnier (2006) describes how she used auto-

ethnography as a feminist response to the post-positivist demands of her discipline. Burnier (2006), borrowing from Patricia Hill Collins and black feminist thought, suggests that auto-ethnography functions as a “both/and” solution, legitimizing the self-reflexive nature of her research while also validating her work as a political scientist (p. 414). Thus, I integrate my dual identities as both an academic researcher and an (in)fertility patient to better understand the nature of (in)fertility as socially constructed.

Reflexively, these interludes allow me to illuminate and complicate the relationships I build with my participants. I am a full member of the research group (i.e., women diagnosed with infertility), but I am also committed to improving the theoretical significance of the (in)fertile experience. By sharing a social identity with participants, I am more apt to understand myself and my participants through examining my own behaviors and beliefs in reference to others, through practicing analytical reflexivity (Anderson, 2006). Before I conceived this dissertation and throughout the data collection, analysis, and writing portions of this project, I wrote my (in)fertility experience into being, expressing emotions, hardships, and underscoring the embodied reality of (in)fertility through journal entries and copious fieldnotes. I used these journal entries and fieldnotes as a reflexive acknowledgement of my own situated knowledge and embodied objectivity (Haraway, 1988).

Methodological Strategies

This project relied on a three-phase process to build immersive, nuanced, and embodied understanding of (in)fertility as organizing. In phase one, I built understanding of the (in)fertility experience through personal experience along with in-depth cyber-ethnographic observations of multiple online support groups. In phase two, I used this partial, yet informed, understanding of the (in)fertility experience as grounds for in-depth, semi structured interviews, integrating network

and narrative data to construct an embodied understanding. Finally, in phase three I constructed a more holistic portrait of the organizing discourse of (in)fertility through the dual process of text mining and semantic network analysis⁶. Thus, through this multi-level, qualitative analysis of the micro (auto-ethnographic and interviews) and meso (ethnographic; text mining and semantic network analysis) processes I look to illuminate the social, communicative construction of (in)fertility as an organizing experience. Each of these phases and corresponding methods are outlined in Table 1.

Table 1: Project Phases and Methods

| Phase | Method | Data Collected |
|-------------------------------------------|---------------------------------------------------------------------------------|-------------------------------------------------------|
| Phase One: Understanding (In)fertility | Auto-ethnography | Reflections and interludes |
| | Online ethnography | Observations of online support groups |
| Phase Two: Embodied Understanding | In-depth interviews with participants of the Podcast Group | 20 participants |
| Phase Three: Organizing Understanding | Text mining and semantic network analysis of online support community on Reddit | Analysis of top 60 posts of all time on r/Infertility |

⁶ My approach to text mining and semantic network analysis is descriptive in nature, engaging qualitative methods and an interpretivist-feminist metatheory to understand the networks as representation a macro-level view of public discourses related to (in)fertility. I further explain this positionality during my explanation of phase three, beginning on page 85.

Phase 1: Understanding (In)fertility

In addition to the auto-ethnographic interludes, I engaged in a multi-year ethnographic observation and participation of multiple online (in)fertility support groups. The goal of the first phase of inquiry was to build understanding of (in)fertility and construct a conceptual map of the field. Hine (2009) suggests that in-depth, embedded immersion into an online community can help a researcher to make tentative connections, make sense of what is going on, and set boundaries for what should be included in the analysis. Hine (2009) draws on her own experiences as an online ethnographer to explain the necessity for building understanding of an online site. Researchers have already begun to use online (in)fertility support groups for ethnographic observation. Lee (2017) engaged in a cyber-ethnography (Good, 2001) of discussion forums on RESOLVE: The National Infertility Association, to examine social support, language norms, and belongingness within the group.

The methodology surrounding online, virtual, and cyber ethnographic endeavors is diverse and growing. Scholars continue to debate the strategic use of terms (Markham & Baym, 2008), tools of inquiry (Hargittai & Sandvig, 2015), and strategic value and ethical dimensions of online research (Markham, 2018/2015). However, in fitting with this project's metatheoretical commitments and feminist-interpretivist framework, I approach the Internet as a 'way of being' (Markham, 1998), that is to say that the virtual is interwoven with our offline life. The virtual is assumed, taken for granted, and in that regard, it is embedded and embodied within the everyday (Hine, 2015). Moreover, these online communities can render offline consequences, shaping social interactions (Gillespie, 2010; van Dijck, 2013).

Key questions surround the virtual ethnographer, not the least of which are concerned with defining the bounds of immersion. Prior to beginning this project, I spent considerable time, well over a year, observing and participating in various online (in)fertility support groups on Facebook

and Reddit. Due to my own experiences with (in)fertility, these groups became a safe haven of information and support. In particular, I most often participated in Facebook groups. While I was a member of at least four different groups, I most often turned to one group in particular, which I refer to in this project as the ‘Podcast Group.’ The Podcast Group was created in June 2016, by a husband and wife duo running a popular IVF podcast. With over 5,000 members, the Podcast Group was an open and inviting space and served as the primary resource when recruiting participants for phase two of this project. As an ethnographer looking to build cultural understanding of the group, rather than transcribe and analyze events, I noted language norms, values, and frequent, recurring topics of conversation. These personal field notes influenced the creation of my concept map (Appendix A) and interview guide (Appendix D).

While I visited and observed multiple groups, I was particularly committed to observing the Podcast Group as a participant observer. Participant observation is defined as “the embodied emplacement of the researching self in a field site as a consequential actor” (Boellstorff et al., 2012, p.65). Through this observation period, I engaged in deep reading of threads and comments in real time. Within virtual spaces, levels of participation range from ‘lurkers,’ who visit the community regularly without posting, to contributors and moderators (Ridings & Gefen, 2004). As my ethnographic observation was on-going, I did not note specific days on which I lurked or participated in the groups, rather I gleaned valuable insight through prolonged, daily readings of the group. In this way ethnography did not become my primary technique, but rather the continuum from which I developed and situated different methodological approaches (Dong & Blommaert, 2009).

It is becoming increasingly difficult for digital ethnographers to draw clear-cut distinctions between online and offline dynamics. As a result, the space and place of the ethnographic site has

likewise become increasingly perverse and complicated (Varis, 2014). Thus, I relied on two primary means of inquiry to concretely collect data. In phase two, I investigated offline experiences of (in)fertility through in-depth interviews with participants of the Podcast Group. Second, in phase three, I used the dual process of text mining and semantic network analysis to analyze prominent patterns of d/Discourse of an online (in)fertility support group. For this second phase I analyzed communication patterns of an (in)fertility community on Reddit, an open-source social networking platform. Later in this chapter I explain the context of Reddit more fully, but unlike Facebook, on Reddit it is far easier to collect and analyze comments without risking participant privacy, thus it was an easier site of inquiry. To be clear on how the methodological strategies for these three phases correspond with my proposed research questions, I have included Table 2 for reference.

Table 2: Research Questions and Methodological Strategies

| Research Question | Method of Collection | Method of Analysis |
|---------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|-----------------------------------------------------------------|
| RQ 1: How do personal narratives of (in)fertility contribute to the organizing of the (in)fertility identity? | Interviews via Retrospective Interviewing Technique (RIT) | Constructivist grounded theory & narrative analysis |
| | Timeline | Turning point analysis |
| | Online ethnography | Text mining & semantic network analysis with narrative analysis |
| RQ2: How are tenuous identities communicated during (in)fertility? | Interviews via RIT | Constructivist grounded theory & narrative analysis |
| | Auto-ethnography | Self-reflexive analysis |
| RQ3: How is resilience developed during (in)fertility? | Interviews via RIT | Constructivist grounded theory & narrative analysis |
| | Personal Network Research Design (PNRD) | Qualitative Structural Analysis (QSA) |
| | Auto-ethnography | Self-reflexive analysis |
| RQ4: How do the social network relationally construct resilience? | PNRD | QSA |
| RQ4a: How does social support evolve over the course of a woman's (in)fertility treatment? | Auto-ethnography | Self-reflexive analysis |

Phase 2: Embodied Understanding

Building off of the observations developed in phase one, the goal of phase two was to develop an understanding of (in)fertility on an everyday, micro-level. Phase two centers on

understanding the lived, embodied experience of (in)fertility by delving deep into the experiences of participants who have spent months or years undergoing (in)fertility treatment in various forms. In this section, I introduce the individual participants of this study, providing a brief explanation of how they were recruited. Second, I review the data collection procedures for both the individual narratives and networks. Third, I explain the data analysis strategies for this phase of the research.

Recruitment of Participants

After obtaining permission from the Institutional Review Board, interviews were conducted with 20 women who were undergoing or had undergone IVF treatment. To be included participants must have received IVF treatment for at least six months, as this allowed for a more holistic, in-depth analysis of the (in)fertility over time. To recruit participants a flyer was posted to the Podcast Group, which was ethnographically observed during the first phase. The group is based on Facebook and is set to private, so in order to follow or join the group members must first confirm they are seeking (in)fertility treatment. While I had planned to recruit from multiple support groups, members of the Podcast Group were so willing to participate that this study reached the maximum number of allotted participants within only a few days.

Upon qualifying and consenting to participate in the study, in-depth, semi-structured interviews were conducted at a public place of the participant's choosing (i.e., office, coffee shop, library, meeting room, etc.) or on video chat. Only one interview was conducted in person, the remaining 19 were conducted over video chat and/or the phone. With the permission of the participants, interviews were recorded and transcribed. I transcribed 11 interviews, and eight of the interviews were transcribed by an out-sourced transcription service. During the final interview, the recording device failed, and the interview was lost. Consequently, one interview was not transcribed, instead I recorded all I could recall from our conversation. The notes were emailed to

the participant, but she did not respond with follow up details. Each interview lasted between one and two hours; participants were compensated for their time with a \$20 gift card. Some participants chose not to collect the gift card, instead donating it to future research projects. To preserve participant's anonymity, pseudonyms were assigned.

In consideration of this project's crystallization perspective, participants of this study had varied experience with IVF. For example, five of the 20 participants successfully carried a pregnancy to term and had given birth. A few months after giving birth to her first child, one participant became spontaneously pregnant with her second child. During our interview, this participant was undergoing IVF in hopes of having her third child. Three participants were in the midst of the two-week wait or had recently received a positive pregnancy test but were still in the early weeks of pregnancy. Nine participants suffered multiple miscarriage. Thus, the perspectives shared, and narratives gathered in his project offer a uniquely broad, yet certainly partial, understanding of (in)fertility. For a full list of pseudonyms and brief summary of each participants' experience with (in)fertility see Appendix B.

Procedure

This project used a combination of in-depth, semi-structured interviewing to connect with participants and help elicit narrative accounts of their (in)fertility experiences. Seidman (2013, p. 9) argues that "at the root of in-depth interviewing is an interest in understanding the lived experience of other people and the meaning they make of that experience." More specifically, interviewing privileges the communicative as it offers participants the opportunity to give meaning to their experiences through language (Seidman, 2013). Thus, the interview protocol follows a loosely guided, conversational style (see Appendix D).

This phase of the research utilized two types of collected data: narratives and self-reported ego networks. In order to elicit narratives from participants, I followed guidelines set forth by Fitzgerald and Surra's (1981) Retrospective Interview Technique (RIT). RIT asks participants to map their psychological and physical turning points. Importantly, the definition of a turning point is ambiguous and left up to the participant, allowing her to explore the many different facets of her (in)fertility journey. Some participants remained conservative in their reported turning points, focusing only on major milestones like an embryo transfers or miscarriages, while others were more liberal, noting everything from a job change to a family death. The diversity with which participants noted turning points only further cements the importance of approaching this project as situated knowledge.

Before the interview, participants were emailed a timeline map on which to record their turning points and milestones. Because the majority of the interviews were conducted over the phone or video call, participants had two options for the style of timeline map (Appendix C). One option was a highly structured table, on which participants recorded turning points, sources of support, and the date that the support was rendered. The second option was merely a line, allowing participants to visually note the linear passing of time while still recording key events and support. Only one participant, Jillian, selected the second option. The maps were designed as not only a means of recording ego-network data, but so too in order to help participants recall key moments. As (in)fertility treatment can last months, or even years, these maps offered participants an opportunity to cohesively organize and summarize their experiences.

In considering the timelines linearly, I explore how sensemaking processes influence support. We often organize and give meaning to events and memories through time, allowing us to gather data that may not be evident in talk alone by focusing on the passing of dates (Brockmier,

200; Murray, 1999; Ricoeur 1984). A timeline method is useful not just as data, but also as a tool for further data production. In this way the timeline approach allowed participants to ground their past, present, and future linearly (Sheridan et al., 2011). However, importantly to this project social constructionist and interpretivist roots, time is subjectively experienced.

Network data were collected qualitatively. Ethnographic, in-depth interviewing is often used as a means of gauging network composition because it allows the researcher to become embedded within the personal histories of the participants (Jack, 2005). An ethnographic approach to understanding social ties emphasizes a social constructionist perspective, where “thick description” (Geertz, 1973) is developed through prolonged time spent with participants as a means to better understand their values, meanings, and beliefs.

Specifically, in order to study the individual ego-networks of participants, this study loosely followed the Personal Network Research Design (PNRD) procedure (Halgin & Borgatti, 2012). The PNRD approach studies how individuals create, maintain, and activate their social network. Ego-centric networks indicate what type of person (alter) an individual (ego) knows and sheds light on the resources (i.e., support, information, or empathy) the alter provides (Rissanen et al., 2013).

Before the interview, participants completed the timeline map and forwarded a copy to me. Before our interview, I looked over their map and any correspondence we had previously shared in order to become familiar with their experiences. Then, during the interview, the participant and I talked through her timeline, beginning with her initial diagnosis and moving up to the present. The interview guide (Appendix D) includes probing questions designed to collect pertinent information related to support. Within the PRND, the first step is name-generating, thus I focused particular attention on learning about an ego’s social relationships (alters). Burt (1985) suggests

one method for eliciting responses is to ask participants who they discuss important matters with, allowing participants to define what is considered important according to their own perspective. During interviews I often asked participants who they turned to after upsetting medical news, who they looked towards for advice or empathy, and who they chose to celebrate alongside. By allowing participants to define the parameters of the question through their own perspective, this process necessarily adopts an interpretivist lens through which meanings and experiences are understood within the context of the participant's own lived reality.

A benefit of name-generator questions is that they allow for inclusion of more qualitative data, including the amount of social resources, the alter characteristic and location, and how embedded the alter is within the ego's network (Rissanen et al., 2013). However, the name generator approach also includes a few notable disadvantages. First, Marsden (2005) suggests that the name-generating questions often only elicits a fraction of respondent's social contacts. Second, name-generator questions often include a bias to stronger ties (Lin, 1999). In considering these weaknesses, I took care to address weak-tie relationships and explore unanticipated sources of support for participants by asking about work colleagues, online resources, and other relationships that may develop during (in)fertility.

The second phase of the PRND approach is name-interpreter questions, designed to learn more about each the ego's perception of the alter (i.e., age, income, duration of treatment, etc.) and her relationship with the alter (i.e., duration, frequency, and intensity of community, or types of information, support, or empathy shared). In interviews, participants and I often discussed her relationship to the alter, specifically how it may have changed since beginning and/or disclosing treatment. Halgin and Borgatti (2012) define the name interpreter phase as unique to the PRND because it emphasizes the ego-centered nature of the ego-network by allowing all alters and their

corresponding attributes to be assessed from the perspective of the ego. Once again, the emphasis is placed on allowing the ego to define both what and who is included in their network, ultimately allowing knowledge and meaning making to be contingent upon the individual standpoint of the participants (Schegloff, 1997).

Through analyzing the changes in participants' social networks over the course of their infertility treatment, we can better begin to understand how personal networks evolve or fluctuate. Studies on social support tend to adopt a longitudinal approach because it allows for a dynamic analysis of how disruptive life events affect the social network surrounding an individual (Lubbers et al., 2010). Longitudinal studies of social network changes have also been used to examine changes in participants' well-being (Costenbader et al., 2006) and as a method of coping during transitional life periods (McPherson et al., 2006). Throughout these studies participants were interviewed at multiple times, both before and after an important event, however the benefit of the retrospective interview technique is that it allows for a visual graph to be constructed during a single interview. Visual graphs allow participants to comment on changes in their network and has been used as a means to examine evolution of social networks (Lubbers et al., 2010).

Data Analysis

While this project used different types of data (i.e., narratives, networks, and visual maps), the data were coded manually. Coding manually allows the researcher to physically touch and mark up the data (Tracy, 2013). Manual coding allows me the ability to mark the text with different color pens, highlighters, and markers, and then cut and paste the data together to see the most relevant and dominant themes (see Appendix E).

After all of the data were collected, I printed hard copies of interview transcripts, notes, and networks and examined these alongside the RIT maps. Because this project emphasizes the

unique, situated experience that emanates from each individual, each participant's data was analyzed and initially coded, before being considered alongside the other interviews. In this way, this project followed Tracy's (2013) recommendation for coding in cycles, while also integrating a narrative and constructivist grounded theory approach (Charmaz, 2006) as a means to emphasize emergent themes.

Interview Data

While I look to understand narratives as organizing, and I privilege the collection and analysis of narratives, this project does not explicitly adopt a narrative perspective. Rather, in an effort to identify thematic patterns of similarity and difference across narratives, I engage a hybrid mix of constructivist grounded theory and narrative analysis. Integrating grounded theory with narrative analysis is not a new trend, previous researchers (Floersch et al., 2010; Padgett, 2008) have combined the structured, systematic analysis of grounded theory with the temporal sequencing of narrative analysis. Considering the important role of time in this study, narrative analysis provides a useful means through which to organize and analyze the situatedness of each individual story. Thus, my study involved a hybrid analytic mix of narrative and constructivist grounded theory. I first began with a narrative approach to understanding each participant's story within the singular context of her own voice. Second, I built a more complete understanding of how narratives converge and diverge through constructivist grounded theory. As past research (Burck, 2005) attests, grounded theory offers a clear framework for scrutinizing qualitative data and an avenue through which to build up theoretical concepts 'grounded' in the data (Burck, 2005). This recursive, constant comparative method is useful for drawing a broader understanding of discursive patterns.

Narrative Analysis. Narrative analysis is concerned with subjectivity and positionality and is focused on how individuals present themselves in everyday life (Riessman, 2000). While there are a number of different approaches to narrative analysis, I am drawn to the concern for identity and meaning making (Riessman & Speedy, 2007). Unlike traditional qualitative approaches, narrative analysis does not fragment text, rather it draws holistically on the storytelling experience and the form of the narrative in order to understand how discourse is organized temporally (Riessman, 1990). Narrative analysis aligns well with my metatheoretical commitments to interpretivism and constructionism (Miller et al., 1990), postmodernism (McAllister, 2001) and feminism (Reissman, 1989).

The narrative approach used within this dissertation falls within a long lineage of illness narratives. These illness narratives, broadly speaking, were designed in response to a biomedical focus on disease and a consequent neglect of patient experience (Bell, 2000; Mishler, 1984; Hydén, 1997; Riessman, 2003). Illness narratives reassert the voice of the patient. However, as becomes evident in the data, many participants denounce (in)fertility as an illness or disease. While it can be a product of a medical condition, such as PCOS or endometriosis, just as many participants suffer from unexplained and/or age-related (in)fertility. While these narratives provide a way of explaining and contextualizing life disruptions, changing relationships, and embodied resilience (Bury, 1982; Charmaz, 1991; Riessman, 2003) through the prism of (in)fertility, (in)fertility is not considered an illness per se, rather it is a medicalized event and can be understood and analyzed in a similar analytic thread to previous illness narrative work.

Mirroring foundational work in narrative inquiry (Riessman, 1990, 1993), after the full transcript was printed, I identified the boundaries of narrative segments. For example, on the transcript, I marked narrative endings and beginnings in order to distinguish between different

thematic stories, such as those related to diagnosis, disclosure, and medicalization. However, I also recognize the interdependency of these concepts and consider each participant's situatedness in regard to her overall construction of meaning and claim to identity. The narrative phase of analysis was particularly useful for understanding the nuances and events of each participant's story within the context of her position. However, in order to more fully engage with the data, and in an attempt to ground the data with a thematic perspective, after the initial coding of narratives, I shifted my focus to a constructivist grounded theory perspective.

Constructivist Grounded Theory. Constructivist grounded theory (Charmaz, 2000, 2005, 2006, 2017) builds on grounded theory, originally developed by Glaser and Strauss (1967, 1978) and later Strauss and Corbin (1990, 1998). Grounded theory encourages researchers to develop theory that is grounded in the data, through systemically analyzing the text (Strauss & Corbin, 1998). However, Charmaz (2003) deconstructs the positivist assumptions of grounded theory by integrating a postmodernist perspective, which recognizes “the relativism of multiple social realities, [through recognizing] the mutual creation of knowledge by the viewer and the viewed and aims toward interpretive understandings of the subject's meaning” (p. 250). Charmaz (2017) further advocates for a critical approach to constructivist grounded theory, prompting researchers to consider emergent questions throughout the analysis process. This critical inquiry is well suited for reflexive research because it urges the researcher to act reflexively in considering their ‘methodological self-consciousness’ and interrogate their historical, social, and situational contexts. In sum, Charmaz’ (2017) (re)conception of constructivist grounded theory as critical and reflexive aligns well with this projects’ metatheoretical commitments to interpretivist, feminist research.

Like grounded theory, a constructivist approach aims to achieve theoretical saturation as a means of setting the sampling parameters (Bowen, 2008; Strauss & Corbin, 1998). Saturation is achieved when relevant themes become redundant. Through a constant comparative method, researchers are encouraged to constantly return to the data to compare and integrate relevant themes until saturation is achieved (Bowen, 2008; Charmaz, 2006). Importantly, unlike the positivist assumptions of grounded theory set forth by Strauss and Corbin (1990), constructivist grounded theory assumes that participants “create meaningful worlds through the dialectical process of conferring meaning on their realities and acting within them” (Allen, 2011, p. 36-36; Blumer, 1969). Through situating the meaning of each participant’s story within the context of her own embodied experience, the constructivist approach recognizes that meaning and reality are locally situated. An important final step of grounded theory is to ‘re-contextualize’ the findings within the larger theoretical conversation (Morse, 1994, p. 34).

However, Allen (2011) highlights a number of potential weaknesses with a constructivist approach to grounded theory, namely that researchers must remember that their analysis is merely a representation of the participant’s reality and must present the research in a way that is meaningful for others who have not directly heard the participant’s description. Likewise, constructivist grounded theory still runs the risk of potentially “othering” the participants (Law, 2006), thus Allen (2011) suggests that part of the “political challenge of the research task” is to empower participants (p. 37).

In order to make sense of the data, after the initial narrative analysis, I employed the constant comparative method (CCM; Charmaz, 2006), to compare the coded data with other available data. During the constant comparative method, codes are modified, or new codes are created, to fit the definitions emanating from the data. The constant comparative method is

especially useful for coding data in phases, wherein data is initially lumped into larger themes before then fracturing data into smaller slices that are increasingly more specific (Bazeley, 2007; Tracy, 2013).

During the first primary-cycle coding phase (Tracy, 2013), data were coded at the narrative-level. That is to say, I used the bounded narratives identified in the first phase of analysis to construct and code thematically (Appendix E). It is then, during the second phase of coding, that analytic memos are created and themes begin to take shape. Analytic memos serve as “sites of conversation with ourselves about our data” (Clarke, 2005, p. 202). Memos serve the important purpose of allowing the researcher to define “fundamental stories in the data” (Tracy, 2013, p. 196). It is also during the second phase of coding where codes are organized hierarchically, as a means of systemically grouping various codes under a larger, ‘umbrella’ category that makes conceptual sense (Tracy, 2013). During the second phase of coding, I categorized an ever-running, ever-changing document that listed participant quotes under the abbreviated code (Appendix F). Finally, as a third phase of coding I then sought to connect the recurring themes with the research questions. I identified primary and secondary labels to help organize themes (Appendix G).

Network Data. Often network qualitative analysis runs the risk of quantifying network composition, which consequently ignores the interpretation inherent in qualitative analysis (Herz et al., 2015); however, this project adopts a purely descriptive, qualitative approach to network analysis. To interpret the network data qualitatively, Herz, Peters, and Truschkat (2015) recommend a Qualitative Structural Analysis (QSA). QSA involves the dual process of analyzing visual networks (like the timeline maps generated through the retrospective interviewing) and qualitative interview data (Schönhuth et al., 2013).

The first phase of the qualitative network analysis involves distinguishing between a structure-focused, actor-focused, and tie-focused description of the social network. Structure-focused descriptions are those that examine the network holistically, considering questions related to cohesion, density, clusters, and structure (i.e., triads, structural holes). Actor-focused descriptions consider the embeddedness of individual actors. For example, the analyst might consider which alters connect to other alters or which alters serve as a bridge. During this phase of description, researchers might also consider which alter characteristics or individual attributes predominate in the network. Finally, in a tie-focused analysis, tie strength, direction, and stability are considered (Herz et al., 2015). When these three descriptions are considered together, the researchers are more apt to understand the network data on a macro, meso, and micro level.

Herz, Peters, and Truschkat (2015) also argue that this structural approach to understanding the network maps can serve as the basis for developing the qualitative analysis procedures for the interview data. Just as the interviews will be coded for emergent themes, so too can network data be coded via grounded theory (Glaser, 1992; Strauss & Corbin, 1990). Through the grounded theory process specific themes are developed through open, axial, and selective coding (Strauss & Corbin, 1990). Codes can be developed to reflect emergent themes from the data, with themes initially arising through the interview coding phase.

In addition to the interview transcripts, the timelines were used as a means of identifying key turning points and analyzing the longitudinal changes of the participants' social networks. Turning points were coded through the hybrid narrative and constructivist grounded theory approach used in the interviews and network data. Turning points allowed for the inductive development of categories (Holladay, 1998).

To analyze the longitudinal data, Lubber et al., (2010) recommends examining if a change in the social network reflects a trend to larger integration (evolution) or a change in the opposite direction (involution). If no change is marked throughout the timeline then the social network is understood as stable. However, stability can also be understood holistically (i.e., network composition), but does not necessarily reflect the same alters throughout. For example, past research (Lubbers et al., 2010) has suggested that involution may reflect a psychological crisis, during which a participant does not maintain active relationships with their social network. Qualitative analysis is beneficial to longitudinal surveys because it allows the ego to nominate the changing composition of their network and provide information as to the potential influences on that change.

After the analytic memos were developed for both the interview and timelines, the notes were combined for theoretical condensing. Theoretical condensing encourages understanding how these two datasets work together by condensing the emergent themes into categories to understand the relevant themes. QSA works to integrate the structural approach frequently used within social network analysis with the qualitative, interpretivist approach (Herz et al., 2015). To do this, I made a list of each ego (participant) and alter (person who rendered support) and assigned descriptive variables to each ego-alter pair, including the type of support rendered, the date of support, and the event that triggered the support (Appendix H).

While originally, I sought to understand network evolution for each ego, it became increasingly apparent throughout the analytic procedures that many egos shared similar network composition. For example, the majority of participants consistently cited their husband as their primary, or only, source of support. As is discussed in Chapter 4, some participants struggled with disclosing their (in)fertility to close friends or family members, thus they remained isolated from

activating any broader support. Because of this trend, instead of analyzing each ego separately, I analyzed the egos together as one dataset.

In order to analyze the social network data holistically, after I compiled the analytic memos and categorical themes relevant to the QSA approach, I inputted each ego-alter pair into NodeXL (Smith et al., 2012), as social networking software. In NodeXL I assigned variables to each ego-alter pair, including event (i.e., egg retrieval, frozen embryo transfer, or miscarriage), date, and support rendered (i.e., empathy, advice, material support) (Appendix H). Next, I ran a number of different descriptive tests to determine node degree (how heavily connected each node is to every other node) and sub-group clusters. After analyzing the data in NodeXL, I visualized the graphs in Gephi, an open-source software used for exploring and manipulating network data (Bastian et al., 2009). This analysis process was repeated a number of times to analyze different patterns within ego-alter pairs. For example, I examined patterns of support between the source of support and the type of support rendered, the triggering event and the support rendered, etc. This process was also repeated to analyze individual ego networks. After networks were visualized and analyzed, I returned to the transcripts and codes to find qualitative support for network patterns. For example, it became clear that disclosure prompted support, thus I looked to understand how support aligned with disclosure.

Phase 3: Organizing (In)fertility

In phase three of this dissertation, I look to understand how d/Discourses of (in)fertility are organized in online support groups. As participants were recruited through an online support group, I was especially interested in investigating how participant narratives aligned with, or diverged from, typical communication patterns in these groups. This component of the research was based on the dual processes of text mining and semantic network analysis.

Phase three explores the d/Discourse of online (in)fertility support groups by examining prominent patterns of communication of communities on Reddit. Discussions of health online, specifically in forum-based communities like Reddit, are regarded as an important resource for sharing personal narratives, engendering emotional support, and challenging the patriarchal discourse of medicalization. These personal narratives often grant patients the opportunity to enact a degree of control over their health experience, allowing them to take on the role of knowledge-producer, instead of passive patient (Beemer, 2016). Patients may, in turn, gain a sense of empowerment in an otherwise powerless situation (De Hertogh, 2015).

Online support groups offer an important source of information, coping, and support for individuals diagnosed with infertility (Kahlor & Mackert, 2009). Because women and men suffering from fertility problems tend to feel isolated and alone, participation in online forums, like those on Reddit, can provide the benefit of anonymity and reassurance, as well as a sense of normalization through conversations with others suffering from the same diagnosis (Hinton et al., 2010).

Specifically, this dissertation uses conversations—that is, threads and commented replies—found on Reddit. Reddit is an open-source platform and internet powerhouse, reporting almost 1.5 billion visits in May 2020 (Clement, 2020); it has become a popular source for examining the discursive construction of interest-based communities. Reddit is an online forum platform with over 130,000 unique sub-forums and communities, known as subreddits. Reddit has been a source of political backlash, with Massanari (2017) referring to Reddit as a “toxic technoculture,” where users coalesce around particular issues or events that present retrograde ideas of gender, diversity, multiculturalism, and progressivism. Because of this, many subreddits

exclude, sexualize, and harass female users; however, while the majority of Reddit users are male, some forums—like r/Infertility, which is examined in this study—are popular for female users.

While Reddit offers a number of different subreddits for those going through (in)fertility treatment; this study focuses on the main (in)fertility subreddit infertility treatment, r/Infertility. Within communities like, r/Infertility, users often include a flair next to their username that lists their gender, age, and fertility diagnosis. For example, a member’s flair might read, “31F, 3IVF, PCOS MFI,” which signals to other members of the community that this user is a 31-year-old female who has undergone three rounds of IVF and the cause of her infertility is a dual diagnosis of polycystic ovarian syndrome and male factor infertility. The r/Infertility subreddit was created in January 2011 and has over 14,700 members; it is designed for women and men dealing with primary or secondary infertility, pregnancy loss, and recurrent loss.

Online Analysis Procedures

The semantic network data was collected by copying the text from 977 posts, which included 36,809 comments, from r/Infertility. Comments were collected on May 16, 2020 through an extension package, RedditExtractoR (Rivera, 2019) used in R Studio. Using RedditExtractoR every post between May 16, 2020 and February 11, 2020 was downloaded into a csv file, which were then copied and pasted into a plain text file. In total, the final text corpus of 36,809 user comments resulted in 4,524 pages of text. Total comments for each post ranged from 1 to 363, with an average of 37.68 comments per post.⁷ The top posts included daily update threads, and titles including, “My doctor made me cry today,” “Asking for advice: Transfer embryo

⁷ Data were collected on May 16, 2020. The total number of comments and upvotes may have increased, or posts may no longer be available on r/Infertility.

immediately after egg retrieval or wait additional month?” and, “Rant: Please stop saying ‘that’s exciting!’ to me.”

The Reddit data were analyzed using the methods of text mining and semantic network analysis. Text mining, as a research method, considers the relationship and proximity between words, concepts, and knowledge through automatically classifying topics into a hierarchical structure. It is through this process that underlying associations between topics are revealed (Lambert, 2017), and discursive patterns recognized. To conduct the text mining, I used a text mining software, AutoMap (Carley, 2001). After the text was uploaded to AutoMap, the text was cleaned through a procedure known as preprocessing.

Preprocessing allows the researcher to standardize and consolidate the text corpus. For example, the cleaning procedures convert words to their root form, make plural words singular, and remove frequently occurring but low meaning words (i.e., prepositions, numbers, and dates). Preprocessing allows the researcher to standardize concepts through creating a custom thesaurus. This thesaurus converted common infertility concepts such as “male factor infertility” to “mfi” and “endometriosis” to “endo.” As members in the subreddit might switch between using the full word and the abbreviation, converting all words to their abbreviated form helped consolidate the text and made the visual networks easier to read. Owing to the large size of the data set, data was split into three separate text files, and each file was separately processed in AutoMap. Preprocessing procedures were performed in the exact same order for each text file.

After the text is cleaned, AutoMap generates a co-occurrence list, which is used to visualize the semantic networks. All three co-occurrence lists were combined into one list, which generated 259,616-word pairs, which ranged in frequency from 915 to one. Due in part to the large size of the co-occurrence list, word pairs that occurred five or more times were then copied to a separate

csv document, this final list included 12,357-word pairs. This co-occurrence list was imported to NodeXL, a social network analysis software (Smith et al., 2012).

NodeXL illustrates the relationship between words through visualizing conceptual hierarchies. In this network a single concept is connected to other concepts that appear within the same two lines of text. In these semantic networks, nodes represent words and concepts, with size and color of nodes reflecting different graph metrics. In order to identify discursive patterns, I examined the most reoccurring, highly connected nodes in the large dataset based on degree centrality. With focus on these specific nodes, I then analyzed the semantic networks using the Clauset-Newman-Moore clustering algorithm in order to identify broader semantic “themes” in the text (Lambert, 2017). Original analysis of the nodes indicated that there were three prevalent clusters in the dataset (Figure 2). Recognizing that conversations trended towards three clusters, I focused my analysis on uncovering themes within each dominant cluster and subsequent sub-clusters. Networks were visualized using both NodeXL and Gephi.

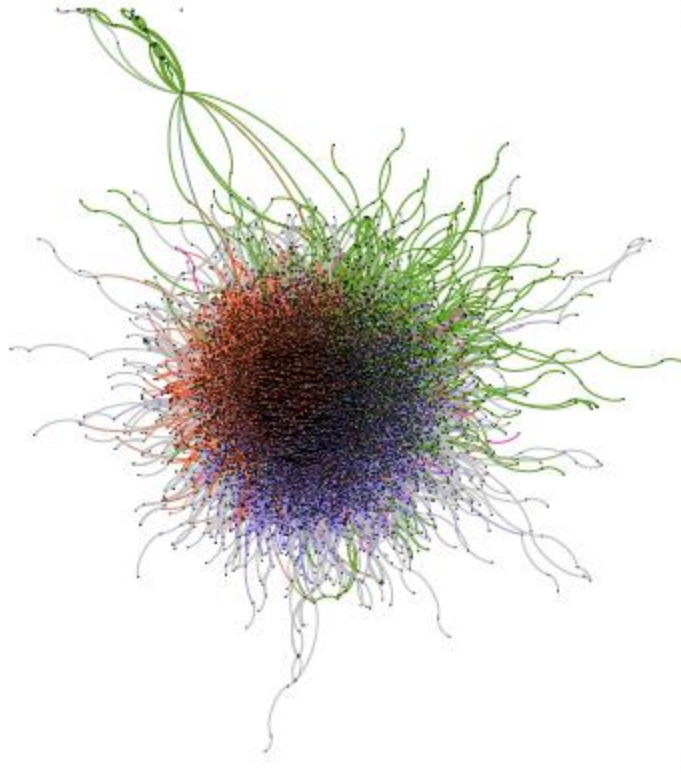


Figure 2: Illustration of three dominant clusters in r/Infertility

While the network clusters provide insight into patterns of discourse, I returned to the original text corpus to better describe and analyze how the patterns evident in the network were situated within the broader text. Thus, using the clusters and my commitment to the principles of an interpretivist epistemology as a guide, I examined prominent themes of discourse by members of the community.

While I had no a priori assumptions of themes, as previously discussed, prior to collecting the data I spent a year ethnographically observing r/Infertility. Because of this observational period, I was familiar with the common dialogue within the community and recognized that supportive community was a central function of the group. Thus, once the clusters were identified and visualized, I returned to the text corpus as a means to connect the discursive patterns evidenced

in the network with examples from the original text. Guided by the semantic clusters, I engaged in a constant comparative method of analysis (CCM; Glaser, 1965) in order to determine themes within each cluster. As I did with the interview data, CCM allowed me to inductively categorize recurring words or phrases, code for themes, and identify shared experiences (Owens, 1984). For example, a central connection was between the “pregnancy” node and the node for “Covid,” thus I searched for quotations that included reference to “pregnancy” and “Covid” and compiled them to better understand how participants were discussing the impacting of the COVID-19 pandemic on pregnancy and (in)fertility.

Cohesive Data Analysis

The final stage of data analysis involved a cohesive analysis of findings to draw commonalities across data sources. Through this stage of analysis, I was attuned to the interplay of data across contexts and levels. Through the interviews, I analyzed micro-level discourse of a specific situation. Relying on past research on the rhetoric of (in)fertility, medicalization, and patient experiences, I analyzed the semantic networks as representing broader social narratives and enduring systems of thought (Fairhurst & Putnam, 2004). And on the meso-level, I looked to analyze connections *between* individual experiences and larger structures (Alvesson & Kärreman, 2000), by connecting micro-level talk with macro-level patterns. Specifically, as a means to interrogate findings across a micro, meso, and macro level framework, I developed ‘structured questions’ (LeGreco & Tracy, 2009) to facilitate a focused, close comparison of themes across contexts. These structured questions are reflexive in nature and different from my research questions, as they involved a close and ordered reading of the data, informed by the literature. I used these questions to facilitate cohesive coding of interviews, ethnographic fieldnotes, auto-

ethnographic reflections, and semantic networks. Themes were refined and organized to address issues of identity/identification, resilience, social support, and embodied-organizing relations.

Member Reflections

Finally, after building a more cohesive understanding of themes and theoretical connections, I invited community members to reflect on prominent findings. Unlike traditional member checking that looks for verification of results, these ‘resonance reflections’ integrate a reflexive component by inviting members to review and comment on findings through an online survey (Appendix I). The survey corresponds to prominent findings, and through Qualtrics all members of the Podcast Group were invited to participate, regardless of if they participated in the interview. This provided an opportunity to gather more perspectives, some which confirmed and others which deviated from the theoretical findings. The survey was posted in the Podcast Group for one week, during which time it received four responses, two responses from previous participants and two responses from women who had not previously participated in the interviews. The resonance reflections are presented as text boxes. Responses were not formally coded, rather I aligned the response with the specific finding to which it was attuned. For example, one question on the survey asked participants, “Some women reported that undergoing infertility treatment was empowering. Do you feel empowered? Has this experience positively changed you?” Responses to this prompt are juxtaposed against the findings in Chapter 5, which discusses narratives of empowerment, hope, and resilience during (in)fertility treatment. These reflections are designed to showcase the situatedness of the experiences analyzed in this project, and to remind the readers that all knowledge is fragmented.

Interlude: Engaged, Embodied Empathy

On May 24, 2019, I go to my RE's office to once again test my AMH . I also go for some much-needed guidance; I want to know how long I can delay freezing my eggs. I know it is what I want to do, I know I must do it, but it is also expensive, time intensive, and I am scared. *Can I wait until I graduate?* If I'm able to get a job in Massachusetts, or another state that requires employers provide fertility benefits, then I'll be able to reduce the cost. If I am able to get a job in New York, not only will I have access to state-mandated benefits, but New York also requires insurance to cover fertility treatment specifically for cancer survivors. I walk through the possibilities in my mind; I map out a list of states that mandate fertility benefits and pray that I will end up back in Massachusetts. I jokingly suggest to my boyfriend that we get married, on paper only, just so I can access his health benefits. I really want to wait until I graduate, when life will be more stable.

My doctor is candid, "If you're going to do this, then you'll need to start as soon as possible. The nurse, Ashley, will answer all your questions." Our appointment lasts less than ten minutes, and already the pieces are in motion, without even time to process it, I am moving forward with egg freezing.

Rushed out of the doctor's office, I am sitting in a conference room with the nurse, Ashley, who walks me through the process. Ashley tells me what medication will be prescribed, how I should store them, and when I should start taking them. She pauses to ask me if I have any questions. I am so nervous, desperately wanting to call my mom. "But, like," I hesitate, unsure how to ask this question, "if I'm not ready this summer, can I wait?" I already know the answer, the doctor just told me I needed to do this *now*, but still, I want some reassurances. I want to not feel like I am being rushed into this process. The lyrics to John Mayer's "Stop this Train" float through my head. I think back to that time a few years ago, when I lived in the city and, desperate

to find an outlet for my loneliness, I signed a gym contract, forked over the \$200 deposit, and then immediately regretted it. The next day I filed a formal withdrawal, citing the pressure of the salesperson and explaining I couldn't afford a high-end gym membership. But in that moment, sitting in the salesperson's office, I felt immense pressure to keep moving forward, even though I knew I wasn't ready, that I didn't want a gym membership.

"Totally," Ashley replies, she is calm, and she smiles with ease; she has been through this a thousand times, "the medication can be stored in the refrigerator for up until one year." As I write this, it has been eleven months since my fertility treatment and the leftover medication still sits in the back of my parent's fridge, just in case I ever need it.

"Ok," I take a deep breath, trying to remain calm. I look for any way to make this conversation less overwhelming, more normal. "I'm writing my dissertation about infertility, actually."

* * *

I knowingly and eagerly commit myself to research on and of the self. Not only in my auto-ethnographic interludes do I lay bare my most vulnerable moments, but so too, in adopting a theoretical and contextual framework that is closely inspired by my own experiences, I build relationships with my participants based on our shared identities. Participants and I share embodied experiences that we talk about with the casual ease of close friends. During my second interview, with Beth, about one week before I start the stim medication, I lament the slow toll of waiting for all this to start, while also disclosing my fears about the inevitability of it starting. "I don't know when my period is going to come," I tell her, as we wrap up our two-hour video call, "and so every time I even get a slight stomach ache I'm like, 'oh I've got to go check,' and when it's not here I'm relieved because I'm not ready. And the idea of shooting myself with the stim shots, it's a lot."

“This is the kind of thing, that unless people, like even those details of like is my period here, is it here yet, and you check every time you wipe,” Beth replies, “that’s not something people could even remotely understand unless you’re part of this world. For whatever reason you’re doing it, all the little details become, and I think that’s the piece, it’s not just the normalizing in those groups, I think there’s the fact that there’s this culture of understanding. It’s probably the same for, I don’t know, parents of kids with Autism, unless you meet another parent who has gone through just those little things that are unique and you couldn’t know unless you’ve been through it, that sense of understanding and comradery cannot be there. So yeah, you’re voicing things that, just so few people get it.”

* * *

After meeting with Ashley, she walks me over to Claire, the financial coordinator. Claire walks me through the payment options, she outlines the total bill, she highlights what might be covered by Fertile Hope, a program developed by the Livestrong Foundation to assist cancer patients with fertility treatment. “I’m not sure if they offer assistance to childhood cancer survivors, but it’s worth applying,” she tells me. If I am approved by Fertile Hope, then they will coordinate the payment for my medication, saving me \$6,000, more than half of the total cost. That night I log onto their website, complete the application and whisper quiet prayers that they will fund me. I pray the Hail Mary three times, believing that the Mother will guide my fertility.

As Claire wraps up our meeting, she gives me directions to the lab so that I can get my blood drawn. A heavy exhaustion weighs on me, I’ve only been at the clinic for 30 minutes, but after years of waiting and wondering, the time has surreptitiously arrived. I walk down the hallway to get my blood drawn, this time not just to test my AMH levels but also to check for STDs and the like. I am a cancer survivor, and while there is not much to be gained from having cancer, the

constant prodding and poking that I have endured for most of my life has made me excellently capable of handling a blood draw with ease. When I was young, maybe eight or nine years old, I became so afraid of the blood draw that the nurse, in an attempt to quiet my wailing, offered to do the blood draw via a finger prick. If, in this entire dissertation, there is one thing I can impart on you, the readers, it is this: never opt for a finger prick. 20 years later and I still recall the weight of my mom's hands pressing against me, holding me in place, as I wiggle and cry out in pain against the constant pressure of the nurse's fingers, squeezing mine for another drop of blood. 20 years later and I can picture the muted yellow of the exam room, overly cheerful posters plastering the wall and a roll of stickers on standby to award me for good behavior. Ever since, I not only do not fear blood draws, I take joy in them because I know the alternative is much, much worse.

When my name is called, I give the technician my date of birth, "My son's about your age," she says with a smile.

"I feel so old," I respond. I try to smile, but I imagine my smile is weighted down by the impending tears, faulted by exhaustion as my brain tries to process the day's events. I am only 27, but I am about to freeze my eggs. Nothing robs you of a youthful mindset quicker than to learn that your fertile years are already behind you.

As I leave the hospital, I finally have the chance to dial my mom. "It's happening," I tell her, "and if I'm able to get the Livestrong support, then it will cost about \$5,000 out of pocket. Maybe I can set up a GoFundMe, ask people to donate? I don't know, I feel weird about that too." I am overly fixated on the cost, my relationship to money is strained by my expensive predilection for antique art and high-end skincare. I am constantly having to remind myself that we earn money not just for items of pleasure, but also in order to survive; to pay for things like this. But still, I am overwhelmed by the cost. Even outside of the \$10,000 upfront cost, there is the added expense of

appointments, tests, and storage fees. Today's consultation and bloodwork, for example, added an additional \$278 to my total bill. Each year the clinic sends me an \$800 bill for 'egg storage.' I board the train, waving my pre-loaded CharlieCard across the scanner. A one-way train ride costs \$2.40, so a roundtrip costs \$4.80. Each day I travel to the city for appointments it costs me \$5.00, plus \$3.00 in parking. I open the notes app on my phone and start a bullet pointed list, noting how much this endeavor is costing me.

That night, when I get home, I lay out the paperwork on the kitchen table. I try to remember everything the financial consultant told me as I relay it to my parents. *How strange*, I think to myself, *most of my participants never even tell their parents about treatment, but here I am laying it bare for them, begging them to help me.* I feel like a child. Later, as I sit with my parents in our small, two-bedroom apartment, watching television after dinner, I become antsy and uncomfortable. I excuse myself and retreat to my bedroom, closing the door behind me. I open a blank Word document on my laptop, unsure what else to do; I write: *Time moves quickly and slowly. Quickly we're doing paperwork, I make the decision to go through with freezing without even realizing that's what I'm doing. Slowly, we have to wait for the insurance to reject the claim, for me to gather the \$4,000, for my period to start. So, we do all this stuff up front, to wait.*

* * *

If you ask any woman going through (in)fertility treatment what the hardest part is, chances are at least some component of her answer involves waiting. Of course, she will mention the emotional pain, the miscarriages and failed transfers, she will mention the lost hope, anger, and isolation. But she will also describe the waiting. (In)fertility is an exercise in patience.

My participants and I commiserate on the torpidity of waiting. During my interview with Carol she looks for some affirmation of my understanding. "It feels very much like we've had stuff

going on for the entire 4 years that we've been trying to get pregnant and it feels like we've been doing something actively towards trying to get pregnant the whole time," she tells me, "but when I look back on the whole story it seems like we really haven't done that much because we haven't had the time, or it's been so much waiting around. So that's one of the hardest things with all of it, right?"

In the midst of anxiously waiting for my own treatment cycle to start, I wholeheartedly agree. "For sure," I say, "like a lot of fertility is just a waiting game. I can relate to that, I think. I'm in that part where I'm waiting for my period to come and I've been running to the bathroom to check, because I just want to start."

* * *

Nearly one and a half months pass before my period starts and I am cleared to begin treatment. My boyfriend is at a bachelor party and I text him panicked, "My period came, I'm freaking out!" then, a few minutes later, when I don't immediately hear back from him, "TEXT ME BACK!!!!!" That night I set my alarm for 5:15am, I need to be at the hospital by 6:30am for testing and I anticipate that if it takes me 20 minutes to get ready, ten minutes to drive to the train station, and twenty minutes to take the subway into the city, then I will arrive with just enough spare time to grab an iced coffee at my favorite coffee shop in Hospital Hill. I set my alarm, I go to bed early, but I barely sleep.

The next morning, I arrive in the city exactly at 6:30; the subway ran late. I get lost trying to find the hospital. Eventually I find my way, walking behind the food court I used to go to as a child after every single cancer appointment, where my parents would buy me a well-deserved Diet Coke and small McDonald's fry. I walk past the food court's dumpster, which reeks of decaying Chinese food and greasy McDonalds; one day soon, as early-morning appointments become part

of my new reality, I will begin to instinctively cross the street in order to avoid the wafting stench. I make my way to the basement of the hospital, following the signs for radiology.

It's 6:45 in the morning and yet the waiting room is full of women, some have their male partners there, one woman has her child. I'm slightly annoyed, knowing how many of my participants would feel incredibly upset upon seeing a child in the clinic waiting room; it would merely be another reminder of why they were there, what they were missing. I think back to an interview I did the day prior with Ellie, who admits to me that she can no longer go out to restaurants for fear of seeing a pregnant woman "all glowing and happy." I look around as I wait, and I wonder if these women know the power of the online support groups. I wonder if these women have discovered the Podcast Group or if they have some other form of support. I say a silent prayer that they are finding the support they need.

After 20 minutes, my name is called, and I nervously follow the lead of a young nurse to the ultrasound room. I'm told to remove everything below the waist, try to pee first too, and lay back. I try to control my breathing during the internal ultrasound. I grip my cell phone so tightly that my palm begins to sweat. She tells me that she is going to look in my right ovary, then my left. I count the minutes. It is not painful, but it is uncomfortable and vulnerable. I keep reminding myself that if I ever do become pregnant, these physically vulnerable moments might become more regular, more normal. It ends, I get dressed; I'm told I do not have to have blood work done today, so I leave.

On the walk back to the train station, I call my boyfriend and recount the whole morning. "It kind of felt like being probed, like if I became the victim of an alien abduction, that is probably what it would feel like." I stop at my favorite coffee shop and order an over-priced cold brew with almond milk and a croissant and eat it in a cozy corner of the coffee shop, making a mental note

to bring a book tomorrow. There are few things in life I enjoy as much as sitting in a coffee shop and reading.

Later that day Ashley calls, and I am cleared to start the stim meds. I should start this evening, she tells me, and do stim meds twice a day, 12 hours apart. I should come back for a 6:30am ultrasound in two days to monitor how many follicles I am producing. I weigh the pros and cons of different times, and eventually decide to take the shots at 10am and 10pm. I text my boyfriend, who is a trained but uncertified EMT, and beg him to come over that evening. He arrives at my family's apartment around 8:30pm and we walk down to Whole Foods to wait out the time. When I was in my early 20's, living in Colorado, I would go to Whole Foods and walk the aisles whenever I was feeling overwhelmed or anxious. When my ex-boyfriend cheated on me, I spent an hour going up and down the aisles, until eventually I went next door to the liquor store and bought a bottle of wine instead. So, with the well-worn feeling of trepidation in my stomach, we walk to Whole Foods to buy ice cream. We walk up and down the aisles, I stop to smell the essential oils, letting their pungent scent calm my nerves.

My mom is on a business trip in Seattle, so it's just my dad, my boyfriend, and myself. My dad excuses himself and retreats to the living room to watch television; he does not want to be in the room. I lay out the medication on the kitchen table, alongside the daily needle, and the alcohol wipes. I position the red 'sharps' container next to my computer, I watch and re-watch the tutorial on how to self-administer the shot. I snap a photo to post to my blog. I am nervous, but I also feel empowered; I am giving myself a shot!

Administration of the twice daily shots quickly becomes routine. Each morning I wake up at 5:15am, I take the train, I get another internal ultrasound, some days I get blood work, and then I am back on the train, iced coffee in hand, home by 8:30am, just in time to remove the shots from

the fridge to allow them to warm up to room temperature. Like that first night, I continue to carefully lay out the needles and alcohol wipes, but I no longer need the aid of a video tutorial. I am an expert. I repeat the process each night and watch as my stomach begins to swell, I feel the flutter of my ovaries enlarging. A participant tells me, “you will be able to feel your ovaries growing, it’s like they’re jumping around in there.” I wonder if this is even slightly akin to the feeling of pregnancy; I wonder if I will ever experience a pregnancy to which to compare it.

* * *

In the weeks leading up to the start of my fertility treatment, as I complete the first handful of interviews, my life converges with those of my participants in unruly ways. During my first interview, for example, I drive 30 minutes west of my apartment to meet Abbey. “I had a blocked right tube,” she tells me, “due to a burst appendix, from when I was in third grade, which nobody tells you about when you have a burst appendix, like, ‘hey, this might affect your fertility in like, 10 years down the line.’ I was nine.”

I nod in complete understanding, “I had the same experience, nobody told me when I had cancer that I might have fertility issues.” Together we share in the similar experiences of begrudging the late effects of childhood illnesses that rendered us (in)fertile. Our narratives underlined with resentment but also attuned towards acceptance of the fate we’d been dealt. As Abbey later remarks, “we went through shit, not as bad shit as other people, but still shit.”

While I was eager to start treatment, I fretted about the details of what would happen. *Will it be painful? Who will drive me to the hospital? What if it doesn’t work?* My participants became the experts that I so desperately sought; they had done all of this before, all of them had undergone multiple rounds of IVF, and I turned to them for advice and understanding. Near the end of our conversation, as they would wish me well, I would often slip in a mention to my own state of being.

I might say, “I’ve been on stim meds for about a week now and they needles are starting to hurt,” or “I think my boyfriend will drive me to the hospital for my retrieval, but I’m worried I might say something embarrassing under anesthesia.” I laid bare the anxieties that plagued me at night, the questions I had that were too personal to ask my nurse and too unique to the IVF experience to ask my mom. My participants respond with emboldened empathy.

Feminist research demands empathetic consideration. For many, including myself, empathy is the goal of qualitative research. Through empathy we emotionally engage, empower and improve; we advance representation (Keen, 2006; Liamputtong, 2007; Stein 1917/1989). Empathy allows us to cognitively, affectively, and even physically relate to another person’s pain (Clark, 1997). Ellingson (1998) suggests that her embodied knowledge of cancer granted her the capacity to empathize and sympathize with her participants. That is, through her embodied knowledge Ellingson (1998) cognitively connects and emotionally engages, building a deeper, more nuanced understanding of the pain of cancer while concurrently crafting empathy for herself and developing a deeper understanding of her own identity. In a similar vein I engaged empathy to more fully understand the pain of (in)fertility, but in doing so I also began to embody empathy. Carol complains about the amount of lubricant her doctor’s office uses and I nod in agreement, I tell her that I think of the internal ultrasound as an alien abduction. We laugh together and share in the physical vulnerability of ‘being probed.’

As I embody empathy, I reinterpret my experiences through a framework of compassion. For example, in Chapter 2, as I recall the summer of anger, I remember not just the mistakes I made and the faulty ways I allowed anger to control my actions, but so too do I remember the immense pressure I was under to succeed at school while the emotional toll (in)fertility wreaked havoc on my mental health. I learn to forgive myself for the errors of my ways and I pray that

those I harmed grant me forgiveness too. In this interlude, as I narrate the conflicting emotions of excitement and trepidation I experienced as I looked towards starting IVF, I reflect back on the role my participants served in providing empathy when I was at my most vulnerable.

Empathy is relational and communicative, allowing for new points of view to emerge through reflexive connection (Clair & Mattson, 2013; Clair et al., 2014). Thus, while much research addresses the reflexive nature of empathy for the author, few consider how participants emerge within the interactive, qualitative research endeavor as a compelling resource for embodied empathy. Participant narratives allow me to reinterpret my own experiences with compassion and nuanced understanding. I hear stories of their anger, and I begin to recognize anger as a standard emotional component of the (in)fertility experience.

Participants' stories of loss and success serve as the foundation through which I understand and interpret my experience. About a week into my stim shots, for example, as my ovaries begin to swell with newly formed follicles, I nervously call my nurse, fretting that I am experiencing ovarian hyperstimulation syndrome (OHS). Earlier that day a participant shared her painful reaction to OHS, "I was laid up for weeks, I couldn't move," she tells me. As she speaks, I look down at my own belly, protruding out from under my t-shirt like it never has before. *Oh no*, I think, *I need to call the nurse and ask if I'm at risk for this!* The nurse quickly quells my fears, "there is no way you would get OHS, the level of medication you're taking isn't enough to trigger it." She pushes aside my worries before they even have time to fully develop. I breathe a deep sigh of relief.

Later that week, when another participant mentions her fears of developing OHS, I share in her anxieties. I tell her about my frantic call to the nurse and we share a laugh over how quickly our minds can spiral towards uncertainty and doubt. "(In)fertility can drive you crazy," she jokes. But empathy does not simply build mutual understanding and compassion, it complexifies

emotions. While one participant may be so deeply afraid of the shots that she closes her eyes and begs her husband to do it, others, like myself, gain immeasurable strength from administering the shots unto ourselves. We build strength by stabbing ourselves with needles three times a day, forcing the needle into our bruised and battered stomachs. Empathy is relational in so much as it allows us to engage in a knowledge-building process together. And so, in considering the empathy I was granted from my participants, I learn to embody empathy for myself. Through our shared embodied experiences, participants and I were able to build a deeper, mutual understanding of the painful, vulnerable process of (in)fertility.

CHAPTER 4: NARRATIVES OF LOSS

It felt sort of like a rupture, when we first started doing even just the blood work for infertility, when they turned around and were like, “Oh, actually, this is going to be so much harder than you thought it was.”⁸

–Nancy

In this chapter I analyze narratives of (in)fertility related to loss. Specifically, this chapter unpacks how identities, narratives, and networks are challenged by the varied forms of loss experienced through (in)fertility. It is through a focus on the changing nature of identities and identification during loss, that I begin to uncover organizational and narrative tensions that allow women to make sense, retrospectively assess, and cope with pain and trauma. In the first section of this chapter, I respond to (RQ2), *How are tenuous identities communicated during (in)fertility?* It is through this section that I theorize on the dis/embodied tensions, changing nature of self, and diminished resilience women encounter during (in)fertility treatment. In the second half of this chapter, I address (RQ1), *How do personal narratives of (in)fertility contribute to the organizing of the (in)fertility identity?* and (RQ3), *How is resilience developed during (in)fertility?* Specifically, I uncover how the (in)fertility identity is constructed through the identity tensions inherent within narratives of loss, and how these tensions assist in a resilient discourse of hope.

⁸ Quotes have been kept in as naturalistic style as possible. In some cases, quotes were appended or abridged to provide contextual clarity. In those cases, ellipses and brackets are used to signify alteration.

Tenuous Identities/Identification

Throughout the interviews, participants consistently acknowledged tensions both within their relationship to the health clinic and within their social identities and social networks. Organizational communication scholars have characterized organizational tensions as the moments of stress, discomfort, frustration, and uncertainty individuals feel when faced with opposing demands in an organization (Lewis, 2000; Putnam et al., 2016). I extend this work to address tensions both within a formal organization (i.e., the health clinic) and identity tensions that arise through experiences (i.e., miscarriage, social interactions). These tensions are evident through narratives of (in)fertility. In the following section I unpack the many ways in which identity and identification tensions developed through the interviews (Table 3). To begin, I address dis/embodied tensions women experience as a result of the medicalization of infertility. Next, I address identity challenges women encounter, including a loss of self, social alienation, and difficult resilience.

Table 3: Identity and Identification Tension

| Theme | Description | Codes/ Examples |
|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
| Organizational Tensions | Participants struggled to align their embodied selves with the disembodied practices of the health clinic. Where health clinics value neutrality, depersonalization, and commodification, patients often felt alienated and ignored. | De-personalization Never Give Up Discourse Evident Consumerism in the Clinic |
| Embodied Emotions | Participants expressed that the process of fertility treatments are hyper-emotional, and frequently described these emotions as manifest physical (embodied) actions. | Depression/ Anxiety Physical Manifestation of Emotions |
| Liminal Identity | Women who had become pregnant through (in)fertility treatment had difficulty accepting a new identity (i.e., pregnancy) because of the past trauma with another identity (i.e., infertility). This frequently left participants trapped between two identities—pregnancy and infertility—while occupying neither. | Ambiguity Waiting for Loss Difficulty Accepting Pregnancy |
| Identity Challenges | Participants reflected that they had changed since starting treatment. This change often coincided with social alienation and an inability to enact resilience. | Identity Change Loss of Self-Concept Social Alienation |

Dis/Embodied Tensions

Throughout the interviews, participants consistently framed their body as a site of conflict. Where the medication and hormones women injected into their bodies served as a physically embodied action, discourse within the health clinic served as a source of disembodiment. As a result, dis/embodied tension developed in narratives of (in)fertility, which left participants in identification limbo as they sought to reconcile the dominant medicalization discourse, which

urged them to disembodiment from their emotions, with their lived experiences of embodiment. In the following sections, I first illustrate how emotions have become embodied within narratives of (in)fertility. Second, I discuss how disembodiment occurs within the health clinic, highlighting the role of medicalization in urging women to look past the trauma.

Embodiment of Emotions

IVF and involuntary childlessness are embodied processes. The embodiment of (in)fertility is frequently discussed in relation to the lifestyle changes, medication protocols, and spontaneous appointments that women must negotiate. These events, in turn, leave women feeling an identity change and a loss of control (Letherby, 2002c). Participants often reflect on their lack of control; as Danielle explained, while women might enact certain activities in order to feel a sense of control, these actions are rarely validated by mainstream medicine:

You read all these threads about eat a pineapple core and do that and don't do that, but women have been getting pregnant since the beginning of time and not eating pineapple core, and all these other things. So, I mean, I still do them, I think it's for ease of mind in the back of my head to say, I did do that so it must not be that, and all these silly wives' tales, but I think being more accepting of the way the field is and the way that everything is so different and everything is so ambiguous, it's made these last couple of cycles a lot more tolerable.

For Danielle releasing control and accepting the fallibility of treatment is an on-going, imperfect process. As is discussed in the next chapter, the ability to accept the loss of control frequently serves as a source of resilience.

On the advice of their doctors, or after reading online research, many women took embodied actions in order to improve their fertility. Carol, for example, first turned to alternative medicine and acupuncture to help her fertility, *"The first thing I did, rather than approaching a fertility clinic, I ended up—well, I had a colleague whose wife was like an acupuncturist who*

specialized in infertility and did Chinese herbs and stuff. So, I went to see her, and she put me on some Chinese herbs and it did help regulate my cycle.” Similarly, Beth, whose (in)fertility is rooted in male-factor issues, explained that she and her husband changed their diets in an attempt to help increase their chances of success:

We tried to be as science-based as possible and looked at different supplements and diet styles and things to change that could improve sperm; some, like, credible websites, although I can’t remember which ones they were. But they spoke to certain things, high antioxidants, cutting out processed crap, things like that. So, we did those things. And we did run those ideas by our doctors, but they were always like, nothing religious, nothing changes sperm, you get lucky or you don’t. So, that was their take. . . So, some of it was anecdotal and you do take that with a grain of salt because that’s just an n of 1. But it was enough to be like, well if that worked and it logically in your mind makes sense then why not try it.

As Beth explains, while doctors rarely endorse alternative medicine, the hope of potentially changing a diagnosis was enough of an impetus to enact change.

Frequently, one of the main sources of control for women was the ability to control when and how medication was injected. As Rachel relays, *“I could control when the needle went in and I don't know. Yeah, I guess that was part of it and, I don't know. It just seems like--I don't know, I just feel less anxious doing it myself.”* While injecting the medicine was initially scary for most women, it also served as a point of hope and optimism. Occasionally, women also expressed that having their husband administer the shot served as a way to reinsert intimacy into an otherwise medicalized process. However, as the shots symbolically served as one of the primary methods of control for women, the risk of losing control of the shots was a source of heightened stress. As Julie explains, the stress of managing the shots and maintaining control over lifestyle changes resulted in unhealthy behavior:

I think that I for a time kinda took it to an unhealthy level because I was so fixated on making sure that I didn't forget medications or that I had enough protein in my diet or whatever the thing was that my brain attached to as being the anxiety of the

week. I do remember though when we were doing so you're at the point of doing the embryo adoption and we were prepping for the mock transfer for the ERA. And I just got put on the meds. I started them at the wrong time, there's just so many to keep track of. I remember being really, really, really upset with myself and really beating myself up about that.

I wonder how much it actually works. I've tried/been trying lots of things, such as yoga, acupuncture, supplements, eliminating plastics and toxic ingredients in my diet and skincare, to name a few. It makes me feel better in achieving overall health, but it's easy to get stuck in a bubble with that, so I've gone easier on myself, especially when I have yet to see any results in this very long, multi-year journey.

People seem to think that unproven remedies can make all the difference. I think seizing control can feel good, but it backfires when you think you have gained control but realize you haven't. You are also spending a lot of extra money.

I do acupuncture, continue to work out as normal (minus jumping), drink alcohol and have coffee. I also meditate and swapped out the toxins in my home. I take all my vitamins and additional supplements and try to align my diet towards more healthy than giving into cravings. I do all of this because there's solid research on how these changes can help improve egg quality. As someone with 8 follicles I need good egg quality. But it most certainly does not make me feel in control. If anything, I worry if I'm doing enough and if it even matters

Figure 3: On Finding Control

Throughout (in)fertility treatment, there are physical, embodied actions participants take to assert control in an otherwise ambiguous process.

While there are clearly embodied actions participants adopt during treatment, participants reflect that the medication often caused them to feel out of control of their emotions. Emotions frequently translated to embodied actions. For example, Julie and her husband made the decision

to pursue embryo adoption, instead of IVF after going through four unsuccessful IUI cycles. Julie describes her decision to pursue embryo adoption in large part because she experienced suicidal emotions as a result of the medication from IUI:

I was suicidal there for a while and I just, I was not in a good place. I did not handle it very well at all. . . But like I said, I sought out help and I did the things that I needed to do to keep myself healthy, but I could not imagine going through that. And then if it did work, all the pregnancy hormones that came along too, I was scared that I would do something that would not allow either me or the baby to be able to be here. And so that was a big part of our decision was that a baby is very, very important. But making sure I'm still healthy is also important too.

Suicidal thought was not a common occurrence among participants, however many women described embodied emotions; that is to say, emotions that became so pervasive that they translated into physical action. Abbey, for example, described the intense anguish she felt when she failed to conceive. Whereas Julie was able to clearly identify the medication as the cause of the depression, Abbey's depression pre-dated her infertility treatment but combined with the medication, it caused her to self-harm:

The whole year before, leading up to getting fertility testing, and then like going through that, like I mentioned I got switched to a different therapist. I hit a rough patch, very hard core, I was really depressed about everything. I was having breakdowns all the time about it, I felt like something was wrong with my body. I was hurting myself; I was actually punching myself in the face. It was bad, I'm on medication now, it's fine, but at the time it was really rough. So yeah, I lost it. I didn't know who I was, I felt I was stuck in this dark pit and I couldn't get out of it. Like if my body couldn't do this one simple thing that it was meant to do, what's the point of everything. . . I tend to be more masculine. So yeah, it just brought up those insecurities from teenagerhood and college and all that stuff back up.

For some women, (in)fertility compounds already existing anxiety or depressive disorders, however for others, it creates newly embodied tensions that the woman must navigate, while also continuing to receive treatment, undergo surgeries, and/or experience loss. Abbey's narrative also highlights the gender dysphoria many women suffering from (in)fertility and involuntary

childlessness experience. Past research (Myers, 2001) has asserted that becoming a mother is critical to maintaining one's gender identity, self-esteem, well-being, and social and economic position. In short, there is a far-reaching cultural and medical discourse that links being a 'real woman' with being a mother (Gillespie, 2003).

While not all women profess depressive symptoms, a large majority of participants discussed heightened anxiety during the treatment process. As Lisa describes, managing the medication became incredibly stressful:

It's so scary. I remember one time, we always did my shots at night and I came back from work and the stim shot was out and I was like, "Oh my God, we ruined it, it's been sitting out." I freaked out, and I was Googling stuff and of course it was like, it's actually fine if it's room temperature. I just remember being like, oh my God, this ruins everything. Like cool, now we have to spend another thousand dollars out of pocket for the stim shot and also, it's nighttime and I can't get it and I need to have that right now.

Likewise, Mary, who successfully became pregnant after a frozen embryo transfer, describes her medication-related anxiety:

When you're trying to have a kid and/or you are pregnant, and I don't know how tight the window is, right? The doctors tell you between 8 and 10. If it was 10:05, I would freak out that I was going to harm my baby. If I didn't do it in the right sequence or right something, I would be like oh my God, I'm not going to get pregnant. Like, everything, your brain goes into, if I don't do everything exactly right or if I don't think the right thoughts or do the right things, it's not going to work out.

Both Lisa and Mary describe the racing thoughts, mounting anxiety, and the panic they suffered as they sought to take control of their health. Mary specifically connects this panic to a broader fear of losing her pregnancy as I discuss in the next section, the unending fear of losing a pregnancy is common among women who successfully became pregnant after infertility treatment.

Participants frequently sought to re-centralize their bodies and emotions in the fertility process. As Julie describes, she experienced hurtful comments that were designed to alienate her from her body:

I think because so often, I think that motherhood is just immediately tied to womanhood and I don't know the phrasing of like, well it's just naturally your body does this. . . We make these automatic assumptions about what it means to be a woman, and if you can't do this then maybe you're not meant to. That was, that was one of the most hurtful comments, like, "maybe you're just not meant to be a mother, because your body can't." So, I'm completely invalidated because my body naturally does this instead? That's harsh.

However, in Julie's description she pushes back against the inherent disembodiment of (in)fertility. She validates her body, and the strength it can enact. Many women saw themselves as developing strength through the (in)fertility process. Oftentimes, as Abbey described, physical strength was connected to the ability to give oneself shots, "*I can handle needles a lot easier now. Like, giving blood is not a big deal.*" Participants reassert their body into the (in)fertility process, despite, as is discussed in the next section, the disembodied discourse of medicalization.

Clinic discourse and the concurrent medicalization of (in)fertility often left participants expressing notions of disembodiment. Nancy clearly conveyed her feelings of disembodiment:

I'm severely disembodied about it now, in a way that like, I just laugh at myself. But I recently had a hysteroscopy to remove a polyp and when I was telling my friend about it, I was like, "Yeah, I have uterine debris, and they're just going to take it out." She's a psychiatrist and she laughed at me and she's like, "Debris, that's usually after a disaster site we talk about debris." I'm like, "Well, that seems about right." It's like space debris to me, I'm just like, my uterus is not a part of me, it's so medicalized now.

While Nancy, a graduate student, is able to explicitly identify the feelings of disembodiment, many other women described their embodied emotions in less exact terms. Faith, for example, describes her physical reaction after suffering from a miscarriage: "*I remember sort*

of sitting there, trying to catch my breath, trying to recover. And when I had the miscarriage that's what it felt like to me, emotionally I fell down and it took me months to be able to get back up."

Despite the deeply embodied nature of treatment—the injected shots, the daily ultrasounds, and physical manifestation of emotions—clinic discourse and the medicalization of (in)fertility often rhetorically constructs fertility as disembodied.

Disembodiment in the Clinic

Regardless of whether a participant opted for treatment at a large, university hospital, or a smaller, infertility clinic, participants frequently expressed frustration with their clinic's medicalized notions of fertility, commercialized pursuits, and repeated miscommunication. Participants expressed feeling as though their doctor ignored the emotional side-effects of the medicine. As Julie relayed, her doctor disregarded her concerns that the treatment was causing her to experience heightened depressive symptoms:

She didn't really talk about what the process is going to be like. When I started the Femara and the Clomid, when I was still going to her office, I was telling her that I was having a really, really hard time emotionally. I responded very strongly to both medications, differently to both, but very, very strongly. And she told me that it was just a symptom of the medication and as soon as I get pregnant it will go away. So, I think there was potential opportunity to talk about how difficult infertility is or the process, but it was always just tied back to some sort of symptom management.

Beth expressed similar feelings, explaining that her doctor relied too heavily on medication and treatment, without considering other healthy behaviors, *"I've been getting this consistent perspective that for them it's kind of like the medicine that makes a difference. I think that's the impression, but I think they forget that there's like a whole person with diet and lifestyle, and that*

stuff helps.” In these instances, medicalization prompted doctors to privilege medication and invasive treatment over other potential solutions.

Past research (Whiteford & Gonzales, 1994) has found that the medicalization of (in)fertility urges women to seek treatment at all costs, emphasizing a never give up attitude. As Kelly, explained this perspective permeates the (in)fertility experience:

I really hate it when someone posts a picture of a baby on one of these [infertility support] groups and it's like, “Never give up, never give up.” And I'm like, there is a fucking cost to never giving up, where the cost is your sanity, your mortgage, your marriage. I really wish we had a much more expandable vocabulary on what it means to give up and what it means to just be content or be able to move on. Because I really dislike how the infertility community is all about never giving up.

The never-give-up discourse can also prompt participants towards particular treatments, with minimal consideration for other avenues. Some participants, in particular, expressed surprise when their doctor suggested IVF without even considering less costly and invasive treatments, like IUI. As Rachel explained, the straight-to-IVF diagnosis came as a shock:

It turned out that I had a low AMH and everything else was normal. Then, my husband had a bunch of issues with his sperm. When the results came back, she was

like, "Given the fact that your timeline seems to be shorter than what you expect at 35, I recommend going straight to IVF." We had the insurance covered, so we were like, "Okay." It just happened. A lot of people go through-- I know there's a lot of people who have the same experience where the doctor's just like, "Don't waste your time." It was just a shock when we were like, "Let's see what she has to say," and she was like, "I say IVF."

Rachel enters an appointment expecting a casual conversation about her fertility status and is immediately presented with the news that she will need to seek expensive, invasive treatment. As I discuss later, the initial diagnosis—especially when the diagnosis is judged as unexplained (in)fertility —can present a significant shock.

Participants expressed frustration with their clinic's communication practices, which often led to feelings of depersonalization. For example, Beth described feeling frustrated that her clinic did not recognize the emotions embedded within (in)fertility, *"At every clinic, whether it's the admin staff or the ultrasound tech, people are just doing their job. And there is this vibe that because this is their norm, they start to get a bit more removed from the emotional nature of it."* Many narratives hinted at frustrations with the communication habits of the clinic, yet Penny described a particularly salient miscommunication, which she felt removed her agency:

I got a phone call that said you're good to start your cycle tonight, start your meds, everything's fine. Literally an hour before we were about to do it, somebody from the office called me back, someone I had never spoken to before and said, "I'm really sorry we're cancelling your cycle." And I said, "You guys just called me like, what do you mean you're cancelling my cycle." Literally the words this gentleman said were, "We've concluded that you're not a fit mother." And I said, "I'm sorry?" And he said, "When you came in the morning for your weigh in, your BMI is over our maximum level, so we're cancelling your cycle because you're not within our fitness parameters." And I said, "How is that possible?" because I knew what my BMI was, I mean I'm heavy, but I'm not there. . . And, he just said, "Well there's nothing I can do about it, it is what it is. It's our policy and you're not a fit parent, you have to wait," and he said it again. I hung up on him. And I called and got my nurse, and I lost it on my nurse. . . So, half an hour later my doctor calls me back, tripping over himself apologizing. So, apparently the nurse that did my check in that morning put somebody else's information in my chart and made me much shorter than I am, like by four inches or something. So, and it could have been a typo, but he didn't call it a typo, and said that's why the numbers weren't working.

Throughout our conversation, Penny frequently came back to this moment, where, in the midst of starting another round of IVF, her medical team employs crass and careless language. She described this moment as one where she felt most alienated from herself. And yet, this instance also granted her feelings of empowerment in an otherwise dysphoric process, *"I think the phone call with the you're not a fit parent, was an ok, we need to take a more active role in managing this because they're clearly not."* As is discussed in the next section, these moments of disembodied loss and trauma are often hailed as turning points for control. In other words, it is

through this pain that participants learn to retake agency, enact control, and communicate their needs in the health clinic.

Depersonalization, and consequently disembodiment, within the clinic often arose as consumerism of the clinic. For example, after three failed rounds of IUI and two rounds of IVF, Gina and her husband sought out alternative medicine through NaProTECHNOLOGY⁹. As Gina described, she felt traditional reproductive medicine focused too heavily on expensive treatments, with less concern for holistic care:

⁹ NaProTECHNOLOGY (NaPro; Natural Procreative Technology) is described as “a new women’s health science that monitors and maintains a women’s reproductive and gynecological health. It provides medical and surgical treatments that cooperate completely with the reproductive system” (NaProTECHNOLOGY, n.d.). NaPro is used to treat a range of fertility and gynecological problems. NaPro was developed at the Pope Paul VI Institute for the Study of Human Reproduction and the National Center for Women’s Health in Omaha, Nebraska.

My doctor and nurses at [my fertility clinic] were the exact opposite of this statement. They celebrated the wins and cried with me through the tough days. My nurse had a prayer circle for me the day of my pregnancy test.

I've had the opposite experience. My RE and the nurses at the clinic are very open to hearing what it is I want to do. If I want to move forward, take breaks, etc. Same with the drugs prescribed. Recently I reached out to my RE about a medication that was not covered by my insurance. She went into detail about the pros and cons of using, how it may help my cycle and the chances of it helping and also said if I don't want to spend the money then that's okay. I chose to purchase the \$1,000 medication out of pocket and if it doesn't provide specific results then we won't use it again.

I don't think I've had this experience. I just switched to my second clinic, and it was a hard decision for me to make because I really love and respect my previous RE, though I had three miscarriages in a row there, the third one supposedly from a PGS normal embryo. I have now moved to another clinic and I will say that, while I feel like our case has been more individualized and my new RE seems personable enough, I sometimes am afraid to ask casual questions about my treatment, perhaps because of his and the clinic's reputation. But, I'm pretty deep into IVF treatment so I get over that fear and just ask, because ultimately, I'm a patient and a customer and it's my health.

Figure 4: On Clinic Experiences

The things that I noticed was that they kind of, and this was something that I had asked the nurse about, because I asked why the mainstream doctors treat endometriosis so differently, why would they not take the time to remove it, and the head nurse at the reproductive endocrinologist told me out right that there is no money in laparoscopies, they take a long time and they make almost nothing, so doctors don't like to do them, so it's genuinely the difference between making money doing this, or you care for patients doing this, that I think is kind of the differentiator that to them it's all a process, and everything is really generalized, and they try to fit everyone into like, one of a couple of boxes, and I just feel like

they didn't take the time out front to figure out which box I should have been in because they were not giving me an endo protocol, which I think made it a lot worse.

Consumerism in the clinic was evident in multiple narratives. Both Nancy and Jillian relayed experiences in which they felt their fertility was commodified. Nancy discussed her first meeting with a fertility doctor, in which she felt simultaneously pressured to pursue treatment while also being stereotyped as impoverished:

[The doctor] said a few times, he's like, "Yeah, you're going to have to lie, cheat, and steal to get money to do this, because you have to get the money together to do it. It's imperative you do it right away." It was very high pressure, and he also was kind of flaunting his own wealth simultaneously, which my husband was like, a deal break, he was just like, "I'm out."

Jillian described a similar experience, during which she visited a world-renowned fertility clinic and was immediately put off by the opulent décor:

For me, the first clinic I was at was a really renowned clinic, like people travel from all over to be treated there. And at first I was like, great, I have this world-renowned clinic and it's only a three hour drive, this is the perfect situation. But the clinic itself, the aesthetics are very opulent, which I found off-putting. Considering all these women are paying out of pocket, I don't want to be in a clinic that has waterfalls and a coffee shop. I also looked up the, you know you can look up how much money doctors get from drug companies, there are these sources online, and the doctor I was seeing was getting huge amounts of money from all these drug companies, so it just kind of made me feel like, I don't trust the advice you're giving me is the best advice for my particular case.

It is the inherent consumerism, in both the discourse and materiality of the clinics, that creates a tension for participants. As Nancy described, her doctor's casual remarks to 'lie, cheat, and steal to get the money' felt increasingly alienating. Likewise, Jillian expressed feeling disappointed when she was faced with paying thousands of dollars for treatments to a clinic that showcased obvious signs of wealth.

Challenging Identities

(In)fertility and involuntary childlessness represents a profound shock to a woman's sense of self, which often results in an identity change or challenge (Letherby, 2002c). Drawing on social identity theory (SIT), which suggests that an individual's sense of self is grounded in social comparison (Letherby, 2002c; Tajfel, 1978), this section explores how the identification process is disrupted when there is not a readily available in-group identity. For women receiving (in)fertility treatment, their identity rests in frequent comparison to motherhood (Gillespie, 2003), consequently leaving women who fail to conceive as an out-group. In the following section I investigate how women's identities and self-concepts are challenged during treatment. To begin, I explore how experiences with (in)fertility cause a loss of self. Second, I address aspects of liminality in the identification process to motherhood. Third, I outline how this loss of self-concept can lead to social alienation. Finally, I connect these findings to aspects of failed resilience and loss of hope.

Lost Identification

Within scholarship on identity/identification, researchers have used concepts like disidentification and deidentification to explore the process of losing an identity (see Scott, 1999, 2007), however neither of these terms explain the loss of self, which many participants describe. Specifically, participants indicate the process of (in)fertility treatment causes a loss of a core identity. However, women are not consciously disidentifying from a social group, rather participants express a sense of loss from their pre-treatment selves. It is recognizing the lost sense of identity, that I illustrate how narratives of self-concept coalesce around the notion of lost identification, wherein participants describe the process of losing a core aspect of their selves.

In losing a core self-concept, participants describe the changing nature of their social identity. For example, Julie, the participant whose reaction to the medication was so intense she became suicidal, describes the drastic shift in her personality:

I do student life and I did [resident] life before. I'm always the happy person on campus. Like I'm always the one that's getting people involved and doing all this. And so, some days I just had to do reports in my office. You know what I mean? And just close the door and there was plenty of paperwork to do. I promise. I was not just making things up, I just couldn't be around people.

Similarly, Ellie described her shifts in personality, as she went from a confident, social person, to someone who was averse to social situations:

The rest of my life just goes away, like me as a person. And my husband will say, I just want to go out to dinner and enjoy ourselves, but I'm like, yeah but there's someone at the next table who's pregnant and all glowing and happy, sorry I can't just be my normal, positive happy self. That is literally all I care about right now in my life, so how can I just shut that off? And I've never been like an angry or jealous person, like I'm super optimistic usually, so that's been hard, I think it's been hard for my husband to see me *not being this strong, positive, happy person. I've definitely lost a lot of my normal identity.*

If anything I think I've found who I am going through this process. I've really had to dig deep and really ask myself what it is I truly want and if I still see kids in the picture or are kids just something I feel I need to do because of the standard life steps.

It feels like I get stuck in a rut. It is more than another job to me, it is upheaving my entire lifestyle, from diet and exercise to what type of makeup, skincare and jewelry I choose to put on or not. Even eliminating as much plastics as possible. It is very easy to get pulled into a bubble when you fail and are looking for anything to succeed. It also feels like innocence lost...like losing a sense that everything will always work out the way you want it to. I don't always see the glass as half-full anymore. A lot of people will willingly share how IVF worked for them, but it is rare to hear from anyone that IVF did not work for.

Figure 5: On Lost Identities

As Ellie's narrative suggests, these identity shifts are often spurred by a feeling of alienation from previous social circles. For Ellie, and many other women, seeing pregnant women, or young children, is a visual reminder of what they are missing. And yet, both women seem to recognize that the lost sense of identity is grounded within the (in)fertility experience, recognizing that when treatment ends, women may regain their lost self.

A second element to lost identification, which differentiates it from theories related to disidentification, is the potential for individuals to retain elements of their lost identity, while also believing themselves to have changed. In our interview, Carol believed that (in)fertility treatment has changed her, but it has also helped to strengthen her preexisting identities:

You know how they say what doesn't kill you makes you stronger, sometimes I feel like what doesn't kill you just makes you more screwed up and that that's not really true. Sometimes it's, like when I'm questioning myself more, it will sometimes make me feel that maybe I'm not that strong, maybe this is just making me less willing to try things because they won't work out. What if it's just making me more risk-averse, and I was never terribly much of a risk taker in the first place, so I don't need to be less of one. What if it's just making me smaller and not stronger. I worry about that sometimes, basically, what if it's just making me weaker. But mostly, that's just in my weaker moments.

Carol also communicated that her identity changes are not permanent, but rather they only come through in her 'weaker moments,' suggesting that her identity challenges are on-going, and non-linear. Tia similarly described changes in her identity, wherein she believes she has retained her core sense of self, yet her personal identity has also been reshaped by the treatments:

It made me stronger and softer at the same time. It made me withstand a lot of treatments. It made me withstand a lot of time that goes by. It's a lot of hurry up and wait. But it's also made me softer in the sense that I'm more emotional, and I'm more sensitive and empathetic to other people and their pain. I feel like those qualities have made me a little bit better in a way. I feel like, you know kintsugi pottery? It's Japanese form of pottery where they take broken pieces of pottery or clay and they put it back together, and the cracks show, but it's the cracks that make that pottery really unique and special. That's what infertility and loss kind of feel like for me. I mean, I've been broken apart before, but I also feel like I've been

pieced back together in a careful, artistic way that's better than I could've been before.

In this way, the identity changes that women experience during (in)fertility are not permanent, nor are they necessarily damaging to the sense of self. Rather these identification challenges present a process, in which participants struggle through loss, but ultimately persevere.

It is important to note that some participants reflect that while (in)fertility has caused them to change, these changes are not casual, and may be related to other key life events. For example, at the time of our interview, Kelly, who has two children (one through IVF, and one spontaneously), was in the midst of using IVF to try for her third baby. She reflects that while she has changed, this change is not necessarily permanent:

I used to want to be somebody who was magnanimous and loving and kind and generous because of my suffering. But I don't think I'm even there anymore. I just think I've become someone who is very self-interested, which is fine because I have two kids and a career, and I'm tired all the time. But I also don't think I have tapped into my better angels and that's frustrating to me when I reflect upon it.

Understanding the lost identification process as temporary and not causally linked to (in)fertility provides a better theoretical framework through which to understand the ambiguity that plagues many women experiencing (in)fertility and loss. In the next section, I unpack this ambiguity through addressing liminal identification.

Liminal Identification

Throughout the data collection process, I was attuned to the ways in which (in)fertility treatment was construed as a liminal transition. However, narratives rarely focused on the liminality of treatment per say, rather liminality was most apparent in the discourse of pregnancy. (In)fertility treatment already changes the pregnancy experience; as Allison describes, because she

shared the date of her frozen embryo transfer with her immediate social support network, she felt immense pressure to disclose if she was pregnant, and moreover to appreciate being pregnant despite the struggle she endured:

They knew when we did the transfer, and they knew around the time I'm going in to find out. So, I knew that they were waiting on us to tell them if it worked, or not. And so, I probably had to tell them, and that just felt rushed, and that the way that I maybe would have wanted to do it. It just happened naturally. I would have wanted to wait a few months probably, and just enjoy that with [my husband]. And I felt like now all of a sudden like, "Oh, I should be so grateful that I'm pregnant." Though I was still upset about how long it had taken. It was a confusing time.

Mary, who identifies as a single mother by choice, shared similar sentiments:

There's this taboo in life about not sharing your pregnancy until your 12 weeks, until you've done your first trimester. And nobody shares until 12 weeks, it's this big thing. So, when you're doing IVF and people that you know, know that you're doing IVF, there's a transfer day, so like you're not really sharing after 12 weeks, if there's people know your transfer day, so it's like do I become really quiet about the transfer day? Or do I talk about it? So, I think, my one cousin who helped me do the shots during the whole process, so she knew exactly about everything. My mom didn't even know when my transfer day was, like there was the right-hand people who knew the specific day, I just kind of said, I have to take meds until my body responds, and I'll let everybody know when it's time, kind of thing. So, after I got a positive pregnancy test was kind of when I shared with immediate family, and then, I mean I'm 11 weeks and I would say other than work, pretty much most of the people that I'm close with in life know.

As is present throughout this research, (in)fertility treatments challenge traditional notions of pregnancy. As Allison shares, there is a belief that women who have undergone (in)fertility treatment must be grateful for pregnancy, and that pregnancy should immediately resolve any residual anger, frustration, or pain related to (in)fertility treatment. Consequently, if a woman who has gone through (in)fertility suffers from intense morning sickness or any other common pregnancy ailments, she is typically told to be grateful and not complain. Women who conceive naturally are not beholden to the same strict judgements. As should be evident through the

following examples, the experience of (in)fertility leaves an indelible impact on the experience of pregnancy.

Of the 20 women interviewed in this study, seven of the women successfully became pregnant through IVF; however, of these seven, six of these women also experienced prior pregnancy loss. The experience of pregnancy loss caused many women to have difficulty in identifying as pregnant. Abbey, who suffered from one miscarriage and two unsuccessful transfers, shares that she struggled to identify as pregnant throughout her entire pregnancy. Despite being able to see her baby's beating heart, she was always waiting for a failure:

I didn't consider myself pregnant, even when it worked with our baby, I didn't consider myself pregnant until I got—we got—transferred back to my doctor, my OB. Like, even when I saw the heartbeat, I was like, any second now he's going like, it's not going to be there anymore it's going to be gone. And I mean, that really lasted through the whole pregnancy.

Beth, who similarly suffered from two miscarriages and a chemical pregnancy before becoming pregnant with her first child, shares that not until her third trimester was she able to accept her pregnancy as real:

The first trimester felt like eternity because we had a first trimester loss after seeing the heartbeat. So, really, we were like seeing the heartbeat is not going to reassure us, seeing it every time we go in for a scan is going to reassure us for like a day and then we're going to get scared again. And I think infertility, and trying so hard to make a baby, you don't get to enjoy pregnancy. . . I think it made it complicated because we didn't really believe he would be ours—or, because we didn't we chose not to know the gender because in case we lost the pregnancy we didn't want to be too attached to if it was a boy or a girl. But I think not until 28 weeks did I let myself even research baby stuff. So, even that, I think it took me so much longer to kind of get ready for baby because I spent so much time thinking it wasn't even real.

Notions of liminality pervade narratives of (in)fertility, especially related to pregnancy. When she is always waiting for failure, the liminality of pregnancy can make it more difficult for a woman to plan for the future.

I am 1000% sure that this will be me, should I ever be successful. If so, I will have to sign myself up for therapy with a side of antidepressants.

Every step of the way, I was scared something was going to happen. I think because I had to push my body into pregnancy instead of it happening naturally, I was scared. I do not feel secluded from other moms or groups because I have a baby through IVF.

Figure 6: On Pregnancy as Liminal

Pregnancy is a transitional state regardless of experiences with (in)fertility treatment. However, the narratives of women who became pregnant on their first round of IVF, or spontaneously became pregnant without the aid of medication, often do not communicate the same heightened sense of liminality. Kelly, for example, became pregnant on her first round of IVF and prior to starting IVF she had not suffered any miscarriages. Kelly describes her pregnancy as joyful, “So, for [my daughter], who is my first, she’s three now; that pregnancy, I was like on cloud nine all the time because I didn’t think I could get pregnant. And then, just like this feeling of anticipation and expectation.” Compared to women like Abbey and Beth, both of whom suffered varied losses, Kelly’s description of her pregnancy was void of many of the anxiety-inducing trepidations. Likewise, Ellie described the first time she became pregnant, before miscarrying near the end of her first trimester:

I think when I got pregnant the first time, I was so happy and just so oblivious, and just like, oh it’s all going to be great. Because we didn’t struggle for that long and if we do get pregnant again, I think I’ll be a lot more sensitive. Well, first of all, I think I’m probably not going to [accept] it the entire time until there’s a baby outside in the world. I think sadly I’m probably a little jaded now and won’t be able to enjoy pregnancy like I did the first time, because I was just so oblivious, and it was great.

Unlike Abbey, Beth, or Kelly, at the time of our interview Ellie had not successfully carried a pregnancy to term, and she recognized the changes that (in)fertility treatment may have on her ability to successfully identify as pregnant if she were to become pregnant again.

Liminality also presented itself during the two-week wait—the time after an embryo transfer, but before a woman knows if she is pregnant. During the two-week wait, Rachel described the ambiguity of possibly being pregnant, and also of not being pregnant: *“It’s a very bizarre thing where you’re kind of pregnant and kind of not pregnant. . . That transfer process was—for whatever reason, if it was just the hormones they were using or if it was more difficult process, I don’t know—but it was way harder than the retrievals.”* Even after the initial pregnancy confirmation, some women, like Mary, are closely monitored to ensure their hormone levels are rising accordingly. As Mary described, this close monitoring, coupled with a lack of pregnancy symptoms, made it difficult for her to accept her pregnancy:

So, my HCG levels were high and so being high like there’s just possibility to be pregnant with twins and then when I went in for my 6 week ultrasound, like during those whole—I had a high beta number and I had no symptoms. So, on one hand I was pregnant with twins in my twins, and on the other hand I was pregnant with a child that had no heartbeat because I had no symptoms.

During our conversation, Mary expressed that she had expected to experience the typical symptoms of pregnancy, such as morning sickness, but when she did not experience those embodied symbols of pregnancy, she quickly became panicked. Participants frequently rely on cultural stories surrounding pregnancy as a way to confirm, or deny, their pregnancy.

Failure to ‘naturally’ become pregnant, often left women feeling as though they were unworthy of motherhood. As Julie describes, the (in)fertility experience forced her to question if she was meant to be a mom:

I've never had any questions if my husband says to be a dad, like he's just one of the best human beings on the face of the planet. But it's just, it's like I wanted the chemical reactions to happen in my brain that would, that would tell me to feed the baby. Like, if I don't have that, will I be a good mom? And I don't know why that question was so apparent to me all the time. And it really made me question my self worth. If this doesn't happen the natural way, the way that everyone else says it does, does that invalidate me in some way?

It can suck when you see a "newcomer" in some IVF groups who arrive sometime after you find success before you. Or, if someone got lucky on their very first round of IVF and first transfer. It can be hard to spend too much time on it, because on one hand, I get jealous seeing other people succeed; on the other hand, when others fail, I get depressed.

I feel jealous when people get pregnant, I feel left behind, and I suffer some class rage when people seem to have unlimited resources for treatments and testing. I can only afford IVF because it's covered by insurance. I know that's its own form of privilege, but it limits my options.

Figure 7: On Alienation within Support Groups

This tension between pursuing motherhood and feeling alienated from the motherhood identity, was evidenced throughout women's narratives of (in)fertility, as women struggled to accept the reality of a successful pregnancy. As Allison relayed, *"You get used to bad news after a while, and you're waiting for the other shoe to drop."*

Social Alienation

Countless women expressed feelings of social alienation when friends or family members become pregnant. As Lisa described, her close friend's pregnancy challenged her previously stable identity as a supportive friend:

One of my friends is actually pregnant right now, she hasn't told us, but we all know. And that's hard because I don't want to see her, but I really like her as a person and I'm excited that she's pregnant and I know it took her a minute to get there. But it's hard for me to be happy for her right now, and that sucks. Because I've never been that kind of person. So, that's like one of those changes that you're

like, oh, that makes you feel bad about yourself. Because, like, I don't want to not be happy for other people.

Oftentimes reminders of their failure to conceive can lead women to avoid social situations. There is a wealth of research that suggests women experiencing (in)fertility feel socially isolated (Hasanpoor-Azghdy et al., 2015; Hinton et al., 2010; Imeson & McMurray, 1996). In particular, women frequently will avoid pregnant friends and baby showers (Parry, 2004; Parry & Shinew, 2004). Tia explains her choice to skip a friend's cookout, fearing the event might be a surprise pregnancy announcement:

I will say, back in the summer they had a cookout party, or a housewarming party and I didn't want to go, so I skipped out. I was afraid because they had been married and I've been to housewarming parties where it became a surprise pregnancy announcement and I was terrified, I was like, "Oh my God, not another couple to do another lap around me, to have a pregnancy before me, a viable one." But it turns out, they're kind of dealing with the same things too. Who knew?

However, as Tia later learns, her friends were, in reality, experiencing the same (in)fertility problems as she and her husband. As will be discussed in chapter five, disclosing fertility problems can occasionally prompt others to disclose similar struggles, which is often a positive experience and helps to normalize and destigmatize (in)fertility treatments.

Pregnant women, especially friends who seem to become pregnant easily, were consistently cited as one of the most alienating groups. As Abbey explained, these women frequently do not understand the experience of (in)fertility and lack empathy for the unique, painful reality of treatment:

There was a friend of mine from high school who, just for context, had a one-night stand and got pregnant at 19, first in our friend group to have a kid because we were 19. I had posted something, and she commented, 'have you considered adoption? have you considered surrogacy?' and I was like, 'I can get pregnant; I'm just having trouble getting pregnant.'

Other women, like Ellie, expressed similar sentiments:

My best friend, God bless her, she's got pregnant twice on her own, by accident at 34 and 36, and she has twins and a 5-year-old—she has twin 2-year-olds and a 5-year-old. And she just doesn't get it, she just lays down and gets pregnant, so she's like, "Can't you guys keep trying like in between [cycles]?" And I'm like, "No that doesn't work, that ruins the whole point of doing this". . . People like her, say all the wrong things at all the wrong times, and I finally had to say, "Can you just Google what not to say because I know you mean well and I don't want to be rude but you can't tell me, oh I know it's going to happen for you guys, I just know it." Because no you don't, you don't know it.

As is further discussed in chapter six, participants frequently perceive (in)fertility as a unique experience, one which other people cannot understand unless they have gone through the process themselves. However, this alienating communication hurts friendships and further isolates women.

Because of the stigma surrounding assisted reproductive technologies, participants encounter alienation within their religious communities. Julie, who identified herself as a devoted and practicing Christian, shared this experience:

There is one guy in particular, and I come from a church background, so I recognize that church is going to play a part in this. When we told, when we told him about doing embryo adoption, he said, "I wish I had never heard that." Because he's so, what's the right word? I guess he just doesn't understand embryos being frozen in general, like the sanctity of life argument kind of stuff. And he just, he made it more about a political issue than about our specific story—that make sense? I recognize that our story can be used for a lot of different elements of your political leaning, but don't do that. We haven't given you permission. So that was pretty ugly.

As is evident in Julie's story, religious alienation was frequently conflated with political ideology, leaving participants to feel intensely private about their experiences. Sarah shared a narrative in which she was forced to implement communication boundaries with her in-laws in order to limit their religiously based, alienating comments:

My husband's one of four kids, his parents got married and just started having babies right away. They're a Catholic family, pretty Catholic. And they didn't really understand like, our decision to do IVF and then once we told them we were doing IVF they were fine at first and then we figured out someone at their church must have gotten to them and was like, "Well you know IVF is practically abortion," or something, must have said something crazy, because all of a sudden they started asking questions, "Well, how many eggs do you expect to get? How many embryos will you get? What are you going to do with those embryos?" And then the final straw for my husband was when his mom said to him, "Do I have a bunch of grandbabies somewhere in a freezer?" And that's when my husband was like, "Ok, this conversation needs to stop right here." And he basically laid out a boundary for them and said, "You need to decide how much this matters to you because it's offensive and hurtful to us. And the fact that you guys clearly can't understand what it means to be infertile, and struggle through that. And so, you have to decide if you want to ask any more questions because I'm done talking about this with you, and it's up to you if this is an issue or not."

Julie and Sarah's stories both highlight the role of religious rhetoric in enforcing social alienation and stigma. Frequently, these fears cause women to avoid disclosing their treatment. As Ellie told me, she was open with most everyone in her life about her (in)fertility treatments, but she *"probably wouldn't bring it up to my super-religious, right-wing conservative family members, just because they might have their own varied views on it."* Recognizing the potential alienation that can occur when someone is public about (in)fertility, women were selective and strategic in their disclosure decisions.

The choice to disclose (in)fertility treatment was often a well-thought out decision. Participants expressed strategy in how they disclosed their decision to seek treatment. For example, Gina shared with friends and family members that she was seeking treatment, and she enjoyed the support she received, however, she chose not to post about it on social media because of potential religious conflict:

I didn't talk about IVF specifically on Facebook, because I do have a lot of like, Facebook friends that are friends of my parents from church, some of them added me since my dad passed, or people that he—he was a high school teacher at a Catholic high school here—and people that he taught with or things like that. So, I

didn't want to cause any weirdness for my mom or any bad blood for my dad now that he's not here to defend himself anymore, especially given that it was something that he wasn't really, I don't know how much he really knew was going on.

Gina, who identified as a devout Catholic, did not fear members of her religious community alienating her, but rather chose not to post out of respect for her deceased father, who, she worried, as a Catholic high school teacher and religious Deacon, might not have supported her IVF if he were still alive. Gina sought to reconcile the tension between her religious identity and her pursuit of IVF through conversations with those she trusted:

We actually have gone to our priest, and told him after IVF didn't work, when we were starting NaPro, we went to our priest and asked him to give us a blessing because I was really nervous about how that first appointment was going to go. And I told him that you know, we had gone through IVF but we weren't sure how we felt about it, and he just kind of said that--I had gone to confession about it because we really struggled with it, and part of it was because never in my wildest dreams would I have thought as someone from the time that I was 13 had regular cycles every month like clockwork, that I would have all of these issues that would even bring us to that conversation, so that was hard in and of itself. But I think what ultimately ended up being the hardest part of all of it was that my dad died before we actually started IVF, so it was kind of that like, he was always our person that like, if he found a way to be ok with it then I was ok with it. And we never got to have that conversation so I kind of always wondered like if this was something that he would have had a major problem with. My mom, equally devout, just she actually almost became a nun when she met my dad and got married instead, so that's kind of the level my parents were at. But she kind of said that it wasn't, she had issues with my sister in law. So my sister in law did IVF with a donor, because she was 39 and divorced and didn't think she was going to get re-married and was sick of waiting for a guy so she was just doing it on her own, and that my mom had a big issue with because she felt like that was kind of playing God just for the sake of playing God. And ours, I don't know if it was just like justifying it to herself, or what it was, but for us she kind of felt like we were told that we had no other choice, and for whatever reason we were being pointed there, and that felt different to her. It wasn't like if we hadn't told we didn't need it we weren't just trying to order a baby out of a catalog, we were told we had no other choice. And that felt different to her, so I kind of rationalized it to myself that way. But we did always struggle with it, honestly, I still do really struggle with it and if it weren't for the fact that we don't know if our frozen embryo is healthy, I probably would opt to adopt it out and not ever transfer it.

Gina sought to reconcile her identity and the risk of social alienation through conversations with those whose religious identity she respected (i.e., her priest, her devout mother) and it was through these conversations that she was able to accept the tension. However, Gina's narrative also highlights an important sense-making process, through which she and her mother identify an out-group member, her sister-in-law. As identity is grounded within social comparison (Tajfel, 1978; Letherby, 2002c), Gina and her mother use this comparison to distinguish a valid reason for pursuing IVF (i.e., the desire for a child within a nuclear family) versus what they view as an invalid reason (i.e., pursuit of single motherhood).

Posting on social media represented a significant turning point in participants' lives. As Carol describes, her decision was heavily influenced by the pain of her unacknowledged and continued losses:

I think it was on Mother's Day this year when it really, I was like 'I think I need to post about how I am feeling' because most—I mean I'm 39 now—most of my friends have kids, almost all of them, pretty much all of them who want kids have kids. Most of my friends are done having kids now, and so on Mother's Day it's just a big Facebook feed of 'I'm so grateful for my children for blah blah blah' and it's hard. It was really hard for me. This was the hardest year for me to see [Mother's Day posts on Facebook] knowing that I could have two by now. I could be done. If I'd gotten pregnant quickly when we started trying, we could have had our family complete by now, we'd had enough time. And it still hasn't worked, I know people must wonder, like we've been married for 2 years, 'aren't you going to—isn't the clock ticking? Like aren't you getting on with that?' like, yes we are. So, it felt really important to finally just say something, so I did.

In the same way that women may choose to avoid baby showers or pregnant friends, Carol's decision to post on social media was heavily influenced by the omnipresent Mother's Day discourse. Similar to Gina, Carol's narrative highlights her out-group versus in-group identity, insofar as her identity as an (in)fertility patient positions her as an out-group member.

A final significant source of alienation occurs within online infertility support groups. As is discussed further in chapter five, these online support groups often offer emotional and informational support, function as a source of hope and resilience, and assist in crafting an identity of empowerment within (in)fertility experiences. However, for women who deviate from the typical IVF pathways, participants frequently reflected that these groups can feel alienating. Gina, for example, had undergone two rounds of unsuccessful IVF before turning to NaProTECHNOLOGY, an alternative, less invasive, form of fertility care. Gina believed that, within the group, her experiences with IVF were not viewed as valid because she did not conceive her child through IVF:

Where I actually feel more isolated is, I get treated like my journey was different because I didn't conceive through IVF. So, they almost kind of treated me like my story wasn't as hard as anyone else's story because I didn't have to do IVF to have him. So, the fact that I went through IVF twice, and the fact that we've lost multiple babies, doesn't seem to matter as much as the fact that I didn't have an IVF pregnancy. So, I've actually kind of stopped participating in that group because it was not supportive.

Gina struggled to find acceptance in (in)fertility groups, which ultimately led her to start her own group specifically for patients of NaProTECHNOLOGY. Yet, as Gina reflects, even within this group she felt her story was invalidated after she started trying for a second child:

I actually started one which is specific for people in NaPro. That one I find a little harder to talk about the second one, because a lot of the people in that group are still trying for number one. One of them, she's been going through infertility and actively going through infertility for 13 years, and she's been with NaPro for almost 3 and has not ever once been pregnant. She's never had a positive pregnancy test, so that one is really hard because I feel, they've never made me feel guilty for it, but it makes me feel greedy, seeing other people, I mean 13 years I cannot even imagine going through this, because we've been in it for 6 now, and even that seems like two lifetimes.

Secondary (in)fertility was frequently cited as an alienating force both within online support groups and in everyday conversations.

Secondary (in)fertility presents its own range of alienating experiences because women are frequently told to be grateful for what they have. As Gina's story highlights, there is a perception that wanting a second or third child is greedy, especially when faced with the narratives of women who have not yet been able to conceive one baby. Kelly, who has two children and was in the process of trying for a third baby through IVF, summarized this perspective:

At this point, it's gotten so regular for me, I don't tell people unless they ask. I was like, it's fine. Like, I'm just going to live and learn, and I will also say that in primary infertility is pretty different than secondary infertility. If anything, I feel like it's more isolating because I have children, because every time I tell somebody that we're trying again, or that I even indicate that it's sort of hard, I always, probably 99.9% of the time someone says, "Well you should be happy you have two." And that is sort of bananas because from a logistical perspective, it's not how many kids you want. It's not about how many kids you have, it's how many you can't have. I think what I'm learning is a loss of agency, it's not my choice, because I have money or resources and it's very hard to explain that to somebody who either A) is infertile or B) has never dealt with infertility.

Participants adopt certain strategies to reduce the isolation and guilt they experience, both offline and online. Kelly explained these strategies as such:

Even on the Facebook groups, I'm very purposeful or I'm very intentional about what I share because if I'm in a group that has a lot of primary infertility people, I don't share that I have two kids. And then on the secondary infertility groups, obviously, I'm much more open about it because everyone else is in the same boat. I remember very clearly, before I had children, I read someone's blog about how someone wanted the third kid and they weren't happy with her two or whatever. And I was like, that person is an idiot, but then here I am.

As Kelly describes, secondary (in)fertility is a unique experience in so far as women who have not experienced it cannot fathom the pain, and yet is potentially more isolating than primary (in)fertility because of the judgment rendered within (in)fertility support groups.

Where secondary (in)fertility is one method of reaffirming in-group versus out-group identity within online support groups, some participants reflect that these groups also felt alienating because of age. Faith, for example, was the oldest woman I interviewed for this project. At the time of our conversation Faith was 49 years old and had just completed her third frozen embryo transfer and was in the midst of the two-week wait. Faith believed being older than many of the women in the online group provided her a unique perspective, which at times had its benefits:

I joined a couple of Facebook groups, but I go back and forth because I also don't feel the shame that I read a lot of people have. It makes me so sad, for them and their situations—to not even be able to tell their families what they're going through, I can't even imagine. . . The other thing about these Facebook groups too, there's so much anger that a lot of people have. It's something that never occurred to me to really experience because no one around me is saying, hey I'm pregnant, I don't have that competition or sense of urgency, and so when someone tells me they're pregnant it never occurred to me to compare myself to them, or to be angry that they're pregnant. So, I feel like a lot of the natural responses I'm having to this are so different from what a lot of people are going through, which makes me feel even a little more isolated.

Faith uses her status as an older woman to enhance her resilience to the process. Instead of using the support groups as a means of comparison, which as I will discuss can be a dangerous tactic, Faith's resilience is bolstered by recognizing that her age is unique, and thus not comparable. However, Heather, who was the youngest woman I interviewed, did not share this same perspective. At the time of our interview Heather was 25, but she and her husband had started trying to conceive two years prior, when she was 23. Heather had completed two rounds of medicated cycles, three rounds of IUI, and one round of IVF, which ended in an ectopic pregnancy. Heather felt as though her age prevented others from understanding the severity of her (in)fertility:

I think its hard because I think even in the infertility world there's, I wouldn't say discrimination, but I do feel like sometimes being 23 or 24 at the time, and then when you're posting something, I think I'm very aware of not to really say my age like other people, 'I'm 41 and I have low AMH.' I do think I'm self-conscious about

that fact. I don't want to piss anyone off because I feel like people may not really understand the struggle when you're so much younger.

Where both Faith and Heather communicate feelings of isolation, Heather takes proactive measures to hide aspects of her identity (i.e., her age) in order to feel more accepted within the group.

Finally, these groups can also become alienating for members who fall within the in-group identity, particularly when others share success stories. As Carol reflects, when a member of the IVF community becomes pregnant, it can be a painful reminder of what you have not achieved:

I had one friend who had been through IVF, the only one I knew of, and I did try talking to her at the beginning, but she was one of those ones who did IVF once and it worked for her on the first shot, and she thought she knew everything about it, and wasn't, I don't know, I found it a bit too much of I told you so, or just telling me what to do, so I didn't really want to talk to her anymore.

Similarly, while Ellie had turned to an (in)fertility podcast as a means of finding information and support within the IVF community, when the podcast host became pregnant, she had to stop listening:

They have a baby now and I tried to keep listening once she got pregnant, but it was too hard, so I stopped listening. And I feel kind of bad because I'm obviously happy for her, but I got to that point in the podcast, like right around the time both my transfers failed, so like the last thing I wanted to hear about is oh my beta numbers came in, it's positive, they're doubling, everything is fine. Like that's great, I just, I need to read about and hear about other people struggling. I think it helps me get through it.

While the groups frequently do provide a strong sense of hope and support, especially when stories of success are shared, some participants, like Ellie, felt a stronger sense of support when reading stories that were not positive. These non-success stories helped Ellie recognize that she was not alone in her suffering.

Social alienation is thus constructed both through the discourse of everyday talk (i.e., religious rhetoric, social media postings, comments from friends) and the broader cultural Discourse of motherhood and (in)fertility (i.e., celebrations of Mother's Day, stigmatization surrounding treatment). Participants negotiate these dual forms of social alienation through embodied actions, such as breaking ties with hurtful friends and family, and social comparison offline and online.

Failed Resilience

Buzzanell (2010/2018) identifies affirming identity anchors as a primary means through which resilience is communicatively constructed. However, as the previous section illustrates, women undergoing (in)fertility treatment often struggle to maintain a cohesive identity. Frequently, resilience is disrupted when a participant is unable to hail a previously stable identity that would, under other circumstances, prove as an identity anchor for resilience. Jillian, for example, identifies as a runner, but because IVF prevents exercise, she expressed how difficult it became to manage the stress of treatment, *"I'm a runner, and I'm a much happier person when I'm running, so that is just like, in life, in general, my first response to stress is usually if I go for a run I feel better afterwards. It's been hard with treatment because sometimes I can't run, and so that's been hard."*

Rachel expressed similar sentiments:

That's been really hard about this too is not feeling great physically and also having limitations on physical activity and exercise, which happens during the retrieval process and then the transfer, and just not always feeling physically good even if there's no technical limitations because I do. Exercising is really something that helps me with relieving stress, so that's been hard.

Thus, while resilience is communicatively crafted during (in)fertility (see the following section, and chapter five), there are times during treatment when resilience fails. In particular, identity anchors can prove to be a difficult method through which to construct resilience.

The changing nature of identity during (in)fertility treatment alters the form resilience takes. For example, many participants described themselves as people who like to be in control, and yet (in)fertility requires women to release control. Frequently, participants found that when they were able to accept the lack of control, they were likewise able to exhibit more hope. As Tia described, learning to release control, allowed her to release some of the stress associated with treatment: *“I was so meticulous about shots and how to—I needed a clean countertop. I mean, I still like a clean countertop but if I have to, I can zap it in my body super quickly, you know, without all the meticulous stuff. You kind of don’t sweat the small things in a way because you’ll probably get the same results no matter what.”* Penny, who has done eight rounds of IVF retrievals, described a similar feeling, when, during her last egg retrieval, she recognized the fallibility of her perceived control:

I think it was the last cycle, one of my really good friends got married in Tampa. And it was an evening wedding, and we had shots to do, and we were both—we’d had a couple glasses of wine, ‘cuz you get to that point, you’re like whatever, so we snuck into the bathroom, and everybody just thought we went in there to get it on. And the next day he was like, “I think I might have spilled some.” So, we don’t even know if I got the full dose that I was supposed to get that night.

As Tia and Penny’s stories suggest, releasing control also imbues some level of resilience. While both Tia and Penny described themselves as people who like to be in control, learning to release control allowed for these women to release stress.

Not all women were easily able to accept the ambiguity of (in)fertility treatment. As Carol describes, the lack of control has challenged her ability to continue on with treatment, *“I’m a*

planner, by nature I have a hard time with not knowing how it will turn out and whether any of this will work. And if I knew I had to do this for 2 more years and then it would be successful, of course I would do it. But in the absence of knowing that for sure it's really hard to keep going."

Later in our interview Carol reflects that perhaps because of the losses she has endured, she is becoming less resilient and less hopeful, *"It's weird because a lot of the time, when I'm going through an embryo transfer, I end up wishing I could be more hopeful because everyone tells you, you know you're state of mind is so important. And it makes me worried that like my, the fact that I am so jaded about it maybe is going to make it fail or something."* Rather than organizing around resilience, participants frequently organized their experiences through narratives of hope. As is further discussed throughout this dissertation, mantras of hope proved to be a critical resource for promoting resilience.

Despite the entanglement of hope and resilience, participants frequently suggested that their hope was diminishing. As Ellie communicated, hope is complicated and can frequently lead to more pain, *"I've been thinking lately that hope is a dangerous thing. If it works for you the first time, that's awesome, that's so great, but don't expect it to because usually it's a hard process, so just prepare yourself if it doesn't work."* As is discussed in the next chapter, a key method of resilience for (in)fertility patients is remaining realistic. As Ellie suggests, hope can often diminish realism.

Synthesis

Through identifying dis/embodied tensions, identity challenges, and the weak role of social support and resilience during (in)fertility, I hope to showcase how these moments of pain contribute to the organizing of an (in)fertility identity. While no two women will share the same experience in their pursuit of motherhood, women undergoing (in)fertility treatment coalesce

around particular cultural messages of motherhood and (in)fertility. What is evident is that the ways in which women navigate medicalized discourse, identity challenges, and social alienation during moments of loss and trauma prove to be some of the key experiences through which they construct their identity. In the next section, I use these results to underscore how narratives of (in)fertility scale up to form a social identity of (in)fertility, one that is organized around experiences of loss and trauma.

Organizing (In)fertility through Loss

(In)fertility is unique, and no two women share a common experience. Participants understand, and often reflect on, the diversity in the form of experiences (in)fertility treatment. In particular, online groups are an often-cited source of informational support precisely because they offer different perspectives. As Kelly described, these groups provide a source of comparison, which can in turn provide hope: *“I’m just constantly comparing, seeing if there’s hope. Everyone is different, but we’re still doing a lot of comparisons because we just want to know someone else out there who is worse off than us. They’ll succeed to make us feel like it’s possible.”* And yet, as Kelly attests, these comparisons are rooted in recognizing the diversity of (in)fertility. Thus, this section seeks to understand how narratives of loss scale up to becoming a defining element of the social identity of (in)fertility (Table 3).

Within this section, I first identify common metaphorical tropes used by participants to describe the risk inherent in (in)fertility treatment. Second, through a reliance on participant narratives of miscarriage, I unpack how participants narrate loss. And finally, I theorize on elements of hope, specifically in the context of loss. It is through this discussion that I position resilience as constituted by hope.

(In)fertility of Risk

Participants recognize (in)fertility as a risk. As past research has attested (De Lacey, 2002; Palmer-Wackerly & Krieger, 2015), (in)fertility is metaphorically construed as a game or a lottery, in which there are ‘winners’ and ‘losers’ in motherhood. Participant narratives reflect this discursive construction; for example, Carol refers to IVF as a ‘numbers game’:

I wish I would have known that IVF is kind of a numbers game, and if you get enough embryos to transfer, probably chances are one of them will stick eventually. But if you don’t have a lot to work with there is also a chance that it won’t work. And I don’t think I got that, I think I thought of it as a magic bullet, and a lot of people think like that.

Danielle similarly refers to IVF as addictive, “*Initially when we started the whole process, we only wanted to do 2 rounds and that was it. And then when you get into it, it’s almost intoxicating, you want to keep going, you want to get to that goal.*” These narratives confirm what has already been theorized about metaphors of (in)fertility, however, what these narratives also communicate is the way in which the risk of (in)fertility is enacted and controlled.

Table 4: Narratives of Loss

| Theme | Description | Codes/ Examples |
|-----------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|
| (In)fertility as Risk | Undergoing (in)fertility is seen as a statistical game. Participants frequently rely on medical research, experiential knowledge, and unguarded belief to combat the risky elements. | Metaphors of Gambling Reliance on Research Superstition |
| Navigating Loss | Miscarriage is a painful, but recurring, element of (in)fertility. Of the 20 women interview, at least half women experienced a diagnosed miscarriage. Of those 10, five women have experienced recurrent loss. | Loss of a Future Losses as Turning Points Need to Start Over |
| Hope Despite Loss | While participants do describe moments of hopelessness, participants also enact discursive strategies in order to enact hope. Hope is considered a component resilience. | Reframing Focus on Future Resilience |

Women undergoing (in)fertility treatment are rarely passive, rather these women take an active role in understanding the risk associated with treatment through a reliance on statistics, medical research, and personal experience. For example, consider Allison's story:

So, we did try I think about four more months, and then didn't have success. So, we went back, and started trying intrauterine insemination procedures. We did that like five cycles in a row, and I think at that point it just felt like it was a numbers game. Like, our first time it wasn't—there wasn't any reason why we shouldn't be able to get pregnant. But I knew that just based on age, and having endometriosis, that it's like a 15 to 20% chance each time so I figured, well, yeah, we'll have to do a few before we get lucky.

Allison frames IVF as lucky, yet she also relies on statistics related to her diagnosis in order to disrupt the notion of luck. In other words, where Allison recognizes IVF as a matter of luck, she

relies on medical research to provide hope. Where a lottery or gambling metaphor tends to diminish the agency of the woman in educating herself about her health, many women actively evaluate their chances of success.

Furthermore, while (in)fertility is a decidedly unique experience, women often rely on the experiences of others in order to more fully understand the risk. Jillian suggested that the knowledge she gains from online support groups is more significant than what she gains through reading medical research:

What I learned from [online support] groups and from the podcast has been more influential than [research] papers, because hearing individuals' stories is just so helpful. And I guess it's also much easier to find your case in other people's individual cases, then when you're reading a study of fifty women that you don't really know the details about other than the particular aspect of the thing that they're studying.

In this way, the online support groups provide a unique sense of knowledge, one which is much more personal and embodied than medical research. The knowledge communicated within (in)fertility support groups functions as a form of invitational knowledge (Author, 2021). Invitational knowledge suggests that the knowledge shared within online communities deviate from medicalized logics and creates opportunities for resilience (Author, 2021). As Jillian's narrative suggests, the knowledge gained through participation in online groups is frequently more helpful than the knowledge shared in the medical clinic.

In sum, this reliance on medical statistics and personal knowledge allows participants to navigate the embedded logic of risk within (in)fertility. While participants recognize that treatment is a numbers game and includes elements of luck, they also take active measures to control how this risk affects them. As I discuss next, this reliance on medical research and personal narratives

is frequently used in women's narratives of loss as a way to instill hope despite the hopelessness of a situation.

Navigating Loss

Of the 20 women interviewed for this study, at least half had experienced a miscarriage. Miscarriages frequently represent a significant turning point in a woman's experience with (in)fertility. As Penny described, miscarrying after her embryo transfer was particularly traumatic because she received different information from her hospital and her fertility clinic:

I think that first transfer and miscarriage was probably another turning point moment because they had all assured us this is a PGS normal embryo, it's a 50/50 shot that it will implant and if it implants because it's a PGS normal embryo you have less than a 10% chance of miscarrying, because we know that 90% of embryos miscarry due to genetic stuff and we know your genetics are fine. And that, once we got past the implantation and everything had been going well, my betas were going really high, it was a bit of a shock when the hemorrhage happened. And we went into the hospital and the hospital was like, "Yeah, this is done, we're sorry." And I called the clinic, and they were like, "Hospitals are wrong some time, you should come in tomorrow." The hospital had said, "There was no fetal pulse, there was no heartbeat, nothing, you're done." And when I went into the clinic the next morning there was a heartbeat and it looked like there was twins, so we stretched that out for a week before it was obvious that it was done. So, that, again was one of those naïve moments of hey, this was supposed to work.

Penny's story is not unique. Multiple women experiencing a miscarriage visited a hospital, received the heartbreaking news of the loss, and then, upon calling their clinic, were told that the loss may not have happened, and that hope could still exist. Moreover, miscarrying is not a linear process, as Gina describes, her third miscarriage took nearly three weeks to pass:

That one did work, and we found out the day before thanksgiving that our beta was positive. But it was only a 17, so it was really low, but anything over a 5 is considered positive, so we're like for right now we're going to take it and we'll just see how it goes. And then at thanksgiving dinner I started bleeding, so I knew it wasn't going to work because well, we've been there before. So, we had our third miscarriage, but with that one my levels continued to go up, I didn't actually

miscarry until almost 3 weeks later, so it was actually around December 10th, before I actually my levels started dropping, and it was confirmed that I was miscarrying. So, I was actively bleeding for almost 3 weeks, kind of panicking the whole time, knowing what was coming, but my levels were still going up, just kind of slowly.

Gina's narrative positions the miscarriage experience as embodied liminality; throughout the three weeks of her pregnancy, her hormones are increasing, her body believes she is pregnant, and yet she also cognitively recognizes that she is miscarrying. This sense of on-going loss is often what distinguishes a deeply emotional miscarriage from one that is much more clinical.

Often times the first miscarriage a woman experiences is traumatic, both because of the unanticipated loss, but also because of the pain and trauma her body undergoes in the process. As Penny described, she took active means to ensure that any ensuing miscarriages would be less traumatic:

The last miscarriage we handled a little bit differently, just based on how absolutely traumatic the first one was, because they hadn't prepared us, it was like a movie scene sort of hemorrhage, and so we didn't want to do that again, and since we had a chance to do a D&C, we just took the clinical route. And that actually, it was strange because it was so clinical, and it was easy. Like, there weren't symptoms afterward, it was just like everything was kind of fine; that was a bit weird because like you know in your head, but your body is just like there's nothing different. And so, it took a day or two to re-orient, so it didn't have the same grief process with it. And it didn't have the same trauma process with it, because it was such a different presentation of how it was finished.

Penny reasserts her agency into the otherwise uncontrollable loss of a pregnancy by choosing to go a medical route. Unlike her earlier narrative, where she described a sense of ambiguity and miscommunication from her clinic, Penny's decision to pursue a D&C (dilation and curettage) allows her to exert more agency. As Penny described, the D&C was a choice she made and one that she would make again, as it helped ease the trauma of a loss.

Participants frequently communicated that a miscarriage was especially traumatizing not just because of the emotional or physical pain, but so too because a miscarriage felt like starting over. As Faith described, she had not even considered her miscarriage a baby, and yet the realization that she would have to go through a retrieval and transfer again was overwhelming:

The first big one that didn't work, I was surprised by how emotional I got after that. Really, I was floored, I was like why am I crying. I mean, it didn't work and that was a bummer, but to me it wasn't a loss. With the miscarriage that one I hadn't considered a baby, I hadn't even called it an em-baby, for me it was an embryo and it didn't make it. The thing that really knocked me down after that one was the thought that holy cow, now I have to do that all over again, like holy crap now I have to go through all those injections and the two week wait, and oh my God.

Participants, like Ellie, similarly reflected that the miscarriage felt like moving backwards: *"We're not even back at square one, we're behind that because you've got to go through the surgery and make things worse. And now, do we do IVF, like it's a whole other, like the goal post went backwards."* As Ellie relays, miscarriage is a step backwards, and can compound an already significant loss.

Miscarriages present lasting trauma and can seriously impinge on a woman's ability to enact resilience. Some participants, like Tia, take active precautions to limit the likelihood of a recurrent loss. For example, Tia made the choice to have her embryos undergo preimplantation genetic screening (PGS), during which embryo cells are tested to ensure chromosomal normalcy. PGS testing helped to ensure a level of control by preemptively cautioning against loss. Yet, as Tia describes, PGS testing is not always accurate:

Going through miscarriage, twice in my case, and the fear of that happening again. That's another struggle, the biggest one, I think. That's the biggest one facing me right now. But we are doing PGS testing, which I know isn't a sure thing, I know it's a controversial science. I look at it more as a crystal ball, I guess. It could tell you what's up with it, no one knows the outcome for sure. It could be like a magic eight ball, I don't know.

While PGS testing may provide a sense of security, PGS testing is a controversial science. Participants who identify as strongly religious frequently did not choose to PGS test their embryos because they feared it would prevent a doctor from transferring a non-normal embryo. As mentioned earlier, after going through two failed rounds of IVF, Gina chose to switch to NaPro. Gina explains that while she prefers to use NaPro, she will eventually transfer her third frozen embryo, which was retrieved during IVF, even if it presents a risk of miscarriage:

We would transfer the embryo when we know we're at a point where if it works, we're happy to have a third baby, but if it didn't work then we're content. So, it's kind of like, we would like to have one more with our current [NaPro] doctor, and then if after that is when we would transfer our embryo back. We don't know. I had so many issues that weren't being addressed at the time, we don't know if that's a healthy embryo. We won't have it tested because I know—so, my sister-in-law had one embryo that tested abnormal, so no one would transfer it and she refuses to let them destroy it. So, she's going to be paying for the rest of her life \$800 a year to keep an embryo frozen that she refuses to let them transfer, so we would be in that situation. And I've always said, I would rather transfer an abnormal embryo than know we threw a baby away. So, we won't do genetic testing, it doesn't change anything except we would have a harder time finding a doctor to transfer if there was a problem.

PGS testing is not an exact science. Multiple women reported that they continued to suffer from miscarriages even with 100% normal embryos. However, PGS testing can reduce some of the lingering fear and trauma associated with pregnancy loss. For women like Gina, PGS testing was not an option precisely because it ran the potential of conflicting with her religious identity. Further, as is discussed in the next chapter, Gina's choice to recognize her embryos as babies, helps her retain the motherhood identity, which ultimately is an act of resilience.

In some ways, miscarriage constructs resilience. Many participants describe that, because doctors often demand women take a break from treatment after miscarrying, these breaks became a crucial time for women to cope with their pain and trauma of a lost pregnancy. These breaks also provided women with the time to make an active plan for future treatments. As Beth discusses, she

used her miscarriage to take a break from treatment and the many responsibilities treatment demands:

We did the transfer in December from our fourth stim cycle, and that one I ended up pregnant and we miscarried right before Christmas. So, I gave myself permission to stop all meds. I stopped taking my prenatal vitamins, I was just like forget this. I knew that it would be awhile before we could get pregnant again, so I gave myself a break from the whole infertility world. So, even though I was prepping in my mind for what to do, I was like I don't even want to remember taking this stupid vitamin because it's pointless. That kind of thing, and then I would like go get a massage or indulge in treats, things like eat sushi, whatever would make me feel like I was treating myself.

Beth speaks not only of taking a break, but so too of making an active plan for how she will approach her next treatment cycle. Often after miscarrying, women try to identify how they can change their lifestyle, or perspective, as they enter into a new cycle. Faith also spoke of taking a break from treatments, and using the break as a means to return to her 'normal' self:

After the miscarriage I just stopped everything, you know when we found out we went to the gyno office to get the perceptions I needed and then I had him drive me to the liquor store so I could get a bottle of vodka and have a cocktail that evening. I just, after the miscarriage I just didn't think about it. I stopped listening to the podcast, I didn't research anything. I was just like, one day at a time.

The time spent returning to their normal selves also helps the women regain perspective. Perspective helps women remember why they are undergoing such an invasive treatment process. As Heather relayed, even though she was scared of experiencing another loss, the break helped remind her of her ultimate desire to have a baby:

I think after my surgery I was like, 'It's not happening, maybe we should stop.' We're really lucky we have seven embryos frozen. So, we've been talking about taking a break, because I have to take a break. Physically and mentally, I'm ready. We're both just really terrified of another ectopic pregnancy. I think I just have to remember the reason why I'm doing this. I'm not doing this because I can't have it, and I have to have it. I'm doing this because I genuinely would like to have kids, so I think that helps. just visualizing that one day I'll have my kids.

As is further discussed in the next section, this type of refocusing also serves as a form of hopeful discourse. Even in the depths of despair, participants are able to actualize hope through narrating their purpose.

Hopeful Despite Loss

Despite these differences inherent within (in)fertility, scholars have sought to understand dominant narrative categories of the (in)fertility experience. Franklin (1990) suggests there are two primary narrative categories for IVF stories: the happy and the hopeless. The happy stories are those of success, with grateful parents receiving a ‘miracle’ or ‘rainbow’ baby¹⁰; in short, happy stories convey the success of technology over nature. However, with only an average of 28% of IVF cycles resulting in a live birth (Pearson, 2009), hopeless stories are far more common. The hopeless narrative speaks of treatment failure, and as a result these narratives frame the patient as a “desperate infertile woman, isolated in her tragedy, engaging in excessive cycles of treatment, and risking relationship ruin, financial devastation, and emotional collapse” (Throsby, 2004, p. 74). Both happy and hopeless narratives are underlined by an assumption of success, that can be damaging for individuals who choose to stop treatment. Most frequently, ending treatment is communicated as ‘giving up’ (Throsby, 2004), which rhetorically positions blame not on the

¹⁰ A ‘rainbow baby’ is a colloquial term used to refer to a baby born to a couple who had previously experienced miscarriage, still birth, or death during treatment. Participants were conflicted on their support of the term ‘rainbow baby,’ with some women happily using the term and others decidedly against the term. As Penny described to me, “*I don’t choose to identify myself by things that happen to me. . . So, for me, if I had a baby now and referred to the baby as a rainbow baby, [it] is defining that baby in terms of the loss that preceded it.*”

failure of the technology, but on the failure of the woman. However, as previously illustrated, participants do have the ability to remain resilient, and enact hope, despite the hopelessness of loss.

Throughout this chapter religion has been constructed as an identity tension that participants must cope with in order to continue treatment. However, a religious identity also provides hope during times of loss. As Penny describes, after a miscarriage, she and her husband were able to turn to their religion to grieve their loss:

My husband and I went and looked at, actually met—even though we’re not super faithful, devout, whatever—actually met with our parish priest. . . when we had our miscarriage and they did a little blessing, had a little funeral service, essentially. And that actually helped a lot, that sort of validating the fact that yeah, this wasn’t just another medical procedure, there was something there, actually twins, there was something there. And with that, I think, brought some closure to that sort of grieving process.

Mary similarly reflected that while she was not a devout Christian, the experience of IVF helped reaffirm her religious identity, *“I think that, so my grandmom died, I hated God and I went away from church and religion and everything and it took me years to get back to that but I had realized through this IVF process that it actually brought me a lot closer to my religion and to God, then I ever had imagined.”* Later, Mary discusses her religious identity as helping her cope when the majority of her eggs did not survive the fertilization process. Mary, who retrieved 22 eggs, lost all but one of the eggs during fertilization:

When it comes to the 22 eggs when I did egg retrieval the doctors told me 10, now my lucky number’s 22, my grandmom’s birthday was February 22, so like my grandmom had just passed away, so I focused on the number 22. I had like, I knew that it was going to be 22, so my brain focused on the positive in what I needed. I really did that for the fertilization process but it was really hard when it didn’t work. So, I live within a couple of miles of a shrine that has an outdoor prayer garden, I would just go daily and light candles and pray for my little babies growing in a dish. I journaled, like I wrote about it. It was not easy, I mean I literally went from 22 to 12 to 6 back up to 7 to 3 and then 1. And I never thought that would be the results

As Mary narrates, she engaged her religious identity through prayer in order to remain hopeful. As previously discussed, religion can lead to feelings of alienation and isolation; however, Mary and Penny both used the religious identity to enact resilience and to keep moving forward with treatment, despite trauma.

Hailing a religious identity proved to be a critical source of resilience for women recovering from a lost pregnancy. However, for women like Gina, who identify as highly religious, these losses can also be misunderstood by health clinics. As Gina described, after her third miscarriage, her doctor's comments left her feeling further isolated:

We went in the day we found out my levels were dropping, we went in to the [reproductive endocrinologist's] office and I remember him telling me, like I'm sitting there crying, and you know my husband's there, and I remember him telling me, it probably doesn't make much of a difference to you, but scientifically it makes a huge difference that this wasn't a fetus yet, this was just a bunch of cells. And I was like, well, that's not what you tell someone who's actively miscarrying their third time.

Later, Gina reflects that this interaction caused her to have PTSD. The tension between her belief that all embryos were children, and her clinic's belief that the embryos were not significant was an important turning point in Gina's (in)fertility journey. This interaction prompts Gina to turn to NaPro, where her belief and religious identity were validated. As Gina explained, the NaPro doctor validated her miscarriages in a way that mainstream clinics did not:

One of the things that was light and day difference and it makes me cry because no other doctor had ever done it, he said, so you've had three miscarriages, and I said yes, and he said did you name them, and he said ok I just wanted to make sure all of the children's names were updated for our chart. And no one had ever treated them like people before, so it was a transformative day for me, it changed everything, and from that day on he was different, we trusted him more and his care was different. But until that day it was different. It was very, very visibly different.

For Gina, this shift in communication allowed her the space to grieve her lost children. Moreover, in actively changing her medical treatment plans, from an invasive IVF protocol, to the more natural treatment of NaPro, Gina used this experience to instill more hope into her (in)fertility experience. Like many other women, making a visible and identifiable change in one's treatment protocol can often serve as a source of resilience after miscarriage. As Gina later told me, *"At least I was able to say out loud, when I got pregnant with my son, this one is different, everything is different now, the PCOS is being treated, the endometriosis is gone, this one is different. And I was able to say that, and know it, and it made everything a lot less stressful."* Being able to identify change, to reassert agency into the process, and to receive validation provide a critical mark of resilience for women who have experienced recurrent losses.

Participants frequently (re)frame their losses in order to imbue hope into the narrative. For example, Gina reframed her losses as a blessing in disguise:

So, that actually helped me kind of see the miscarriages as a little bit of a blessing in disguise, because I realized if those pregnancies had made it, I would have had no folic acid support, so they could have been autistic, they could have spina bifida, they could have been really severe problems that they now don't have to worry about, like those are babies that don't have to ever worry about being sick. So, there was that, that it kind of helped me see a little bit of the why people have to go through this, because there's the question of like, why does this even have to exist in the world, and that kind of helped remove a little bit of that and it also, once they were addressed and they were treated, it kind of made me feel like I wasn't crazy.

Gina's narrative also highlights the importance of finding a diagnosable disorder. As mentioned previously, after Gina was diagnosed with, and treated for, PCOS and endometriosis, she was able to confidently believe that her chances of success had improved. Many participants who suffered from recurrent miscarriages found hope in having a diagnosis. As Jillian relays, discovering she had a uterine anomaly helped her accept IVF:

I think getting that diagnosis, I was initially much more open to intervention than I had been. And then it became a little bit complicated because that's when I got pregnant on my own, and that made me resistant for a long time. But initially, it made me feel there is a clear reason why intervention will help in this process.

Before her diagnosis, Jillian was hesitant to pursue IVF because it was expensive and invasive. When she became pregnant on her own, without medical interference, she became even more hesitant, however the diagnosis provided hope that treatment would fix her recurrent losses.

Communicatively (re)framing losses as an act of resilience also allowed women to recognize how treatment has aided in their personal growth. As Sarah describes, after a miscarriage she regained more agentic authority in her life:

I was so deeply unhappy and sad and depressed, and it manifested itself in some really amazing ways in my life. Like, using that [depression,] I instigated a number of new practices, I started meditating, I started a bullet journal to keep organized my dissertation life. I decided I needed to get rid of this toxic relationship with my advisor. . . And so, it ended up, I was able to draw a lot from that and reshape a number of areas of my life for the better that I still carry forward today.

Sarah used the miscarriage loss to reassert her agentic control in other areas of her life. In our conversation she continually returned to the idea that her miscarriage spurred her to enact control in both her professional and personal lives. Sarah switched her graduate advisor and found improved support with a new advisor, she began running marathons, and taking up more creative projects. Gina similarly shared her belief that (in)fertility treatment has allowed her to agentic control, which she did not have previously:

I'm a lot stronger than I ever gave myself credit for, first of all. So, I don't know, I always said I probably curse myself, I told myself after we had our first miscarriage, I looked at my husband and I said, I don't know how people do it, I don't think I can do this for two or three years. And we didn't have my son until it had been almost four and a half [years], so apparently, I was wrong. So, I said that and then I was tested. So, I'm a lot stronger than I ever gave myself credit for. . . Generally stronger, and I also my fuse is a lot shorter, like my BS limit is much smaller than

it used to be. Because life is too short so it's really just like, I don't, I'm sorry you're having a bad day at work but you're not going to ruin my day, because it's just not even the biggest problem in my day. So, like, you don't get to take it out on me because it's not even the biggest problem that I'm dealing with right now. So, my fuse has been a little bit shorter for negative stuff, but kind of my perspective has completely changed.

As is discussed in the next chapter, participants often reflected that while (in)fertility was imbued with loss, trauma, and personal sorrow, it is also an experience that allows for positive identity growth. Participants (re)frame their losses to signify positive self-development.

While all the women interviewed for this project were still in the midst of treatment and actively trying to become pregnant, many participants reflected that if IVF does not work and they are not able to have a baby, they will not be without hope. Rather, participants often (re)framed narratives of their future in order to instill hope into whatever outcome they experience. As Penny told me, she and her husband spent time reminding themselves that they are happy, even without children:

We just wanted to remind ourselves of how much bigger the world is than this little bubble that we had been living in at that point in time for a year. That world is big and beautiful, and life goes on all the time. . . But lately the joke has been, we have two cats that we adopted from the shelter, it was like their assholes, but you love them, well yeah, kids are like. So we kind of remind ourselves about the vacations and going away, I think it helped us feel like, when things didn't work, it was just that one thing that didn't work. You're not grieving the loss of the cycle, and the loss of the dance that you didn't go to, and the loss of the beach that you didn't walk down, and you know, you're not grieving that chunk of time either, and that was super helpful for both us the entire time. As awkward as it can be to like, walk around with needles in your purse all day long, it's totally worth it for the resilience piece to keep going.

Penny frequently communicated her goal to not let IVF dictate her life. Lisa echoed a similar sentiment:

As awful as I feel, I also feel super grateful. I have a great partner, I have a really great life. I'm really fortunate that we were able to even try this process, even if it

doesn't work. Just being able to get that treatment is incredible and a lot of people don't and will never have access to it. I feel very grateful. And also, something that I did after one of the miscarriages was to make a list and it's of things about yourself and I made this list and put it on my fridge and the top thing says resilience. It's just things about myself that I like, I'm strong and compassionate, I'm kind and honest. It's a nice sort of reminder.

Lisa also reflects on the privilege of IVF, which many other participants similarly recognized. IVF is expensive, time consuming, and overwhelming only available to middle- and upper-class people. Many participants emphasized that they would be happy—not grieving, desperate, and unfulfilled—if they were unable to have children. Participants frequently shifted their perspective to include reminders of a supportive marriage, happy pets, and exciting adventures that would still exist, regardless of IVF success.

Synthesis

(In)fertility can be, and often is, traumatic. Participants experience a wealth of varied losses, most significantly the loss of multiple pregnancies. However, this does not mean that women are hopeless, rather women utilize the losses to (re)frame and (re)focus their future. Women use losses to take active control of their medical treatment, to challenge traditionally dogmatic medical beliefs, and to manage the risk within the treatment cycles. It is these experiences which provide a counter-narrative to the (in)fertility identity. Where cultural discourses and medicalized logics position women without children as unfulfilled, narratives of the women undergoing (in)fertility treatment suggest that the (in)fertility identity, while far more complex and tenuous, is one which is grounded within hope and resilience. In the next chapter, I add to this theorizing through analyzing stories of success. It is within this next chapter that I shift focus from moments of loss

and trauma, to moments of supportive organizing, positive identification, and empowering organizing.

Interlude: Negotiating Identities

On Labor Day Weekend 1993, while my dad was changing my diaper, he noticed a lump on my abdomen. Cancelling an afternoon barbeque, he took me to the hospital to have an immediate x-ray. That week, at two years old, I was diagnosed with stage 3 Wilms Tumor, a rare kidney cancer that most often develops in children.

Telling someone you had cancer frequently leads to a sad-eyed look that makes me physically uncomfortable. I've experienced this song-and-dance so many times that I could write a script of the performance. I avoid eye contact, shifting my gaze to the ground or a spot just above the person's shoulder. It does not matter who the person is; a beloved boyfriend or a stranger at the beach, the enactment is always the same. I mumble the words, *as a child, I had cancer*. The person looks at me, deeply troubled by this new-to-them information that does not, in reality, affect them at all. I wonder how sad they can actually be for me, a long-term cancer survivor, and more importantly, I wonder why they appear sad for me. *I'm fine*, I say in a slightly exasperated voice, *I had cancer 25 years ago, I am fine*. I emphasize the last three words, taking a pause between each word in an attempt to drive home the point: I am fine. Yet somehow, despite this effort, I never succeed, and the person continues to look at me as if I am pitiable. After years of begrudgingly disclosing my cancer status, I have come to understand this experience as a performance in recognizing the severity of cancer; doe-eyed vigils to bodily trauma.

I do not remember my cancer experience, but I do understand the consequences of cancer. I watched two close friends suffer through the immense loss of their fathers. My dad underwent cancer treatment, and I sat with him in his hospital room as he recovered from a surgery which

removed a quarter of his left lung. We thought, perhaps naively, that the surgery would remove the cancer but three months later, after I moved 1,000 miles away to Indiana in order to start my PhD program, I find myself sitting in my new office during the first week of school, answering a phone call from my dad. On the phone, my dad tells me he has an extremely rare blood cancer. The tumor in his lung was not a tumor after all, just an infection brought upon by the leukemia. He is in the middle of explaining this to me when a student shows up for office hours, shuffling awkwardly in the doorway, and I rush my dad off the phone, promising to call him later. After the student leaves, I wander the hallway in a daze. I seek out my advisor, my graduate mentor, and my closest friend (all of whom I've known for less than two weeks) to disclose that my father has cancer. They are empathetic but I can't tell what I need from them, I barely have processed the news myself; I wish I could go home to my family, but I just got here, to my new life in Indiana. That night, after a graduate class, I order takeout from Applebee's because I am too overwhelmed to cook.

When it comes to cancer, I walk through life alternating between optimism and fear. I survived cancer, my father survived cancer, my grandmother survived cancer. But also, my friends have lost their parents to cancer and I have spent enough time in a cancer ward to understand that not everyone survives. When I was in high school, a second grader in our small-town died after a two-year battle with leukemia. Our town mourned; I cried in church.

I do not willingly disclose my cancer identity, but I used this identity to singularly justify my need for (in)fertility treatment. My (in)fertility is a direct result of the cancer treatment that ravaged my body. As women are born with all the eggs they will ever have, and as the ovaries are quite close to the kidneys, when the radiation targeted that evil, cancer-riddled kidney in my

toddler-sized body, it disturbed my ovaries, killing off a portion of my eggs and rendering me an (in)fertility patient.

I used my cancer identity to leverage financial support for my fertility treatment. I received partial funding through the Livestrong Foundation and its Fertile Hope program, which was designed to help newly diagnosed cancer survivors who need to preserve their fertility before starting treatment. I was not a newly diagnosed cancer patient, I had been cancer free for over two decades, and as such I was an unusual case requiring added approval. The Livestrong Foundation paid for my medicine, which accounted for half of the \$10,000 expense. After I realized how much (in)fertility treatment would cost, I also set up a GoFundMe fundraiser in which I explained that, because of a childhood cancer treatment, I needed to freeze my eggs. I laid bare my anxieties and trepidations for distant relatives and the work colleagues of my parents. I bracingly published my medical test results in order to prove that I was (in)fertile. I pleaded for empathy that might give way to financial support as I sought to offset the remaining \$5,000. Donations poured in. I raised over \$2,000 in less than a month. I capitalized on a cancer identity I had all but hidden for most of my life.

Prior to my (in)fertility, I distanced myself from my cancer identity. I did not claim this identity because I did not feel a sense of connection to cancer. I saw the marks upon my body, the long scar that intersects across the length of my abdomen and the smaller scars across my chest that mark where the port was placed, but I avoided disclosure because of that awkward performance that left me feeling uncomfortable and insecure. In part, this subconscious decision was grounded in cultural and organized messages that told me cancer was finite (Ellingson, 2017). My experiences with cancer had only ever been structured through a return to normal life or a

tragic death (Frank, 1995), I was not prepared for the late-term consequences that would develop after over 20-years of health.

When I started interviewing women for my dissertation, I shared aspects of my identities with my participants. In my recruitment letter, posted to different online infertility support groups, I explained that my personal need for fertility treatment was a consequence of childhood cancer. I used this identity as a way to prove to my participants that I was worthy of their stories, that I was interviewing them from a position of understanding and empathy:

My interest in infertility comes from a personal interest—I was diagnosed with a low AMH when I was 26 years old, thanks in large part to a childhood cancer diagnosis. I say this because I want you to know that my interest is personal, and the interviews will always come from a place of empathy and a desire to listen to people's experiences. I'm interested in recruiting participants through this group because I have used this group as a resource over the last few months as I prepare for freezing my eggs this summer.

When I formulated my recruitment letter, I took special care to emphasize that my (in)fertility was a long-term side effect of my cancer treatment. I was worried that my participants, most of whom were in their mid-to-late 30's and all of whom were actively trying to become pregnant, would not see me as an insider to the (in)fertility experience; I was young and I was undergoing fertility preservation, an elective procedure many of them regretted not doing earlier in their lives.

I emphasized my insider status by describing my diagnosis and recounting my participation in the online forums. But despite this I also hailed my outsider status, as not only as a researcher, but so too as a cancer survivor; as someone whose (in)fertility has an identifiable cause. It is rare that a woman in her mid-20's is diagnosed with infertility, and recognizing this, I feared that my participants would not see my (in)fertility as valid, so I used my cancer treatment as a way to justify my insider status. And yet, when so many women are diagnosed with the dreaded,

ambiguous ‘unexplained (in)fertility,’ I felt a sense of power in my identity as a cancer survivor. I negotiated between these two identities, hailing one when it was convenient, and shedding the other when it was superfluous.

I explain this position—in which I have both refuted and embraced my cancer identity—as a means to clarify the *radical specificity* (Sotirin, 2010) that informs my data collection, analysis, and writing. Radical specificity prompts the writer to engage with the particulars of their lived experiences in a way that does not aim to find generalizable significance, but rather focuses on specifics of their story. As a self-reflexive practice, I use the concept of radical specificity to critically examine how I negotiated these two identities through the process of developing, researching, and writing a dissertation that represented my lived experiences just as much as it represented those of my participants. What I realized, through this process, was that I had idealized myself as a participant-observer, someone enmeshed in the experience of (in)fertility and someone who could draw similarities to her participants’ lived stories. I developed a dissertation as a means to bolster my understanding of and identity with (in)fertility, while transgressing the boundaries between insider and outsider.

Relying on participant narratives, I attempted to illustrate the various hardships of an infertility diagnosis and subsequent treatment. I found solace and community in the narratives I collected. I named my participants after friends, and in conversations with my advisor, I would casually mention a participant, remembering the intricacies of her experience as if it were my own. Before my dissertation, I felt so alone in my diagnosis. Now, when a participant shared her struggle to find empathy amongst her peers, I unreservedly nodded in agreement. I had spent years trying to help my friends understand the devastation of my (in)fertility diagnosis, but it was increasingly difficult for them to grasp the severity of my situation. The same month that I received a letter

from my insurance company informing me that my treatment would not be covered, I also sat with a friend as she fretted over a potential pregnancy scare. I understood her fears, but at the same time, I was left feeling even more isolated. I knew it was unlikely that I would ever experience a pregnancy scare, and I felt angry at her for being apathetic to my condition. *Just two days ago, I thought, I cried to her that I might never have a baby and now here I am praying with her that she isn't pregnant.* At the same time, I understood why my friends could not empathize with my predicament. Only a few months prior I was in their same position; I was terrified of an accidental pregnancy, I was not proficient in the medical logistics of (in)fertility, and words like *intrauterine insemination* or *follicle stimulating hormone* did not so easily roll off my tongue. I saw the divide between my friends and I as a clear line in the sand; where they were able to live free and carelessly, with the confidence of a fertile future, I lived in the shadows of despair silently seething. I was jealous, uncouth, and angry at the unfairness of it all.

And so, I developed a dissertation that spoke to my fractured sense of self and my desperation for an empathetic community. I sought to find evidence that my participants were like me, and I used those similarities to bolster my own hope in the process. When I spoke with a woman in her living room, her IVF baby napping in the corner, I saw myself. Like me, she loved Harry Potter, was born and raised in New England, and had suffered a childhood illness that rendered her unable to conceive naturally. I thought, *if she can get pregnant, so can I.* In as much as I studied the resilience of my participants, I used my dissertation project as a way to craft resilience for myself.

Yet, throughout the dissertation process, as much as I tried to identify with my participants there existed a nagging, hollow divide between their experiences and my own. I was not simply an (in)fertility patient; I was also a cancer survivor. I could never fully share in their experiences

because none of them were in their mid-20's, angry at a childhood illness they could not even remember having. Thus, while I navigated the bounds of insider/outside via my (in)fertility/researcher identities, I so too navigated the radical specificity of my insider status. I was not merely an (in)fertility patient, I was a childhood cancer survivor who continually recalled the cancer identity as a means to situate herself.

In each interview I was affronted with all the possibilities of what could go wrong. As one participant shared with me, she voluntarily froze her eggs in her early 30's as a precaution. Like me, she was single and unsure when she would meet her partner, so she froze her eggs as an 'insurance policy,' a metaphor my doctor had also relayed to me. She successfully froze 22 eggs, but during the thaw and insemination phase she lost all but one. She was pregnant during our interview, well into her first term, but she warned me to go back and freeze again.

"Freeze embryos," she suggested.

I looked at her a bit hesitantly, "I don't know," I said, "I've only been with my boyfriend a few months, I'm not sure he or I am ready for him to have a legal say on my future offspring." I tried, and failed, to laugh it off.

After our interview I tried to put her story out of my mind. She was not me; every medical diagnosis is different; every person is different. And yet, I couldn't help thinking, *I retrieved half of the eggs she retrieved, what were my chances that they would all survive the thaw?* That night, as I lay in bed and reflected back on the day's events, I felt my heart begin to race. Not only did I worry about the thaw, but I fretted over the fertilization, the success of implementation. Even now, nearly one year after conducting those initial interviews, I am affronted by a sense of hopelessness and powerlessness. Throughout the interview process, I felt myself yearning for answers to the

undetermined future. I wanted to see myself and my identity reflected in my participants, especially those women who had successfully become pregnant after recurrent losses.

Throughout all of this, I continued to emphasize my cancer identity as a component of my infertility identity. In my mind, they were synonymous. My cancer had caused my infertility; without the former the latter would not exist. It was perhaps this entanglement of identities that left me feeling especially strong emotions when my participants referred to (in)fertility as similar to cancer. I felt my cancer identity appropriated by my participants. As two women told me, for them, (in)fertility was like cancer:

I was reading the other day that this is a life crisis, like you shouldn't feel like you need to be positive and happy. A lot of people equate it, or they've done psychological studies that say **it's almost equivalent to dealing with cancer**, so it's a big deal and like I shouldn't feel bad for the way I [act]. So, I think it kind of helps validate those feelings, and it gives me kind of some things to talk about, you know, with my husband, like 'this is what I'm going through, and this is why it's so hard.' So, yeah, mainly a lot of reading; I should exercise or whatever, but I don't want to.

There is like the whole God is pulling me through this because he wants to show me something, or I'm not ready, or I need to trust him more. And then there's the whole kind of like bioethics of, is IVF like natural or God-given, or is it like playing God. . . The way that technology is going, like you just don't, this starts getting blurry about what's this assisted reproduction versus something that's a little bit more, proactive. And I remember having conversations with other Christians and I was like, **"Is infertility like cancer where you might have this affliction and it's completely within your right and if not your obligation to treat it."**

Participants hailed a cancer identity as a way to situate their own experiences within a common, shared vernacular. In other words, participants attempt to convey (in)fertility as traumatic, life-upending, and ambiguous by likening it to cancer.

However, when my participants compared (in)fertility treatment to cancer, I could not help but think of my dad, recuperating in a hospital room after having a quarter of his lung removed.

He spent a week in the hospital, learning how to breathe again. When I compared his physical pain to the pain I endured after my egg retrieval, my pain was negligible. The egg retrieval process, probably the most invasive aspect of IVF, is still an out-patient procedure. Despite the cramps and bleeding, I was out of the hospital within four hours, stopping for donuts on the way home. More than the physical pain, when I compared the emotional trauma of a cancer diagnosis, to the emotional trauma of an (in)fertility diagnosis, the (in)fertility diagnosis seemed far less foreboding. (In)fertility and cancer cannot be compared, the pain of the two exist on different planes of medical and emotional suffering. My two identities allowed me to understand that while (in)fertility was traumatic and heart-wrenching, (in)fertility was not life or death.

During the coding phase, because of the radical specificity of my own (in)fertility narrative, I became attuned to the ways in which cancer presented itself in my data. In particular, participants evoked the sense that (in)fertility was like cancer in so much as it was life-altering, and presented unique disclosure challenges at work:

[My boss] was so sweet, he was so thoughtful. . . And **I found out later on that he thought that I like had cancer** or something. He was like, "I didn't know, I didn't want to ask questions to you because I wanted to be thoughtful about your privacy, but I just want to make sure you're okay."

I had to lie to most people in my life and my boss at work, I couldn't be open about what was going on. And, so it did, like having to go in for an appointment every other day, is not—and, **I think of some people thought I was dying of cancer**, I really do, I work for a pharma company and we do T-cell therapy for cancer treatment. We deal with cancer patients all the time, I really think they assumed that there was something really, really wrong with me. And not that I wanted them to think that, but if you don't share information people make up something.

In these instances, when participants implied that evading disclosure of (in)fertility left people to assume cancer, I was left wondering, *do people often hide their cancer diagnosis from*

their employer? Just a year prior, my dad took six months off of work after his cancer treatment left him immunocompromised and unable to breath. Because of the nature of leukemia, all of his white blood cells were removed through chemotherapy. He could not leave the house or go to work for six months because without white blood cells he would be unable to fight any form of infection. Cancer treatment, unlike (in)fertility treatment, is not scheduled to accommodate work hours. Where (in)fertility appointments typically occur between five and seven o'clock each morning, chemotherapy appointments can last all day. (In)fertility appointments are designed to be minimally disruptive to everyday life. Likewise, cancer treatment, unlike (in)fertility, can leave one bed-ridden, nauseous and exhausted for months. While there were days when my stomach became swollen and bruised after two weeks of daily injections, the pain was temporary, leaving me before I could even grab an ice cube from the freezer. And, cancer treatment, unlike infertility, leaves permanent marks on the body, both during and after treatment. In other words, cancer treatment is not easily hidden.

And yet, I understand both the instinct and the necessity to keep (in)fertility treatment hidden from public purvey. From my experience, (in)fertility, much like cancer, is traumatizing, life upending, and ambiguous. When I received my initial (in)fertility diagnosis, I spent months shedding tears in my car, on the bus, and behind closed office doors. I struggled as I questioned my gender identity, my religious convictions, and my commitment to my career when, seemingly in a matter of minutes, the assumptions I had about my future were gone. I had always envisioned having children, and suddenly that vision was ripped away from me. For a year I kept my (in)fertility diagnosis to myself, fearing that if I told anyone then it might limit the dating pool. I was terrified that I would fall in love, but he would leave me when he realized I could not bear his children.

While conducting the interviews, I spent little time reflecting on the complexities of personal research. Rather, it was during the coding stage of my analysis process where I began to be plagued by the recurring nature of the cancer discourse. I felt as if my participants had appropriated cancer, and the bodily trauma associated with it. Moreover, I was left wondering if there was a significant cultural misunderstanding on the nature of cancer; *do people really not recognize the colossal differences between cancer and infertility?* It was in these moments that my carefully crafted identity presentation became fractured. I wrote myself a dissertation in the hopes of finding community, but I became affronted by that community's linguistic choices. There were other moments throughout the dissertation process that left me frustrated or annoyed, but none were so omnipresent as the cancer discourse. The casual references to cancer rendered me powerless, it seemed to take a sacred experience—one that I and others had suffered through in fear and agony—and make it sacrosanct.

Through research we begin to know ourselves in conversation with others (Kannen, 2011). In this sense, identities are relational, built through active engagement with a research context. As participants narrated their (in)fertility through discourses of cancer, I began to understand how pervasive dominant narratives of cancer are, even outside of individual survivors. Participants who related their (in)fertility to cancer did so by recognizing the hallmarks of a devastating diagnosis, aggressive treatment, and, optimistically, a finite recovery. That is, as Ellingson (2017) illustrates, cancer survivorship is frequently, publicly, and organizationally communicated as 'happily ever after.' My participant's understanding of (in)fertility *like* cancer, is an example of how these macro-narratives imbue the everyday understandings of cancer. Identities can both help and hinder the research process and the construction of meaning (Geist & Gates, 1996; Reich, 2003). As I constructed the meaning of my own (in)fertility through the context of my cancer survivorship, I

too began to better understand my relationship to cancer. However, as participants laid claims to these identities it forced me into an uncomfortable position of a researcher navigating insider/outsider statuses.

CHAPTER 5: NARRATIVES OF EMPOWERMENT

It wasn't as overwhelming as I thought it would be. I was kind of in awe of, wow we live in this day and age where we have these options and we're fortunate to live in a state where we have, for the most part, pretty solid infertility coverage. I know it's not true for everyone unfortunately, even here in the States. But we're one of the lucky ones in that way.

—*Tia*

Despite the loss, (in)fertility patients remain hopeful, optimistic, and resilient. In this chapter I analyze the narratives of (in)fertility related to resilience. This chapter follows a similar format to Chapter 4 by first examining how an in-group identity is developed through the (in)fertility experience, relying particularly on online support groups as a source of identification (RQ2). Then, I illustrate how resilience is successfully crafted through communication (RQ3). Unlike Chapter 4, which specifically analyzed stories of loss and trauma, this chapter seeks to illustrate how empowerment is developed during (in)fertility. It is through unpacking narratives of empowerment that I illustrate how these narratives constitute the organization of the social definition of (in)fertility (RQ1). In short, where Chapter 4 was used to illustrate the negative, depressing, and traumatic experience of (in)fertility, Chapter 5 is developed as a counterpoint. Through Chapter 5, I emphasize that, despite the hopelessness, (in)fertility can be empowering.

Empowering Identities

Throughout the interviews, participants (re)framed their identities in order to emphasize their personal growth and emotional maturity. In part, narratives shared via online support groups assist in producing a salient in-group identity. Identification with online support groups served to provide participants with a counter-discourse to the alienation and stigmatization surrounding the

(in)fertility experience. In this chapter, I first unpack how identities are (re)framed in order to position (in)fertility as a learning process. Second, I examine how the discourse of online support groups, coupled with the narratives shared in interviews, led to the organizing of a social identity. Third, I illustrate how definitions of the in-group identity serve to destigmatize the (in)fertility experience (Table 4). It is through these three discursive processes that participants construct (in)fertility as an empowering identity.

Table 5: Empowering Identities

| Theme | Description | Codes/ Examples |
|-----------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|
| (Re)frame Identities | Participants (re)frame the (in)fertility experience as leading to new, positive identities. | Accidental Expert/ Self-Advocate Increased Empathy |
| Social Identification | Participants coalesce around an in-group identity of (in)fertility that serves as an identity for resilience. | Empowerment Disclosure |
| Destigmatization | Participants, particularly those who have spent years in treatment, often reflect that IVF has become normal. This is sometimes spurred by finding a community of others, but also through developing a routine. | Finding Community Accepting Treatment Routinization |

(Re)frame Identities

As discussed in Chapter 4, identities are negatively challenged, lost, and altered during the (in)fertility experience. However, when asked about their changing selves, participants also reflect that they developed increased empathy, gratitude, and confidence through the (in)fertility experience. In particular, participants frequently construct (in)fertility as a process, which helps to diminish the ambiguity and loss of control. Through (re)framing (in)fertility as a process and

ascertaining positive identities participants imbue greater meaning into the (in)fertility experience, which extends beyond the medicalized discourse.

As a Process

As is evident in Chapter 4, (in)fertility is fraught with ambiguity and uncertainty. For some women, this loss of control can be difficult to navigate and lead to increased feelings of depression, lower levels of well-being, and a diminished self-concept. However, as patients become accustomed to the ambiguity of (in)fertility, they also become more comfortable with (in)fertility as an uncertain process. As Danielle explained, she used the ambiguity in the process as a way to reduce the stress of the situation:

I think that we're becoming more comfortable with the ambiguity. I don't want to say that we're totally accepting of it because it's hard to do that, but we understand that this part of medicine is very—like, yes, they've been doing IVF for many years now, but not that long, so it's still in its pioneer, it's never going to be perfect, every patient is so different in what they're experiencing and how they react to different medications. So, I feel like just accepting that it's not clear cut, black and white situation had taken away that stress and that wonder of the unknown.

Medicalized discourse suggests that science and medicine will triumph over nature, (Jensen, 2015), however as Danielle's narrative indicates, (in)fertility is not a perfect science. Danielle provides a counter-discourse to medicalized understandings of (in)fertility by (re)framing infertility as an in-progress science.

Recognizing (in)fertility as a process also prompts women to (re)frame how they identify with (in)fertility. For example, participants reject the idea of (in)fertility as finite and instead embrace an understanding of (in)fertility as ambiguous. Recognizing (in)fertility as ambiguous is a pathway towards hope, as Carol illustrated:

I am very comfortable being part of the infertility world, but I cannot get on board with calling myself infertile. I can't do it, it's not the same thing somehow to me. I am going through infertility; I am not infertile. I have not been told that I cannot have children, I haven't been told I'm barren, I'm just having trouble right now. It hasn't been a smooth journey, but I haven't been told that it's not worth pursuing. I feel like saying you're infertile seems like a very finite statement and diagnosis that could not be overcome.

Embedded within Carol's narrative is the discursive construction of hope. In embracing the ambiguity of (in)fertility, Carol expresses a feeling of purpose. Similarly, Allison recognizes (in)fertility as a medicine in progress:

There's different choices along the way. And that I guess also warn you that there's a lot of gray area in terms of, I think probably earlier in my life I would think of someone's fertile, or not fertile, but there's a lot of in between where there's not always a clear answer, but there are lots of options, and there's lots of different treatments, and research going on in this. So, there's a lot of reason to be hopeful.

Like Carol, Allison uses the fallibility of (in)fertility medicine to imbue hope into the process. As is discussed later in this chapter, discourses of hope serve as critical elements for constructing resilience within narratives of (in)fertility. Danielle, Carol, and Allison shift thinking of (in)fertility as an uncertain process, moving away from the medicalized conceptions of (in)fertility as a definitive, objective science, they are likewise able to (re)define their identities as progressing, rather than static.

Through Control

The second way identities are (re)framed is through associating control with empowerment. As previously discussed, participants use their losses to catalyze control and agency within their medical and professional lives. For example, Sarah, who was initially diagnosed with unexplained infertility, eventually received an endometriosis diagnosis. After years of dealing with unexplained

loss, Sarah recalls the moment of receiving a diagnosis, which she suggests allowed her to become a better self-advocate:

I would say, I've always been fierce in some ways, but I feel that I can own that fierceness a lot more now. And saying and asking what I need and putting that out there as "this is what I need." And that's just—I've said it more in the last year, and I like to think of myself as a strong person, and a strong willed person and, you know, someone who doesn't take crap, but like literally realizing last year, oh my God, I've put up with so much crap and not said what I needed. . . Last year was a huge change in terms of my ability to self-advocate, like, hey turns out I had this major medical issue and it was affecting my quality of life, but I never knew it was, and no doctor even really tried to pursue it or questioned it, just said, oh that's normal, bad periods are totally normal. Well, when they're this bad are they totally normal? I could have addressed this much sooner had I, you know, had I advocated for myself.

Existing literature (Grace, 1995; Hamberg, 2008; Ruiz & Verbrugge, 1997) indicates that male doctors are apt to diminish the health concerns and negate the pain of female patients. As Sarah's narrative highlights, this system of gender bias played an indelible role in her inability to find answers for her medical pain. And yet, for Sarah, finding a cause of her (in)fertility was a key moment of empowerment and made her feel 'fierce.' It was this fierceness that allowed Sarah to advocate for her needs—both within the clinic and outside of it.

Communicating a diagnosis and resolving unexplained (in)fertility can be a critical source of closure for many women who struggle with the ambiguity of this process. As Gina explained, after she received an identifiable diagnosis and subsequent treatment for her endometriosis, she felt much more confident in pursuing (in)fertility treatment:

One of the things in infertility that is most frustrating is, yes I have like 6 diagnoses, but you hear all of these people who say their infertility is unexplained and they've had 7 miscarriages and no one can tell them why and they're both healthy and no one can figure out. And I'm just like, could not imagine how maddening that could be.

Resolving unexplained (in)fertility is a meaningful turning point for women, and one where they feel more confident in making medical decisions and asserting agentic authority in their healthcare.

Becoming a self-advocate was a consistent, reoccurring identity evident throughout the narratives. As Ellie described, she was forced to become a better self-advocate, in part, because of consistent misunderstandings from her friends:

I kind of stop when they say, “Oh, it’ll happen I just know it.” I kind of stop and say, “Actually you don’t know that, like I know several people who have gone through 10 IVF cycles and it hasn’t worked and now they don’t have any money to even look at any other options because they spent it all on that, so no, it doesn’t always work and you can’t tell me that.” And that’s not what people want to hear. So, I kind of have become a better self-advocate because I think most people genuinely, they do care, or they don’t and they’re just saying things to make themselves feel better.

Ellie conceptualizes a self-advocate as able to tell friends when their comments are hurtful. Often, participants note that friends’ comments could be emotionally damaging and frequently involve unhelpful stories that were meant to convey hope, yet, more often than not, conveyed idealistic, but unrealistic, understandings of fertility. Ellie reasserts her agency into these conversations, emphasizing the lived expertise she developed through treatment. As was initially highlighted in Chapter 4, women frequently lose their social network during (in)fertility treatment, but Ellie’s narrative shows an effort to retain connections by reducing harmful discourse.

Participants frequently reflect that, in living with (in)fertility, they have become accidental experts. Kelly suggests that this expertise is necessary in order to be an effective self-advocate in the clinic, *“I’ve also understood through this whole process that you have to be an advocate for yourself because nobody cares more about getting pregnant than you.”* In this sense, advocacy becomes a form of control. The accidental expert identity is rooted within the lived experience of

(in)fertility; as Ellie said, *“I’ve gone through so much and I’ve read so much and I feel like I’m an expert at things that I don’t necessarily go to those groups for medical advice, it’s just more about sharing advice or stories, like hey has anyone tried this HGH thing, it’s kind of new.”* Online support groups often serve as a forum through which patients gain access to new medical information and receive non-medical advice. The knowledge shared in these groups is deeply embodied; participants call upon their lived experience to share knowledge, reassert their agency, and reduce isolation (Author, 2021).

Online support groups serve as a locus for attaining control and (re)framing the (in)fertility identity. Fostered within these groups are discussions of treatment protocols, tips for navigating the social experience of (in)fertility, and access to material support. As Gina described, she turned to the (in)fertility support groups when she needed optimism:

So, the support groups, there are a few that have been game changers, they have been so necessary honestly, just a wealth of information you can ask a question like, “Has anybody ever gone through this?” And you immediately feel a little better, whether or not that’s legitimate, you just do, because if someone else has—when we were pregnant with my son, my first blood pregnancy test, my HCG was only a 20 and I freaked out a little bit because my last miscarriage my pregnancy test was a 17 and I was like well here we go again, but they wanted it to go up 60% and in 48 hours it went from 20 to 84 so it quadrupole, more than quadruple. So, you have that group that you can say, “Ok, my levels were only at 20, someone give me a positive story that started this way and ended good,” and you get people that are just enough.

The support groups provide a forum in which women can relay their medical experience and receive positive, hopeful discourse. Similarly, women turn to the support groups to seek advice for non-medical reasons as well. As Rachel describes, an (in)fertility forum provided her with the best language for informing her superiors of her upcoming treatment:

Actually, sometimes I go on Reddit and look at their infertility message board and there was this one post where someone was like, “How do you talk to your job about it?” All the days that you need or the monitoring and things like that, and I remember that this one person had a great response and I just used that as a script. It was just like, “I’m dealing with a medical condition. It’s not serious, but I’m going

to need to have some time off for some outpatient procedures and I'm going to need lab work, so I'm not going to know exactly what day it is."

In part, empowerment is fostered through access to the right language. As Rachel's narrative showcases, the group provides the proper verbiage for describing the (in)fertility experience, usually in loose medical terms. Finally, these groups also provide material resources that provide significant financial relief:

In fact, when I was pregnant and didn't need to be on medication anymore, I posted it in an infertility Facebook group with the leftover medication that I had, that was unopened and about to expire because it'd been forever. . . I ended up sending some of my medication to another Abby. . . and then the other medication, I gave it to my mom who gave it to the mom of someone else in the group. . . And then I met someone else in the Target parking lot and just did a hand out. All from this infertility Facebook group. We didn't have to pay for any of the medication either, it was just a small co-pay of like 60 bucks. So, I knew that stuff was 1,000's of dollars, so I was like take it before it expires. People that weren't in the fertility community were like, "Isn't that illegal? Why would you give prescription medication to someone?" And I was like, "You don't understand, this stuff is super expensive, and it is literally the same thing as they would get. I just saved them a couple 1000's dollars." I was like, "This is the least I can do."

Online support groups (re)frame identities through these discursive-material lenses. In creating a community that is supportive, informative, and empathetic, the participants are able to develop a sense of agency. As Nancy explains, she took the information gained in the support group to her doctor:

I found out that there was the Facebook group, I think after my first transfer, that's when I posted something because I was like, "Hey ladies, has anyone else experienced this because I have my doctor's appointment and I don't know what to ask." And then a couple of people suggested that I get an ERA, which is where they test your uterus to see when it's receptive. And I talked to my doctor about that and he was like, "Well, we usually don't do that until two failed transfers." But then at the end of our conversation, he was like, "Okay, let's do it because you're not going to be happy unless we do this and let's just do it now."

In short, the discourse of the online groups reaps offline consequences. Patients like Nancy and Gina feel more empowered to take control of their health by making recommendations to their doctors.

However, the accidental expert identity, while empowering, can be difficult to navigate in non-(in)fertility contexts. As Faith explains, after her attention became too singularly focused on (in)fertility it was increasingly challenging to converse with people who were not familiar with IVF:

It's amazing how much I have learned about this stuff that I never knew existed. And that's another thing, now I forget when I'm having a conversation with people that not everyone knows what IVF is. So much of what is part of my daily and hourly life that most of the world doesn't even know exists. So, I'm also having to remind myself that when I do talk to people, I'm having to use very general language and not assume that people know what a frozen embryo transfer is.

Carol shared similar sentiments, *"These treatments, they're so invasive, they take over your whole life for a while, they make you obsessed with the topic, even though I don't want to be. Nobody can get that unless it happens to them."* Thus, while self-advocacy can be empowering and can reaffirm a women's agency, both inside the health clinic and in her social circles, it can also further isolate women.

Enabling Empathy

In addition to becoming self-advocates and experts, nearly every participant identified herself as becoming a more empathetic person. Empathy was the most reoccurring response participants shared when asked *"How have you changed since starting treatment?"* As Abbey describes, empathy helped her recognize the diversity of hardship:

I feel like it's probably made me more compassionate, empathetic to people. Because you really don't know what everybody else is going through, and when

you're in your 20's, now I'm in my 30's, but was just in my 20's, you don't really think about all the other people it's just kind of like how am I going to survive until the next thing.

Similarly, Carol suggests that (in)fertility allowed her to understand hardship in a more complete manner:

It made me more empathetic I think towards people who are going through any type of hard thing. This has just been my hard thing, but I suppose it could have been anything. It has made it so that I have been less likely to say a dumb thing to anyone else, just able to let them talk and hear their story, without trying to offer advice.

The ability to become compassionate and more fully understand hardship helped participants to feel that their (in)fertility experience was not in vain. As Carol later shared, her empathy allowed her to connect with her sister-in-law who was undergoing a different type of hardship:

It's probably made me more empathetic for others who are going through a hard thing. Like, I know for a fact that it has made me more comfortable showing up for people who are going through something hard. My brother-in-law's girlfriend recently lost her sister-in-law to cancer and I don't know her that well, and I think if I hadn't been through any of this, I probably wouldn't have known what to say, so I probably wouldn't have said anything, and then I would have second guessed myself. And instead, I just went and gave her a hug and I said 'I'm so sorry,' and I don't know if that's, it's not like I said anything earth shattering, but at least she knows I am there for her, and am not ignoring what she is probably going through. And, I hope that that made her feel good a little bit. So, it's probably made me more empathetic in that way.

Because participants so readily identified empathy as a significant point of change, it suggests that participants were actively trying to (re)frame their experience as something that was not purely hopeless. Rather, participants viewed empathy as a positive outcome of an otherwise taxing experience.

Empathy was employed in how participants chose to share positive news. Many women who became pregnant after (in)fertility emphasized that they were cognizant of how difficult it is to hear positive pregnancy news while still in the thralls of treatment, consequently, these women employed empathy in their communication. As Kelly describes, she reduced the visibility of her pregnancy both online and offline:

Because I know what it feels like to be on the other side, not being able to get pregnant, I tried very hard, or not tried very hard, but I try to be really cognizant of how I present pregnancy on social media and also in my surroundings. I didn't buy a single piece of maternity clothing. I never emphasized my bump.

As is discussed throughout this chapter, social media serves as a central organizing force for (in)fertility; it helps to legitimize the social identity as empowering, rather than hopeless, while also providing an outlet for women to gain access to new treatment options. Because participants were so actively involved with the online fertility support, they often took considerable care in monitoring how they presented their online social media. As Sarah describes, she spent weeks deciding when and how to post her pregnancy news on Facebook:

We didn't do a Facebook announcement, mostly because I kind of felt weird about doing it, but that's something that IVF and being part of [the online support] group made me really sensitive to other people who I might not know are going through IVF or infertility, so I didn't want to put I'm pregnant all over Facebook. So, we actually didn't like share that information outside of people we see, we tried to call most of my friends who we thought would care. But my husband didn't post any pictures of me until I was 22 weeks pregnant, actually 24 weeks pregnant, and even then, we publicly stated "#IVF" and we had a few people reach out and say, "You guys went through IVF?" But I labored over how to share that information in a way that would be sensitive, but also like, "Hey we've been through this, I know some of you guys are going through this." I don't know, it became this kind of like—my husbands like, we just need to post something, and I was like fine you do it.

Online groups are a critical outlet for garnering community support for women receiving (in)fertility treatment; participants continue to foster a supportive environment through employing empathy.

Participants also enabled empathy interpersonally, through expressing compassion with their former and lost selves. As Sarah describes, her empathy not only extends to those who are going through hardship, but so too towards herself:

Here I am, I made a decision. That was what shocked me so much, I think, when we were talking about doing IVF, I'm making a decision about something I never thought I would do, and I have such a different perspective on it than I did before. You can't help but cultivate empathy with that, both with your former self and with everyone else who's going through that.

These nuanced understandings of empathy suggest that participants are actively searching for meaning within an experience that has been defined by loss.

Social Identification

As outlined in Chapter 4, infertility support groups organize around specific in-group identities. For example, participants who fall out of the expected age-range of IVF (typically mid-30's to early-40's) feel alienated within the groups; so too do women who pursue an alternative path to IVF. However, these groups also serve as a source of empowerment because they allow participants to feel a sense of belongingness during an otherwise isolating experience. As Abbey describes, while she initially felt alone after her miscarriage, when she turned online, she found a broader community of support:

The miscarriage was probably my first realization that there was this larger community out there. I blogged about my experience. . . I had a WordPress blog and I wrote about what I was going through because, at the time, I was the only one I knew that had a miscarriage. But as soon as I posted, everyone came out of the woodwork. Like, parents of might high school friends, like this is why this son is

so much older than the other son, we had a miscarriage in between, here I'll send you these books and then like a few months later I found some high school friends had had miscarriages. One of my friends had secondary infertility and it was just like, it was a lot of stuff we don't talk about.

Like Abbey, many participants started blogs as a way to cope with the isolation of treatment. These blogs helped participants find community and reduced the stigma of the experience. As Kelly suggests, she was initially hesitant to disclose her treatment because of her religious identity, however when she wrote a blog about her treatment, she found an unexpected source of support and community:

I wrote a blog about my infertility and I got almost 400 likes. And like, everyone came out of the woodwork, and everyone was like, thank you so much for talking about this, blah blah blah. So overwhelming because most of my friends are Christians, like the reaction was very positive. I personally wish that there was more kind of intellectual leg work, theological leg work, done on this technology.

These public forums, where participant's share their experiences, serve as the building blocks for the social identity of (in)fertility.

Narratives found on forum-based websites and on personal blogs are significant resources for women who struggle to cope with the losses of (in)fertility. As Ellie explained, these blogs helped validate many of the emotions she was experiencing:

I do a lot of reading, like I read a lot of blogs and different things that are like, how do I cope with it? There are just little nuggets here and there that come out. Like, I was reading the other day that this is a life crisis, like you shouldn't feel like you need to be positive and happy. A lot of people equate it, or they've done psychological studies that say it's almost equivalent to dealing with cancer, so it's a big deal you and like, I shouldn't feel bad for the way I do. So, I think it kind of helps validate those feelings, and it gives me some things to talk about, you know, with my husband, like, this is what I'm going through and this is why it's so hard.

As is discussed later, validation is a key form of communicative resilience. Participants look to have their experiences and losses recognized as real. Chapter 4 highlighted how frequently the d/Discourse of health clinics and medicalization diminishes the embodied emotions of (in)fertility patients. These groups, as Penny explains, were one of the only places where she could receive validation for her emotions:

Even with the first miscarriage I had gone there and was looking, how did this happen, what was your, because my doctor had said, this will be just like your period, and literally it was literal contractions, it was not like a period. And so I think knowing that I should have been told about that helped make it feel less traumatic and more normal, and clearly I wasn't going to get that from the doctors office, it is not a conversation you're going to have with your parents. If your mom has not had a miscarriage then she doesn't even know. I think chatrooms are important, because even if there is not as much stigma around it, there definitely still is.

For women at various stages of IVF, these support groups function as a critical resource for self-acceptance.

Online groups are a source of empowerment, in large part, because they diminish hopelessness. As Beth describes, the groups provide support, and diminish the loneliness and stigma inherent in the experience:

If I turned to the support groups when I'm feeling helpless and hopeless and I don't know where to go from here, and I feel like this is the craziest problem ever. And then I throw it out there in the group and people will be like yeah, we're going through that and this is what's working. I think for me, just literally knowing I'm not by myself and this problem is something that others go through and there can be light at the end of the tunnel instantly activates that sense of ok, I feel better now, because the worst would be if you throw something out and everyone's like, oh that's weird, that's not normal, there's nothing right about that. You know what I mean? Just recognizing that sometimes that feeling of hopelessness is just a feeling and challenging that by being like, there are these other people who've dealt with it. So, from a mental level, you can be like ok, other people have gone through that, there are certain solutions we can try, so that rebuilds hope.

As Beth's narrative indicates, online support groups foster a sense of community through the promotion of a positive social identity; one which develops out of shared experiences. Many women highlight the uniquely situated experience of (in)fertility, an experience which is difficult to understand unless someone has lived it; Beth summarizes this belief, "*That is the kind of thing that unless people, like even those details of like is my period here, is it here yet, and you check every time you wipe, that's not something people could even remotely understand unless you're part of this world.*" The (in)fertility identity is fostered through shared experiences, including a mutual sense of loss, hopelessness, and defeat, coupled against a discourse of hope and resilience. As is discussed in the following section, within (in)fertility, successful resilience is often crafted through mantras of hope and realism that are shared throughout the online support community.

(In)fertility is stigmatized and, consequently, participants express hesitation in disclosing their condition. As was discussed in Chapter 4, participants often experienced alienating discourse in their religious communities and pre-treatment social circles. However, when participants contributed to the online support groups and identified with the social experience of (in)fertility, they frequently felt more empowered to disclose their treatment online. As Beth explains, these groups promote a culture of 'unconditional acceptance':

In the groups there is a whole lot of unconditional acceptance because everyone gets it. It's a very unique situation because in normal life you're not going to be surrounded by people where everyone just knows, you know what it's like, you know how long the wait is, you know how hard it is to get a loss. Like in the real world, like even in the doctor's office I think they're so medical and so clinical about it all that they forget the emotional side, they're almost in a hurry, right? So, if you're anxious and you have extra questions because you're nervous about something, they kind of just push you through because they're in a hurry—and I get that because they're busy. But it's inherently, if you're in a fertility clinic getting treatment, you're going to be stressed, right? So, they're in that boat. . . On the support groups the fact that there is this sense of understanding, that makes it easier. There is this sense that you can put out something that might seem weird and that most people would judge and then people in the group validate those feelings. So,

it's just a really good thing to be a part of. It was a game changer for me to be part of these groups because initially I didn't have that, and I felt a lot more alone.

Disclosing the (in)fertility identity online allows participants to receive validation, a key component of resilience. As Beth's narrative indicates, women frequently feel ignored in their health clinic and misunderstood in their social circles, however the groups provide a safe space that reduces stigmatization.

For many participants, participation on these online forums is a new experience. As Sarah explains, the supportive culture inherent within the groups is distinct from many other online forums: *"I felt like, in general, overall, there was a culture of supportiveness that wasn't present in most other Facebook conversations that I've seen. But it was interesting because that was right around the time that the podcast changed because they got pregnant and so there was a lot of people who were kind of bitter at them."* For Sarah, participation in online (in)fertility communities was a novel experience; a place where she *"felt a kinship in an online community that [she] had not before."* While online support groups take a variety of forms, Jillian suggests that Facebook provides a unique atmosphere because it is not anonymous:

I had never been part of a Facebook group before this whole thing, and now I am in, I mean there are a lot of things to be angry at Facebook about, but I am so thankful for these groups, I think it's been by far the best thing that Facebook does. And I think it works a lot better than online groups outside of Facebook because people are anonymous in those groups, so I don't think they behave as nicely in those groups when you're not as anonymous.

Unlike previous studies on infertility support groups (Author, 2021; Malik & Coulson, 2008b, 2011), Facebook is an understudied hub of fertility discussions. However, Facebook presents a unique case study in research on (in)fertility discussion boards. As Facebook profiles

are frequently linked to a participants' offline identity, participants may feel more security and trust in the environment.

De-stigmatization

Finally, within (in)fertility, an empowering identity is developed through a discourse of destigmatization. Participation in (in)fertility support groups and the adoption of an in-group identity assisted women in overcoming the social isolation and discursive stigma attached to (in)fertility. Destigmatization develops through three processes: (a) finding community; (b) accepting treatment; and, (c) developing routinization. These processes serve as a social buffer against the stigma-based identity threats of (in)fertility.

Finding Community

Participants reflect that their involvement with Facebook support groups is a new social experience, however the groups provide a critical outlet for women seeking more information and an empathetic form of support. Carol describes the groups as filling a void in her social life:

I didn't really know anyone. . . So, the groups I started seeking them out to try to, also because I found myself kind of obsessed with the topic, tracking my periods, tracking ovulations, tracking my temperature, peeing on sticks and like, my husband doesn't want to listen to that all the time, my friends don't want to listen to that all the time, and I needed an outlet. So, I'm pretty sure that's what drew me to the groups in the first place.

Carol's narrative reflects her fear of being burdensome to her friends, an often-cited concern of women undergoing (in)fertility treatment. As is discussed at greater length in Chapter 6, the fear of being burdensome often inhibits women from disclosing their fertility status. However, the community of online support groups is constructed around shared experiences and

this provides a significant source of support. For Kelly, the groups provide a forum to share in expertise:

I get that itch scratched via the groups online because there's just a shared vocabulary. If people are going to get it, so that's where I find my support now, I just post something random and people are usually—[they] swarm around you with their own stories or with their own kind of advice.

As previously discussed, many women undergoing (in)fertility treatment identify as accidental experts, and yet as Carol and Kelly both describe, there are few places where they are able to share this accrued knowledge, the support groups serve as a place to enact this identity.

Beyond shared identity and accidental expertise, the support groups offer a forum to find support. As Jillian shares, participating in the online support communities has not only allowed her to access new information, but to form friendships:

Hearing success stories is really, has been really motivating, especially in women who seem like they had cases that are as challenging or more challenging than mine. I've also met like a whole bunch of people who are in the same sort of place and it's been really great to connect with them and feel like we're kind of following what's going on with each other.

Participants noted that their involvement in the online groups led to the development of offline connections. Some women, like Jillian, followed along with others' progress, noting their successes and empathizing with their losses. Others, like Julie, developed offline connections through online participation. For example, while Julie describes herself as a 'lurker'¹¹ within the groups, she does note that she developed friendships through the group: *"I have met two really fantastic women from my area, from that group too. And so, I've connected with people outside of*

¹¹ Lurkers are defined by Cambridge Dictionary (2020) as "someone who reads messages in a chat room without taking part."

the group and made friendships there. So, I'm thankful to the group even though I don't really interact with it that much." In this sense, even minimal participation in the groups can lead to a sense of community.

Lurkers make up the majority of members in online groups and discussion forums (Katz, 1998; Mason, 1999; Nonnecke, 2000; Nonnecke & Preece, 2001). Lurkers have been described as communicationally incompetent (Mason, 1999), free-riders (Wellman & Guilia, 1999), and abusers of the common good (Kollock & Smith, 1996). Others have described lurkers as wanting the safety and privacy of anonymity (Nonnecke & Preece, 2001). Regardless, participants who identified as lurkers within (in)fertility support forums continued to feel supported by the community. As Danielle describes, while she does not frequently participate, the stories she read in the support groups helped diminish her isolation, *"I do find myself reading threads about how her husband was not being so supportive, or just feeling like I'm not the only one, even if I'm not chiming in, or answering a question, or posting my own questions in the group."* While the majority of discussion is directed towards medical treatment, participants also discuss the social experience of (in)fertility. For example, Tia turns to the groups to rant about her frustrations about other type of trying-to-conceive groups:

I have a rant group that I'm in, and there you're like, "Can you believe this person who is complaining about, like—oh gosh, like wanting to try to get pregnant for, you know, they have five kids and they're trying for a different gender." It's like, why are you here? It's about infertility, not to create your designer family.

The social experience of (in)fertility is just as unique as the medical experience. As the narratives shared throughout this project have highlighted, women undergoing (in)fertility treatment are navigating multiple forms of alienating d/Discourses and the support communities provide a forum for women to share their socially frustrating experiences.

Communities are designed for different purposes. Tia, for example, discusses her membership to a ‘ranting’ group that serves a unique purpose; other women participate in local or clinic-specific groups. Carol describes her local group, where she is able to form offline connections, share protocols, and exchange information:

I found this Ontario IVF group and that’s been amazing, both because it’s only people who are doing IVF so you’re not getting a lot of questions of “what’s IVF,” and it’s not IUIs and stuff. But it’s also location specific. They talk about the different doctors and the different approaches and the wait times and all of that. And it is incredibly helpful. And through that, and also because I’m new to the area and it’s a little lonely, I was able to reach out and say, “Hey is there anyone who’s in my area who would like to meet up?” And now I have a little meet up group and there’s like four ladies who like come to every meet up. One of them in particular, I really like her, and I have friends from the group.

As Carol describes, many of the topics discussed in her local group are similar to what is discussed in larger groups, however the local group provides more specific, personal details on what to expect. (In)fertility treatment can vary and doctor recommendations can be clinic-dependent, thus these local groups provide an invaluable resource. As Jennifer describes, she is able to determine if her treatment protocol is normal through participating in a local group:

A secret group for women who were being treated at the clinic, and that’s been also enormously helpful in order to exchange ideas about different protocols and when they send me something to do, I often write to the group and say, “Did they tell you to do this too?” Just like, to find out what other people have done.

It is important to note that many women do not have access to these clinic-specific groups. These types of support groups vary depending on location, but for those women who do have access they proved invaluable.

Finally, while most participants were members of Facebook groups, some women noted they preferred message boards and anonymous forums. As Tia described, groups on the social-networking platform Reddit felt safe because of the insured anonymity:

[Reddit] feels like a safe zone to unload all that stuff because your name is not attached to your posts either, so you can hide under these avatars, so to say, and just really spill the tea, I guess on what is going on in your life. You know? So, I like that about Reddit and their threads. So, it's good, you know, any support that you can find, any release that you can find, can be helpful.

Reddit is frequently characterized as part of the 'Manosphere,' an aggregate of men's right communities where misogyny runs rampant (Ellis, 2019). And yet, Tia's narrative highlights the unique benefits to Reddit, where women can organize without the pressure of their 'real life' identity.

However, by and large most women preferred Facebook groups because anonymous forums and trying-to-conceive (TTC) websites often used de-medicalized language that can feel alienating and childish. As Nancy describes, trying-to-conceive websites are not necessarily designed for women undergoing (in)fertility treatment:

I would look at those TTC sites, which are ridiculously overwhelming. Like, I don't know how much time you spend on them, but I find them to be like A) super overwhelming, and then B) filled with—like some were useful, and then some of them were just nonsensical. There was so much pseudoscience bandied about, that I would get kind of overwhelmed and frustrated with myself for looking and feeling like I could find any answer I want to my question if I look enough.

When first diagnosed with (in)fertility, many women turn to TTC websites, but are unable to find the shared sense of experience they desire. Other women avoid message boards because they frequently employ non-clinical acronyms. For example, within Reddit sex is commonly referred to as 'baby dancing,' which participants felt was childish and reduced the seriousness of trying to conceive. However, regardless of what form a community takes, participants frequently cited the groups as a key source of support in helping them through the (in)fertility process. These groups fostered a sense of belongingness, which in turn, helped reduce the isolation of the experience and bolster a sense of empowerment.

Acceptance

The (in)fertility identity is destigmatized as women begin to accept the reality of (in)fertility. In part, accepting the treatment was built through the social support groups. As Jillian describes, once she found an online group for her specific diagnosis, she felt much more comfortable proceeding forward with treatment:

I found a group for my uterine anomaly, which has been especially helpful because I hadn't—I mean there is no one I know in person who has this rare uterine anomaly. So, it's been really, really useful to—when I was going into the surgery, when my doctor said he wanted to do the surgery, I relied on that group a ton to learn about other people who had the surgery. Other people had opted not to have the surgery. How much is it really a concern about having an ectopic pregnancy with this rudimentary horn? And that was very influential on my decision to go ahead with it. And then in a diminished ovarian reserve group, that was actually how I heard about the clinic in California.

Jillian was initially hesitant in pursuing (in)fertility treatment, especially because she had previously become pregnant on her own and thus was not sure she needed treatment. However, as she read other's experiences and learned about the limitations of her diagnosis, she became more confident that undergoing treatment was the right choice.

Many women also describe the culture of the online groups as one of total acceptance and support, consequently, women often seek to confirm their choices. Confirmation helps women trust in their decision-making. As Mary describes, she is conscious that people desire confirmation, and this shapes her level of involvement:

Sometimes I give my opinion, and sometimes I just back off, because you don't, yes you're on there because you want other people's opinions, but you also—I don't really know if you want other people's opinions that are contrary to what you think, you want people to affirm for what you feel, and not—if I didn't affirm what they felt, I didn't want to be the one to say maybe you should do it this way instead.

Participants in the online groups navigate constraints as they seek to foster a culture of acceptance and normalization. As Mary's description illustrates there is a need to be unconditionally supportive, which may inhibit communication.

Developing Routinization

Finally, it became evident that the (in)fertility identity was destigmatized as participants developed a routine, which helped normalize the treatment process. As Kelly described, in the midst of her third IVF cycle, and with two young children at home, she was not left with much time to think through the social experience of (in)fertility:

We've gotten to, now, my third cycle, third IVF cycle, [and] I just, I don't bother because I'm like, what's the point? Like, unless there's something to report, there's, I don't really know if there's a need or if they proactively ask me, I'll let them know. I think before I was like, "Oh, I really want prayer." But for whatever reason I've gotten much more, just utilitarian about it, just a lot more like, let's get down to business, let's get it done. And then if there's something to report, I'll tell you guys later, no one's asking me, it's fine.

As is discussed in greater detail in Chapter 6, Kelly's social support evolves over time. As she becomes more routinized into the (in)fertility process, she has less need for social support. Kelly is a unique participant because she has two young children, however, participants without any children similarly reflected that as IVF became embedded into their daily routines, they needed less support. Lisa, for example, reports that as she adjusted to the medication, she was able to go more easily about her daily life:

I think it's interesting how easily we adjust to doing the medication. For the first time, I would always have my husband do the little shots, the Lupron is with a really small needle. And by the time we were doing the second transfer, we were like, we were at a concert and I just went to the bathroom and did it myself. I stopped caring about where I was so much.

Carol similarly felt that after multiple rounds of IVF, she had become used to the process, “*When the day arrives, when I have to start doing medications for the cycle, I’m like, oh that’s today. And it’s not like I didn’t know it was coming, it just always seems to catch up on me, it catches me by surprise every time.*” IVF can be disruptive, but for participants in this study who have undergone multiple rounds, IVF can also become part of a daily routine. This routinization diminishes feelings of overwhelmingness and reduces the stigma attached to the process. As Lisa described, by her second transfer she had integrated IVF into her life, instead of letting IVF dictate her life.

Being a single mother by choice, this decision was totally empowering and has made me the happiest momma in the world!!

I feel like a bad ass. I’m putting myself through hell to build a family and when the day comes, I’ll be more ready than ever. It’ take a whole lot of emotional strength to go through IVF. Like training for a marathon, you have to be mentally prepared. Not anyone can train for a marathon. Not anyone can handle IVF.

While I don’t shout it off the rooftops that I am doing this, I was reflecting on how long I’ve been doing this. My first fertility consultation was in March of 2015. I still have not had a baby yet. I was really feeling pretty bad about myself the longer I’ve been doing this and with nothing to show for it. That said, I think had time to reflect during lockdown, and I feel like, because I have been at it for so long, it hasn’t made me weaker. It’s been quite the opposite. I am very likely much stronger than I think, and had I been successful in my first couple of cycles, I wouldn’t have the fortitude or courage that I have now.

Figure 8: On Empowering Identities

Synthesis

(In)fertility does not occur in isolation, rather it is shaped by and through participation in online support communities, where women are able to join with like-minded others and engage in supportive dialogue. The in-group identity fostered through the support communities is one guided by lived expertise, empathy, acceptance, and empowerment. As I discuss in the following section, the in-group identity developed through the support groups is an important component for enacting successful resilience. In contrast to previous research on the link between identity and resilience, where resilience is built through affirming existing identities (Buzzanell, 2010), the empowering identity of (in)fertility is improvised. As I will illustrate, as women participate in the groups and adopt the empowering identities of (in)fertility, they engage in resilience.

Successful Resilience

Buzzanell (2010) lays out five processes in the Communicative Theory of Resilience: (a) crafting new normal; (b) affirming existing identities; (c) maintaining and using communication networks; (d) employing alternative logics; and, (e) emphasizing positive emotions. The participants in this project employ many of these processes as they enact resilience through communicative interaction, material considerations, and d/Discourse. Particularly, these five processes are employed through four recurring patterns: (a) communicating intrapersonal and interpersonal hope; (c) employing realism; (b) (re)framing meaning; and, (d) seeking validation through social interaction (Table 5).

Communicating Hope

Research on resilience tends to emphasize the proactive and reactive actions a person takes in the face of adversity. This perspective often frames setbacks as a springboard for growth;

however, in my research it became increasingly apparent that while women may adopt certain changes to improve their treatment cycles (i.e., research, engage in conversations with doctors, try herbal medicines or acupuncture, or adopt an overall more relaxed approach), these marginal changes are not necessarily in-line with the productive changes that Buzzanell (2010) emphasizes. Instead, what became clear in conversations on resilience was that women enact interpersonal and intrapersonal hope as a discursive motivation for treatment.

Table 6: Effective Resilience

| Theme | Description | Codes/ Examples |
|------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|
| Hope | Hope is a discursive construction and it can be fostered through dialogue with doctors or others, but it can also be developed through a reliance on intrapersonal mantras. | Mantras of Hope Doctors Communicate Hope Individual Agency |
| (Re)Frame | Participants (re)frame their narrative. Participants recognize the positive identity changes, small victories, and the family they have created with their spouse. | (Re)Define Family Opportunities for Growth Celebrate Victories |
| Realistic | Participants seek information, set expectations, and construct a plan in order to remain resilient. This negatively affects hope. | Sustained Functioning Setting Expectations Constructing a Plan |
| Validation | Resilience is communicatively constructed when participant's experiences and emotions are validated. | Venting Social Support |

Hope is traditionally defined as “a positive motivational state that is based on interactively derived sense of (a) agency (goal-directed energy), and (b) pathways (planning to meet goals)”

(Synder et al., 1991, p. 287). Traditionally, these two features—agency and pathways—have guided psychology research on hope, and certainly these thought processes are evident in narratives of (in)fertility. As has been previously illustrated, women develop and assert agency within their treatment and this agency undergirds the social identification process of (in)fertility. Agency, advocacy, and expertise are developed through participation in the medical treatment and membership to online groups. Likewise, women use setbacks—including miscarriage, misdiagnosis, and miscommunication—as a means to evaluate pathways and develop new plans. As was explored more fully in Chapter 4, women act upon moments of loss by meeting with doctors, exploring new treatment options, and taking a cognitive shift in their approach to (in)fertility.

Hope fostered through these material and interactive actions offer women avenues through which to craft resilience; however, hope was far more frequently crafted through interpersonal and intrapersonal discourse. For example, participants conveyed hope through personal mantras. As Faith describes, she used an intrapersonal mantra to guide her through the pain of a miscarriage and instill hope within herself:

For the brief time that I was pregnant I went to the prenatal yoga classes at the studio and one of the things that focused on in that class was what they called ‘discomfort practice’ where you get yourself into a pose and then hold it for a very long time and use self-talk and breathing to get yourself through it. And that actually helped me a lot, even when I was miscarrying because those cramps are so awful. I remember thinking, ok I practiced for this and this sucks, but it will stop at some point and I just need to breathe through it and get through it.

Faith used her past experiences to not only envision a pathway through the physical pain of her miscarriage, but so too used her past experiences as a discursive mantra to instill hopeful thinking for the future. Carol employed a similar mantra of hopeful thinking: *“Sometimes I almost feel the same feeling of this is never going to work out for me, no matter what I do. But I also try*

to remind myself that eventually I did get a really good job and I was wrong, so maybe I'm wrong about this too. It just doesn't feel like it, it just doesn't feel possible." At the time of our conversation, Carol expressed feeling hopelessness as she struggled through repeated failed cycles, yet she also used her past experiences with hopelessness to convey optimism for her future. In other words, Carol, much like Faith, uses her past as an avenue through which to elicit hope.

Frequently, women undergoing (in)fertility treatment are on the receiving end of well-intentioned hopeful discourse. For example, as Faith relays, her best friend tried to communicate hope through a positive, optimistic story:

When my first one didn't take, my best friend, bless her soul, and I think she was trying to make me feel better, but she texted me and said, "Well, you know, both of my sisters had at least 2 to 3 miscarriages before they got pregnant, and our friend Sarah had a miscarriage." All of these people I know and didn't know they had miscarriages. And she kept telling me and telling me, and oh my Gosh, this is freaking me out, I'm never going to have a baby.

For Faith a story meant to convey hope, in reality, became burdensome as she sought to grieve her own loss. Similarly, Beth describes the pressure miracle discourse can hold on hope:

When in April we got pregnant naturally there was a moment when I thought, "They were right, all these people who talk about miracles, it's happening." And then we miscarried, I was like, "I knew I was right." There's this emotional need for people to know like, yes you hear these miracle stories but you can't put that on someone because we're not going to sit around waiting for a miracle. . .It's weird because this experience of getting miraculously, naturally pregnant, part of me feels this pressure from the world, because you hear these stories of just like, quit it all and just take your time and just see if you get naturally pregnant again. . .But then my rationality kicks in and I'm like, forget all these judgers, just do what you need to do for you because it's our journey and we can do it the way we want to.

Miracle stories add increased pressure to an already tension-ridden experience. For women navigating a cultural d/Discourse that privileges motherhood as natural and presumed (Jensen, 2016), miracle stories only serve as an added reminder that (in)fertility treatment is abnormal.

Rather than locate hope in miracle narratives, women find hope by focusing on their identities outside of fertility. As Sarah described, she and her husband sought to remind themselves of the life they had without children:

The thing that we always said throughout the whole IVF process, that we always tried to reaffirm with each other was, we will be fine either way. Yeah, no one has ever regretted having a kid, but they also don't know any different. We've been married now for 13 years, we've had a great life without kids, and we will continue to have a great life, and that doesn't mean there won't be grieving or sadness and loss, but we also have some really great role models in our life who are childless or childfree, depending on the journey they have been through. And we can accept that there will be grief, and also know that we know we'll have a great life.

In other words, hope is not located outside of the woman, rather hope is constructed within her own selfhood. Tia described a similar feeling, *"The fact of the matter is, I would love to have kids with him. I can't imagine who else I would want that with. And if it doesn't happen, we can still have a good life together."* Throughout the interviews, participants reflect that even if they never have children, they will still lead fulfilled lives; participants note they will be able to travel, find outlets for caregiving, and, ultimately, find happiness. In contrast to the traditional ways in which hope is communicated (i.e., miracle narratives), these methods of communicating hope reassert a woman's worth regardless of her motherhood status.

Participants also engage in hopeful thinking by remaining optimistic. Research has sought to disentangle hope from optimism. Within psychology, optimism is treated as a future-focused trait (Chang, 2001; Gillham, 2000), whereby individuals "believe that good rather than bad things will happen" (Scheier & Craver, 1985, p. 219). Both hope and optimism are goal-based (Snyder et al., 2000), and research frequently orients these processes as trait capacities, rather than communication processes. However, many of the narratives position optimism, and hope, as

discursively constructed. For example, as Penny described, her hope has ebbed and flowed as she navigates treatment:

I am probably more hopeful now, than I was in the beginning. Yeah, not necessarily in the sense that this will work, kind of hopeful, but more in the sense that part of me that wants to share what I know and share the love that I have, and share the traditions, is hopeful that there will be an outlet somewhere, whether it's a biological child, or an adoptive child, or a dog, or whatever. I feel more hopeful that we'll be ok in the end of all of this.

For Penny, hope is not a personality trait, rather it is discursively constructed as she envisions her future without a child. Her ability to envision a future beyond (in)fertility treatment is what ultimately grants her hope.

Hope is crafted through comparison. Participants, for example, develop hope when they see friends go through the treatment process. As Lisa describes, watching her friend succeed after multiple losses helped her to remain hopeful:

One of my friends, she had a few miscarriages right before I had my first and my second, she had one and then I had one and then she did IVF, but all her eggs came back abnormal. And then she ended up getting pregnant naturally and having her first baby at 41 or 42. She made me feel like I could do it. She is a really strong person and she was like, whatever just do it, it's easy. So that was really helpful.

Similarly, Allison felt that seeing friends succeed could foster hope at moments where she felt weakest, *"I don't always feel like, 'Oh, because it happened for them it's going to happen for me.' I think throughout the process I have always been aware of that for some people it doesn't happen. So, it's good to see those stories where it works out."* While Lisa and Allison describe hope as developing through stories of success, these stories are different from the miracle stories shared without regard for the lived experience of fertility treatment. As participants remarked, hope is grounded within watching someone who has struggled for months or years become

pregnant and celebrating with them when they finally have a baby. As Ellie describes, there is a difference between celebrating the success of your close friends, and celebrating the success of disembodied strangers:

When people on the Internet have success and you're like, I don't want to be on Facebook with that right now because I just got news that my second transfer failed, I can just ignore the people on the Internet. Where, with my good friend it's been super helpful to go through it together. . .but now she's pregnant, I still love her and she's my friend, but it's going to be hard to see her and I can't just ignore her like I can with Internet people.

In other words, the type of hope that is fostered through comparison is useful when women can identify with the individual. Comparison is a constantly cited avenue through which hope is crafted, as Kelly described, she's *"just constantly comparing, seeing if there's hope. Everyone is different, but we're still doing a lot of comparisons because we just want to know someone else out there who is worse off than us. They'll succeed to make us feel like it's possible."* In many of these instances, women came to find hope in comparison with others, yet it was always through the women's own efforts of seeking out hopeful stories. Women never cited an unprompted, miraculous story shared by a relative, co-worker, or friend as helping them find hope.

Hope is organizationally rooted in clinic discourse, where doctors rely on the confidence of medicine to convey hope. As has been discussed throughout this project, medicalization can wreak negative consequences on a women's psyche. However, medicalization is also a source of hope that allows doctors to feel confident in the success of treatment. Heather, for example, started treatment in her early 20's, and remembers her doctor's confidence that she would become pregnant soon: *"I was 23 when I started trying and seeing my doctor. He was like, 'It should not be any issue.' I think we had some tests, it wasn't the best, but it's also not the bottom or we're just kind of in the middle. Nothing was too concerning for him, our RE, I just remember he was*

saying that, 'Oh, you definitely will have kids.' I was like, great!" And yet, participants who did not achieve instant success often felt let down by their doctor's hope. As Beth shares, her doctor was hope-building, which left her unprepared for a loss:

The doctor, love her to death, but she was kind of like, you'll have all your babies in our freezer. So, she was hope-building, but almost I think too confident, because it left us with very little protection emotionally to think that it might not work. So, I think, when we found out nothing—and even when the embryologist called and day three it was like they look wonderful, like everything looks amazing—so, we were really unprepared for the fact that there would be nothing. So, we were kind of like, why didn't they transfer something on day three, like maybe the lab screwed up. Like we had all the emotions going on because I think it just hit us, this might not be as easy as we think, like this might not be as fast track through science and you'll have your baby. . . I think when we got pregnant the second time, I had never seen a positive pregnancy test, the beta numbers looked amazing, the doctor called and was like "Congrats! I'm so excited for your baby in May and we'll meet your baby." And just like, when I had bleeding that fall and then they found the heartbeat they were like, "Ok, don't worry, like bleeding happens, but you have the heartbeat, you're good." So, they were like, "After you see the heartbeat the chances of miscarriage are so low, like don't worry about it." So, when we went to Toronto to meet up with our doctor who made the baby and found out there was no heartbeat that was definitely like, the entire process has never been as bad as that, I think because of all the years we'd been trying and the fact that we were pregnant and it was exciting to be pregnant, and I felt pregnant and I was exhausted and nauseated and all the things that make you think it's going to work, and the fact that it was really prolonged miscarriage.

Beth's medical team continued to emphasize hope through confidence, even when she was experiencing loss. Relying wholly on science, left Beth even more traumatized by her miscarriage experience. For women like Heather and Beth, who have received confidence from their doctors, hope is initially easy to construct. However, as they continue to experience failure, hope becomes increasingly difficult to maintain.

Perhaps because doctors are apt to construct hope, participants' whose doctors did not enact hope, but rather were realistic and honest about the success of treatment, felt more empowered. Sarah, for example, felt that her doctor did not try and appear overly confident:

Our doctor, she like immediately squashed most of my hopes, and I actually really appreciated that. Like she was very much no nonsense, very straightforward, very well informed, like stuff that was being talked about on the podcast, she was up to date on all of her—like, I would ask her a question and she would bring something up that was just discussed on the show and I was like “Oh my God, you’re good.”

Mary had a similar experience with her doctor, and while she was initially upset by the lack of hope in their interaction, she eventually appreciated her doctors realism:

I remember in going to the first, the first consolation in January about doing the IVF and thawing the sperm and all this stuff, she kind of walked me through it, like “You have 22 eggs, and a certain amount will survive the thaw and a certain amount will fertilize, and you’ll get this and you’ll get that.” And literally in 30 seconds she killed like 20 babies. And my friend Amy, whose, in her early 70s, she’s very Catholic, she left and she’s like “I don’t like that doctor.” And I didn’t either, I was mad because she kind of threw it all out there and then now, looking back on it, I actually thanked her for that day, I told her, “I was mad, and I thought you were insensitive, but you were explaining reality to me. If I didn’t have that reality, then I would have been even more heartbroken in the end.” And the nurse, and the nurse and support staff, had been amazing. I was really sad to be leaving the fertility clinic and go to a regular OB. So, what I thought I would have wanted different, I actually really appreciate now.

Ultimately, hope is communicatively crafted. Self-mantras of hope, interaction with others who have been successful, and communication with medical professionals all serve to communicatively craft hope. However, interaction can also diminish hope. As participants highlight, miracle stories that came from a place of misunderstanding rarely promoted hope. Rather, these stories diminished resilience as women felt further admonished for their failure to conceive naturally. Moreover, hope is closely tied to the organization of medicalized d/Discourse. Doctors play a significant role in constructing, and diminishing, hope. Through these examples, hope is closely tied to resilience, wherein hope is communicatively crafted to encourage women to keep going, despite setbacks. Setbacks, in this context, are moments of doubt and insecurity, rather than pronounced, negative change. Hope is most readily needed as women navigate the everyday

experience of (in)fertility. Rarely is hope discussed in the context of a hopeless loss, like a miscarriage. Thus, in considering (in)fertility as resilient, hope is an important communicative process, but hope only helps sustain the status quo, rather than the upending process. As is discussed next, resilience and hope are most closely tied to narratives that employ a realistic perspective.

Employing Realism

This study relied on a definition of resilience originally put forth by psychologists, which positions resilience as “sustained functioning . . . in the face of comparably mundane stressors that exist on a day to day basis” (Vanhove et al., 2016, p. 15). Like those definitions of resilience put forth by communication scholars, this definition similarly frames resilience as a process, rather than an outcome. Participants framed their moments of resilience as a process of soldiering on, as Tia describes:

The fact that I just made it a point to soldier on and keep going, I think that alone is helpful and really sets the tone for me continuing with this. Because there are times when I don't want to, where I just maybe want to close the book on it and live my life again, because it's like a merry-go-round, really. But I always think, “Well, maybe this could be it, this could be the one that works.” Plus, I'm in a position through financial support through insurance, and I'm at that age and stage in my life where I have a shot, so why not take that shot? Literally and figuratively, why can't I give myself that chance? Because you know, someday that chance might go away, so why not try it and see what happens?

For Tia, without a definitive ‘no’ from her doctors, she continued to pursue (in)fertility treatment because she had the resources to do so. Where changes in cost, medical advice, or age can end a woman's pursuit of treatment, without major setbacks, women like Tia continue to hope for success.

Realism often means focusing on a bigger picture as a means to find purpose within the (in)fertility experience. Rachel, for example, explains how she remained resilient through sustained functioning:

In terms of preparing to do it again, I feel like I really am not prepared to do it again and don't want to. . . But I also still want to have a baby. So, I do want to also, really badly, but it's just terrifying to think about. So, I think that sort of just putting one foot in front of the other and doing the things that I need to do, like going to the appointment and just doing it despite. Just sort of going through it without. Just not giving up, basically, which I think is how I get through challenges anyway, a little bit.

Rachel focuses on moving forward, even when she did not want to, in large part because of her bigger goal. Through focusing on the larger picture, Rachel is able to be resilient.

Sustained functioning was mostly frequently expressed as participants sought to remain realistic about their chances of success. As Penny described, realism can be a form of resilience in so much as it helps her to keep going:

I'm looking at realistically, what are the numbers and trying to look at it from a more detached perspective. Which sometimes I guess can be kind of unhealthy, but I don't think I went there with it. I think I just wanted to know realistically, kind of what I should be doing. That helped, because there were sometimes where I was like, I don't know if I can do another round of needles, but then they're like up to 8 [IVF cycles], and I'm like, ok, I can do this, one foot in front of the other. And I kept myself busy, you know I have hobbies. I knit, I read, I bake, I paint, I whatever, and I just make sure that I continue to do those things.

As has become evident throughout this study, (in)fertility treatment can become all-consuming. Women become accidental experts in large part because they become obsessed with their treatment. Penny remains realistic by reasserting her agency into the experience. Agency is fostered both by doing things she enjoys and by controlling the number of cycles she completes. At the time of our conversation, Penny was finishing her 9th round of IVF and knew she wanted to end treatment. After doing research on her own, she discovered that most doctors agree that after

nine cycles of IVF, it reaches the point of diminishing return. She reasserts her agency by advocating for the end of treatment to her doctor and her husband. She relies on science as a way to imbue realism into what was beginning to feel like an uncontrollable process.

Remaining realistic is a communicative process that is often developed within social support groups where women gather to exchange ideas, seek new information, and plan for the next steps. Beth describes turning to podcasts to help her establish clear expectations: *“I think listening to those kind of things (podcasts) and consuming all that information helps me with expectations, because I just learn what’s normal and what happens, and what doesn’t happen and that kind of stuff.”* Most women enter (in)fertility with very little information about the treatment, its side-effects, and its success rates, so, as Beth describes, accessing this type of information can be a critical source of resilience. Kelly describes a similar experience where, after a failed cycle, she turned online to find relevant information:

I think it was super helpful because last time, when I had really crappy results, which was for the empty follicles, because I had another round in January when I had two empty follicles and I was getting really pissed off at this empty follicle stuff. And there’s not that much literature or information about it on the Internet. So, I found it actually very therapeutic and helpful to like, fire off in the group and people would respond with their own stories because it’s like instant gratification and allowed me to rant in a safe space where people understood and also dealt with the same things.

Kelly’s narrative highlights that realism is not always geared towards keeping negative results in mind, rather realism can also be geared towards hope. Kelly describes feeling angry after a failed cycle, but by turning to the group and hearing others’ successes, she began to feel more hopeful.

Realism is closely tied to setting expectations. While many women describe entering their first round of (in)fertility treatment with high hopes and optimism, participants reflect that as they

undergo multiple rounds of IVF, they start to set expectations for success. As Sarah describes, she built her expectations after seeking information from support groups and podcasts:

When we actually started the process of IVF, I think I was trying to be pragmatic, like okay statistically speaking, you know, listening to the podcast and their stories, and how many times they did IVF, and like that really prompted my husband and I to have the conversation like, we're doing this once and that's it. And that was, I wouldn't say it wasn't hopeful, I think we made that decision both because we finally had a place where we could put a limit.

Sarah allowed this information to guide her decision-making during IVF; she entered the process with a mindset on how many cycles she could afford and allowed this reality to limit her. Where IVF can quickly become addictive, Sarah controlled the addiction. On the other hand, Carol described using her expectations to tamper her hope:

But in terms of does it help me manage my stress through it, I think what's helped me more than anything else manage having to go through this process for so long has been more of a setting of expectations. . . I think mostly just having gone through it for so long and not have anything really work has made me not really expect anything to work. Which sounds like a bad thing, but it actually makes me less emotional going through it. I'm just going through the motions, I'm doing the things. . . Like, the last time when my embryo transfer didn't work, when I got the call with the results my reaction was to shrug my shoulders and be like, huh figured, and that was pretty much my reaction, like I didn't get upset, it was fine. And I think it was more just because my hopes have been tampered quite a bit, it makes it less of a roller coaster for me.

As Carol describes, while her expectations may diminish her hopes, it also helps her stay in control of her emotions. For Carol, her lack of hope is a resilient act; it helps her to sustain the process by reducing her emotional reaction.

Resilience can take many forms, and women within this study exhibited varying degrees of resilience. However, most women sought to sustain treatment, despite setbacks. For some women, realism meant moving forward despite setbacks, for others realism was communicated through self-advocacy and by recognizing limits. Still for other women, like Carol, who have

experienced severe losses, realism can serve to hinder hope while promoting sustained functioning. Employing realism relies on a communicative process, as expectations are developed through participation in online support groups, conversations with doctors, and building plans with partners. Oftentimes, realism is a mundane belief; it does not emphasize optimism or hope, but it does provide an avenue for resilience.

(Re)framing Meaning

Within narratives of (in)fertility, resilience is often enacted as women (re)frame their experiences. As discussed in chapter four, (re)framing narratives are a frequent way in which women construct hope during moments of loss and thus a critical aspect of resilience. (Re)framing does more than provide hope though, it also serves as a communicative sensemaking process. Throughout this study it became evident that women were working to make sense of their changing identities and traumatic losses. Weick's (1995) theory of sensemaking was developed as an alternative approach for understanding the process of organizing by seeking to understand how individuals and organizations give meaning to events. Weick (1995) identifies seven properties of sensemaking, including sensemaking as enacted, ongoing, retrospective, plausible, social, focused on extracted cues, and concerned with identity. In the context of (in)fertility, participants engage in sensemaking as a communicative process in order to remain resilient.

Sensemaking is socially processed through the online support groups, where participants have the opportunity to help others make sense of their diagnosis and treatment options. As Faith explains, she enjoys participating in the online support group because she receives personal satisfaction from helping others, *“Genuinely I love to help people, so whenever someone—most of the things people ask about, ‘well what was your experience with this?’ If I feel like I have*

something that I can contribute, then I will answer those. I respond to other's posts more than I post my own." Similarly, Julie described feeling satisfied when she was able to help others:

Just hearing other people's stories or like, "What did you do with this? How did the ERA feel?" I've answered a lot of questions about things like that. And it's cool to actually have something to give back. This may not be what you experience, but I at least have this to offer. I feel better when I'm able just to hopefully give something back to somebody else.

As previously discussed, online support groups are a critical means through which patients come to know the ins and outs of (in)fertility. However, as participants are able to use their accrued knowledge to help others, the narratives also suggest that participants engage in sensemaking by finding additional meaning in their treatment experiences.

Likewise, participants engage in sensemaking as a retrospective process as they seek to find greater meaning in (in)fertility. As should be evident, no one desires an (in)fertility diagnosis, yet participants take active means to communicate their physical and emotional growth through treatment. For example, participants develop empathy that helps them communicate with others. Other women describe being able to handle shots much more easily. As Carol describes, (in)fertility treatment has helped her better understand herself and her marriage:

One of the interesting things that brought us closer together I think, was the first time that we went to our very first fertility clinic appointment, which we thought was just going to be like a conversation with the doctor, but she was like, would you like to check your follicles right now?—which I have since learned that if you're going to the clinic you're getting probed, that's just the rule. But anyways, I didn't know that at the time. So, I was like, sure that would be great to know. I didn't know my husband would be in the room. And so that was the very first time that he had ever sat next to me and you know, I've had a million pap tests and whatever, and it's never been weird when it's just me and the doctor, but when you have your husband sitting there too, that felt very intimate in a way that I was slightly uncomfortable with the first time. And now it's fine and I'm used to having him see me like that, and I feel like it will make it easier for us to go through that together if we are ever able to become pregnant because I know there's going to be a lot more of that during pregnancy too, so I'm glad we have that foundation.

Other women also communicated that (in)fertility allowed them to find greater meaning in their marriages. As Ellie described, (in)fertility highlighted the strength of her relationship with her husband, *“Going through the loss and all of that, it made me realize that we can get through that kind of stuff, so it was like encouraging and to know that he was there and supportive and didn’t totally shut down.”* Similarly, Heather disclosed that her sex life with her husband has improved since IVF, *“I think after IVF, I don’t know if I’m allowed to say this, but I do think our sex life has been a lot better after IVF. Before when we were doing IUI’s intercourse is very much structured. . . After IVF, it’s been a lot more spontaneous, it’s been helpful for us for sure.”* Participants use this retrospective sensemaking to find meaning in spite of loss.

Participants also find meaning through (re)framing their conceptualization of family. While many women describe entering fertility treatment and believing a family *had* to include a baby, participants begin to describe their family unit as full regardless of a baby. Consider, for example, Rachel’s statement: *“Also, just trying to remember that we already have a family. That’s been really helpful and just continuing to do things like go out of town or see friends and things like that, but I have been thinking a lot, just reminding myself that we’re not starting a family. We already have one. So, having a baby is just sort of adding to that.”* While (in)fertility can often be considered a deficit, Rachel (re)frames her family unit as already complete. Abbey expressed a similar feeling, *“Before going through this I was part of that group that would call a family a couple with kids, or parents with kids. Not that I would discount a couple as a family, but it was really settled into if you have offspring. And there were a lot of times when we were like we might not ever have kids, we are still a family, like our cat is our kid.”* Rachel and Abbey engage in a sensemaking process to (re)define the meaning they attribute to family, removing some of the undue pressure that they may experience when IVF fails.

Finally, the last way in which sensemaking was enacted to (re)frame meaning was through celebrating small, mundane victories. As Julie describes, she began celebrating even minor milestones during the IVF process:

I'm a pretty optimistic person by nature, so my go to is to try and find good things to be able to focus on. Like for instance with doing our transfers—I cannot think of what word it is, the shots that you do two weeks before and oh, progesterone shots, so they're not fun. You know what I mean? They're not a good time. I would continually remind myself we're going to have an extra thing to celebrate someday and that we're going to have one last shot one night. That's a celebration moment. Whereas other couples don't get to have that celebration moment. Like we get an extra thing.

While celebrating minor victories was not a common practice. Many participants did attempt to find meaning in even the smallest event. As Sarah describes, when the box of IVF meds arrived on her doorstep, she immediately took time to take photographs, call her family members, and celebrate the excitement of possibly having a baby:

It was kind of exciting, I remember when we got our box of meds I took a picture of it and sent it to my aunt and uncle saying, “look what you guys helped us get, it’s Christmas!” I just remember sitting on the floor of my kitchen unpacking the box and being like, “Oh, this is going to be the trigger shot!” So, I was pretty excited and also like, the drive up north, like yes, those definitely got old, but at first my husband and I kind of made them special, like we got to be in the car together, he didn’t have to be at work, he was able to take medical time, like sick leave, for each of my appointments, and his bosses were actually super supportive.

As Sarah goes on to describe, she took concerted effort to remember the positive elements of the IVF experience; for example, she was able to spend more time with her husband. Participants are constantly seeking ways to make sense of the immense sense of loss and failure they have experienced during IVF, (re)framing IVF as meaningful despite the loss is useful for helping participants to keep moving forward.

Seeking Validation

Finally, the last way in which resilience is communicatively constructed within the (in)fertility experience is through validation. By and far, participants reflect that validation is the most important form of communication from their partners, social networks, and family. For example, Julie describes asking her husband to validate her experience, even if he cannot understand it:

We started this thing, I guess we had been trying for a while, and I just started crying and I was like, "I don't know why, but I just, I just need you to validate me. I just need you to, to just tell me I'm going to be okay." And so now he says that to me just in random moments. Like, "I don't know why I'm validating you. I think you're important. I love you." He just does sweet little reminders of that even when I'm not upset. But it's the funniest line to me. "I don't know why I'm validating you but I am." He's very thoughtful about everything.

Similarly, Rachel reflects that validation was the key type of support she desired from her husband, *"I just want validation and I want him to just sort of, kind of, be in it with me. And I think he always just wants to make it better and fix how I'm feeling and that's not always possible. I also need to communicate more, but I think that I've just wanted him to be my cheerleader a little bit more."* As is discussed further in the next chapter, husbands provide the most consistent form of support, and participants consistently remark that validation is the most desired form of support.

Participants also seek validation from their friends. As previously discussed, friends who are not familiar with IVF frequently jump to miracle stories as a way to imbue hope and resilience, however, participants note that validation is by far more helpful in allowing them to remain resilient. Beth describes searching for people online and offline who could validate her emotions:

All I needed was someone to hear me and tell me my emotions were ok. Because the minute I got validated I could find a path to move forward. . . As an extrovert, like to process my emotions in the context of being with friends or someone who cares. So, whether it's my sister, or a good friend, or someone online who I found

through a forum who had a similar issue and we would message back and forth about it, just something so I could feel heard.

As Beth describes, validation allowed her to keep moving forward. Participants remark that validation does not mean finding solutions to problems, but rather allowing time to wallow in sadness. Julie describes her friends as particularly helpful in this regard:

And then my friends are really good at allowing you to kind of sit in what you need to. Like not leave you out too quickly if they need to pull you up, they'll pull you up. But they're not the type that are going to say like, "Well everything happens for a reason." They are more so the type that are going to say, "Wow, that sucks. You want a bottle of wine or do you want ice cream, or do you want me to just sit with you or do you want me to not be in your house?" Hopefully they'd say that I do the same thing for them. I don't know. They're just, they're really good people. I think is what it is.

Validation is a critical means through which resilience is crafted. When women are able to receive recognition that their losses are traumatic, that their pain is justified, and that their experiences are difficult, they are able to remain resilient. Validation may not be the easiest form of support for people to give—especially people who do not have experience with (in)fertility—but it is what participants desire the most.

Sometimes validation also comes through as venting. Venting can be an incredibly useful communicative experience for women struggling to make sense of their losses. As Abbey explains, venting to her husband allowed her a safe space to come to terms with her loss:

My husband was the most valuable, because he was always there. Even if I just needed to spout off and say some really awful shit, he would listen without judging me about it. He's not great about the advice part, but he would at least listen if I needed hugs, he was there to give me a hug through it. And if I needed to go out and be spontaneous, we would go see a movie and get ice cream. He was there to make sure I didn't do that alone.

Julie also reflects that venting was an important component of her resilience,

I'm bad about complaining about things, or venting, I guess. Like, "Did you hear this girl complaining about her baby heaping her up all night?" And like, "Does she know how rude that is?" and you know, all that kind of stuff. So sometimes our walks would turn into venting sessions, which is not, not great on my part. But if we did talk about things, it was almost easier to talk about it in a venting way. As opposed to these are my actual feelings that are going on. It's easier for me to be mad at somebody else and complain about them as opposed to I'm feeling really crummy about all of this and I wish that I was the person getting to do that.

While venting may not be a productive form of communication, it does provide participants with the opportunity to express frustration without fear of judgement. Comparison is inevitable in (in)fertility, as women work around the social and medical d/Discourse that validates 'natural conception;' however, venting may provide an outlet through which to recognize the fallibility of this d/Discursive pressure.

Synthesis

Resilience is innately communicative, but for (in)fertility, which is a personal, embodied experience, resilience must be considered as not merely an interactive process, but so too an intrapersonal process. Participants are able to craft resilience interactively, through social sensemaking, online and offline support, and hopeful communication with doctors, but they are likewise able to craft resilience through intrapersonal mantras of hope and empathy with themselves. Participants use sensemaking especially as a tool to find meaning in their experiences, and motivation to keep moving forward.

In the previous two chapters I described the varying ways supportive communication took form, both as harmful, stigmatized rhetoric, and as helpful, validating communication. In the next chapter, I address the final research questions (RQ4), *How do the social networks interactively contribute to resilience?* and (RQ4a) *How does social support evolve over the course of a woman's*

(in)fertility treatment? Through a combination of social networks and interview data, I illustrate the evolutionary nature of social support during a health crisis.

Interlude: Endurance

I pause here, in the midst of interludes designed to reflexively share my own experiences of (in)fertility, in order to reflect on the endurance of research and writing. In particular, I am attuned to the ways in which my research was both shaped by my own experience with (in)fertility and the COVID-19 pandemic. It would be remiss to ignore how heavily shaped this project was by the influence of a global crisis, economic downturn, and heightened moment of shared hysteria.

As a graduate student I have long been enchanted by hearing my professors' recollections of their dissertation experiences. Even as an undergraduate, sitting in my first Communication course with a newly appointed Assistant Professor, I was enthralled by her tales of finishing her dissertation in secluded corners of Manhattan coffee shops. I envisioned the juxtaposition of busy streets with the quiet murmur of a coffee shop. I was young, only 21, and had not yet tried coffee, but I loved the idea of sitting for hours in a public space, just me and my laptop. Two years later and I was sitting in a graduate course, during the final semester of my Masters' program, when my professor began to reminisce about his time as a doctoral student in idyllic southern California. He shared memories of days spent writing, broken up by afternoon walks to the farmers' market, where he would collect fresh produce for that night's dinner. At the time he told us this story to stress the importance of having an outlet, like cooking, but what I took away from it was a romantic notion of dissertating. I romanticized the dissertation process and envisioned myself cozied up against the wood paneled walls of an independent coffee shop, sipping an oat-milk latte, or ending the day with freshly cooked meals for my beau. Instead, the brunt of this dissertation was written

under the immense pressure of the COVID-19 pandemic, sitting at my kitchen table, next to my cat's litterbox, chugging homebrewed coffee and eating boxed macaroni and cheese for dinner.

Two weeks into quarantine, I get a call from my mom. My beloved grandmother, who lives in a memory care, assisted living facility, and who suffers from advanced dementia, has *not* contracted COVID-19, but someone else in the building has gone to the hospital with the virus. "Not to worry," my mom says, even as I feel my heart begin to race in uneasy anxiety, "the director has informed me that the risk for Grammie is minimal, she's safe."

Three weeks into quarantine I get another call from my mom. "So, an aid who was assigned to Grammie a few days ago was diagnosed with COVID, but the director called me and assured me that her exposure is still considered low risk. They reviewed video footage and the aid was wearing gloves and a mask the entire time she was assisting Grammie."

"Ok," I say, apprehension creeping into my voice, "but if she was exposed four days ago, then she would probably have already started experiencing symptoms, right? Right?" I do gymnastics with the math in an attempt to avoid the inevitable conclusion: my grandmother, who raised me, who I often consider my soulmate, who I have not seen in five months, was exposed to coronavirus.

Three weeks and three days into quarantine, on a Friday afternoon, my dad calls me. My mother is in the shower, he tells me, she's too upset to talk with me right now. My grandmother has gone to the hospital, she's not getting much oxygen into her lungs; she has coronavirus. He stays on the phone with me as I try to breathe through the mounting hysteria. He asks me about my dissertation progress, my cat's health. After we hang-up, I call my boyfriend and I cannot speak, I cannot breathe, but I think, *she's alive, I'm optimistic*. But I am grieving the possibilities, and I

am grieving the unknowns. And while I usually post even my most mundane of passing thoughts to social media, I do not share my grandmother's diagnosis. I do not want anyone else to know because I do not want their doubts or undue sadness. I believe, in my heart and soul, she will persevere, but there is a public discourse surrounding coronavirus that is grounded in pessimism and fear. I worry that people will undoubtedly view her diagnosis, at 87 years old, as fatal. But I do not believe it is a death sentence; I cannot believe it is a death sentence.

Four weeks into quarantine, I take my cat to the vet. He has been sick for some time, often leaking excrement onto my notebook as I sit at my kitchen table scribbling notes. The vet runs a fecal analysis, she performs a blood draw, and he comes back with Feline Leukemia Virus. He is immunocompromised, there is no treatment or cure. Our new reality is closely monitored health appointments, expensive medicated food, and praying against the odds of a shortened life span.

Four weeks and two days into quarantine, I email my future employer, where I accepted a position as an Assistant Professor, to inquire after my contract. It has been a month since I accepted the position, but I still do not have an official letter. It is April and I need to start planning where I will live, I need to hire a moving company, and coordinate my summer plans. In naïve optimism I already applied for and placed a down-payment on a two-bedroom apartment in my new city; I filed an intent to vacate with my current apartment. I learn that because of a hiring freeze, they are unsure if they will be able to offer me employment, after all. Despite years of careful and fastidious planning, not only may I not graduate in three years, but I may be forced back into an uncertain job market. I fear that losing out on this job may mean the end of my academic career.

"I'm not stressed," I empathically tell my boyfriend over video chat later that night, "if I was stressed, I think I would know I'm stressed."

He sighs in reply, “All you ever talk about is how much you have to do, the deadlines you’re facing, and you keep taking on more projects.”

“Yeah, but. . .,” I trail off, recognizing an argument lost. Later that evening, as I brush my teeth, I look in the mirror and I begin to see the faint outline of a rash across my cheeks.

About four weeks into the stay-at-home orders, I develop a rash on my face. Actually, I develop a rash and experience a resurgence of psoriasis. Two separate things, my dermatologist clarifies after a brutally expensive appointment. The rash is caused by a new moisturizer I compulsively ordered on Amazon after deciding that my quarantine needed more skincare. In the early hours of the morning, when my stress rendered me sleepless, I place an order for a daily face moisturizer with SPF. Even though I’m not going outside, my kitchen table, where I sit and write my dissertation for eight hours each day, faces a large, bright window. I become increasingly preoccupied by the thought that I might get a sunburn merely from sitting near a window. The rash is a tangentially related outcome of stress.

I first develop psoriasis ten years ago, during my first semester of freshmen year in college. I am incredibly homesick, I cry at all hours and even though my family is only 90 minutes away, I nonetheless try to convince my parents to move to my college town. I Zillow houses in Manchester, New Hampshire and send the listings in an email to my mom. “Just imagine it!” I write. I go so far as to search job openings for her in the immediate area, even though I still, to this day, only have a superficial understanding of her number-crunching insurance job. The psoriasis gets progressively worse, it spreads to my eyelids and across my face, until it is treated by a steroid cream, and then it is gone. Well, that is, until four weeks into my social distancing, where it slowly begins to pockmark my face, neck, chest, and arms. If the rash is a tangential outcome of stress, the psoriasis is the embodiment of stress.

I perhaps should have recognized stress in the sleepless nights, in my apathy towards my hobbies, and my general lack of productivity. For while I do indeed sit at my kitchen table for eight hours each day, my dissertation chapters open and ready for editing, I am more likely to be found paroling Reddit, or watching cooking tutorials on YouTube. During this time of quarantine, when grocery trips are limited to two-week intervals, I find cooking tutorials especially calming. The orderly combination of ingredients is much like a dissertation.

In and of themselves, dissertations are stressful. There is a wealth of evidence to be found within academic scholarship (Devonport, 2006; Russell-Pinson & Harris, 2019) and online forums and blogs (Packman, 2016; Poorman, 2018; Pegg, 2016) that attest to this stress. In truth, there was far more evidence of, and advice for, dissertation stress on public forums than there was within academic research. However, during this pandemic, as I attempt to finish this dissertation in a reasonable time frame, I am confronted with the fact that I am exhibiting resilience. Of course, as many of these interludes will suggest, I enact resilience throughout the course of my (in)fertility experience, however the resilience of writing this dissertation has been a unique form of endurance.

Research into resilience has rarely considered endurance as an aspect of resilience. Definitions of endurance conceptualize it as “the ability to keep doing something difficult, unpleasant, or painful for a long time,” or more simply “the ability to continue doing something for a long time” (Endurance, n.d.). However, more frequently in popular press and academic research, endurance is linked to a physical effort, or tough athletic activity. Endurance is almost exclusively studied as physical by researchers in psychology (Gill et al., 2008; Hasenbring et al., 2009) and sport (Lemer & Locke, 1995; McCormic et al., 2015), however some research does relate endurance to mental toughness (Crust & Clough, 2005; Zeiger & Zeiger, 2018). As I reflect

on my resilience during COVID-19, I am overcome by the urge to name my resilience as endurance. Because endurance is so frequently linked to physical toughness, endurance broadens the scope of resilience to consider resilience as an embodied process.

Certainly, there were moments of embodied resilience woven throughout this dissertation process. There were times when I sat at my kitchen table, watching cooking videos ad nauseum, and making silent bargains with myself: *I'll watch one more and then I will finish that article, or I'll watch one more, wash the dishes, and then when I sit back down and I will write for thirty minutes straight.* But perhaps, more than intrapersonal promises, were the embodied acts of being physically present. By merely sitting at the kitchen table with my laptop open for eight hours each day, allowing time to pass, I exhibited continued efforts to work despite the grief, anxiety, and pain that COVID-19 related-stress was wreaking on me.

Buzzanell (2018) positions the key to the communication theory of resilience as the ability to “foreground productive actions while backgrounding unproductive behavior or negative feelings” (p. 16). However, as I endured the disruptions of COVID-19, I did so by occasionally privileging the unproductive. I sacrificed writing time to carelessly enjoy cooking videos, and when I brought my laptop into the living room for nightly writing time fueled to the background noise of mindless television, I instead found myself shopping the J.Crew sale or trolling second-hand clothing websites for great deals. Often, I looked for clothes for summer or business clothes that I could wear in my future career as an Assistant Professor. In that way my actions, my distractions, were productive, geared towards an imagined future, after the pandemic.

If the trauma that demands resilience is embodied, like the pockmarked signs of stress on my face, then so too should resilience be considered a partially, if not fully, embodied process. Buzzanell (2010/2018) theorized resilience as an adaptive-transformational process, triggered by

disruption. Endurance, if considered the embodied component of resilience, is likewise riddled with adaptive-transformational tensions. In my choice to occasionally forgo work on my dissertation in favor of mindless Internet scrolling I adapted to the stress. COVID-19 demanded that I adapt and transform my expectations on what I had envisioned as the *mise en scène* to my dissertating process. I abandoned notions of romantic writing time and, in lieu of mornings spent at coffee shops, I instead attempted to adapt by sitting at my kitchen table. The sitting itself was embodied, it was a test of my ability to focus, to endure not only the disruptions to my planned dissertating, but so too to endure the overwhelming stress of a global pandemic.

In Chapter 7, endurance is reconsidered and more fully conceptualized as communicative. As was evident in Chapters 4 and 5, participants draw on embodied acts of resilience as a means of ‘self-care.’ That is to say, participants see distractive, unproductive actions as the key motivator for later productivity. However, it was not until I considered my own embodied resilience, in the face of COVID stress, that I began to theorize and conceptualize endurance. My own experiences gave way to a more nuanced understanding of my participants’ experiences.

CHAPTER 6: NETWORKS OF SUPPORT

I believe in as much as people are kind and good, we also have limitations. So I do not like to be too calculative, but I also try to not exhaust my human capital with people who I love and I don't want to lean on them unless I feel like I really need to, which maybe is not the best approach, but in some ways online support groups are kind of freebies. Because you're ranting into the ether. –Kelly

In chapter six, I address the final research questions, (RQ4), *How do the social networks interactively contribute to resilience?* and (RQ4a) *How does social support evolve over the course of a woman's (in)fertility treatment?* Owing to the nature of support, this chapter relies on two different sources of data to understand the multi-level organizing of support. As is illustrated in the previous two chapters, support can be an arbiter for resilience, hope, and optimism, however a lack of support can lead to feelings of isolation, anxiety, and depression. Moreover, support can be given, but not effectively received. Thus, participants frequently rely on two different forms of support, (1) support rendered in-person, at the micro-level, and (2) support developing at the meso-level through public discourses and interactive communication found in online support groups.

Individual Support

Recognizing the prevalence of these two forms of support, I first utilize a combination of participant narratives and timeline data to visualize the patterns of support at the micro, individual level. Through this I illustrate how support waxes and wanes over the course of (in)fertility treatment. I draw connections between the amount of support received and disclosure decisions. Next, I illustrate the prevalence of weak tie support, where social relationships are developed and/or changed during (in)fertility treatment. Then, I briefly review how husbands, as the most frequent source of support, provide critical day-to-day emotional support.

Support and Disclosure

In many cases, the form and source of support were dependent on the triggering event. As is illustrated in Figure 9, certain events fostered more support than others. For example, centralized events in Figure 9, including miscarriages, egg retrievals, and initial appointments, all generated more frequent support, while events that were still traumatizing, but less visible, engendered less support. In Figure 9, certain events, like clinic errors and miscommunication, depression, and chemical pregnancies are all located on the peripheral of the network. In part, these events were segregated to the peripheral because they were unique to the individual experience, however, the few connections these events elicit also suggest that women are seeking out and/or receiving less support during these times.

Kelly, who at the time of our interview had two children and was undergoing IVF for her third child, felt the support had significantly dwindled over the course of her treatment cycle. Kelly compared the support she received during her first IVF attempt with the support she receives now, in the midst of her third cycle, as a mother of two:

We've gotten to now, my third cycle, third IVF cycle, [and] I just, I don't bother because I'm like, what's the point? Like, unless there's something to report, there's, I don't really know if there's a need or if they proactively ask me, I'll let them know. I think before I was like, "Oh, I really want prayer." But for whatever reason I've gotten much more, just utilitarian about it, just a lot more like, let's get down to business, let's get it done. And then if there's something to report, I'll tell you guys later, no one's asking me, it's fine.

In part, Kelly recognizes that support has decreased because she has sought out less support. While during her first round of IVF, Kelly actively sought out support, she now faces the unique challenge of undergoing IVF treatment while simultaneously caring for two young children. For Kelly, IVF has become a routinized part of her day; IVF is no longer something that represents a

significant challenge to her, and she is too busy to seek out support. As she is busy running after a toddler and caring for a baby, she has little time left to consider the emotions attached to IVF.

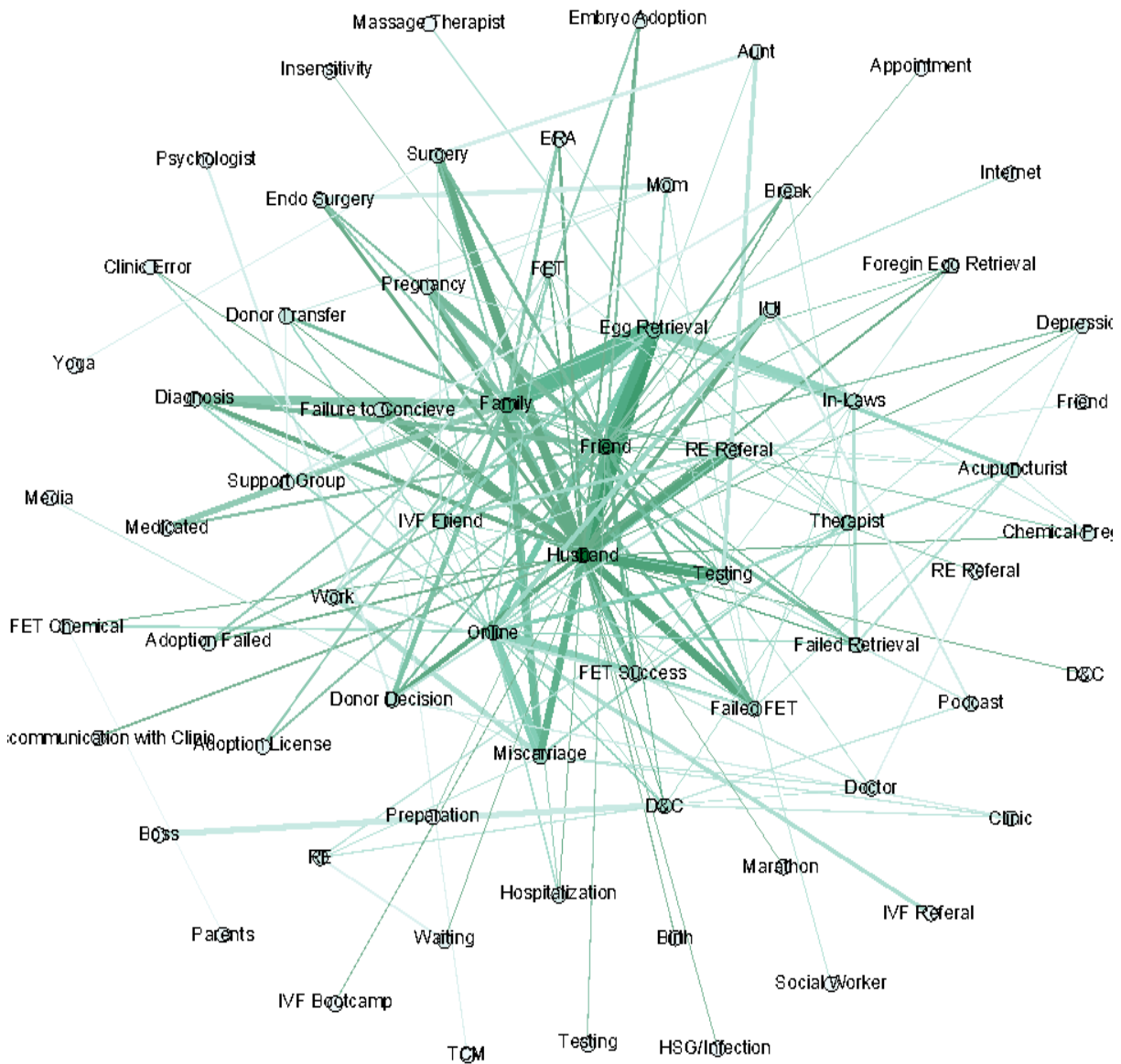


Figure 9: Connections of Support and Events

And yet, Kelly also suggests that support during her third cycle of IVF is lower because her (in)fertility is no longer considered a tragedy:

People understand and no one's going to be feeling the burden of it because they're choosing to respond. And that's also a low lift. Whereas leaning on people that you know, they are very loving, but there are limitations to the human ability to absorb. Right? So, I know that if, and unfortunately in our society there's a whole spectrum of things that are shitty. So, if someone had a stillbirth, obviously the amount of support rendered would be commensurate with the tragedy. Right? But infertility, I think that, especially in my case, it's not commensurate with a whole lot of empathy or like support, no one's going to bring me meals, so I try not to pull that lever unless I really need to.

In other words, as Kelly sees it, support—especially during the third round of IVF—is not rendered because it is no longer perceived to be a significant loss. This is not a wholly unique experience, participants who were undergoing IVF to have a second, or third baby, often remarked that family and friends seemed surprised to learn they were trying to have another baby. Participants receiving treatment for secondary (in)fertility often remarked that there was an unspoken sense that they should stop treatment and just be grateful.

Support waxes and wanes over the course of infertility treatment, in part, because women limit which members of their social circle are aware of their treatment status. From the onset, Carol was public with family and friends about her (in)fertility; however, this publicity made it more difficult for Carol to reserve a sense of privacy:

I'm really bad at keeping news to myself. Actually, I wish that I would have told less people at first. . . I wish that we hadn't told people we had started trying when we started because we never had any news to announce. So, after, when we first started trying, I told my sister, I told my best friend and probably ended up telling most of my close friends, fairly shortly after we started trying. It's just good to have support, but sometimes it feels like a double-edged sword. . . Most of them have known for a while that we've been trying and so they just keep, well they all just assumed eventually it worked and there still hasn't been news we've been able to announce.

Many women express similar feelings to Carol, wherein they feel as though they have let down their friends and family by not having good news to report. This guilt creates additional pressure during an already stressful process. Danielle expressed a similar feeling of guilt:

I told my parents and my two sisters, and they've been supportive through the whole thing. The only difficult thing in getting people involved is having to update them with their expectations. And they're just genuinely concerned and are genuinely asking about things to be supportive, like how are things going, where are you now? But also, that's stressful in itself too, I find. Especially when you get to the point that you're going down an embryo transfer and they want to know what's going on and you kind of want to keep it a secret until you have good news to share because it's harder to tell people bad news than it is to tell people good news.

The burden to share only good news often meant participants limited their disclosure and, in turn, this limited disclosure reduced their amount of accessible support. For this reason, husbands often bore the brunt of support. As is discussed later in this chapter, husbands tend to provide a variety of support and take on a number of different roles throughout (in)fertility treatment, however this can also create added marital tensions.

Not only did disclosing create an undue sense of pressure for participants to deliver happy news, but so too did it constrain how a woman processed her emotions. Mary, who decided to become a single mother by choice, had a strong support system, yet in a similar vein to Carol and Danielle, she felt pressure to immediately share her news:

When I did the thaw process, I kind of regretted talking to everybody about it, because when somebody knows that you're going through it, I didn't realize the emotional rollercoaster that I would go through, through that process. And it's fun to share happy news, but you need to digest the not so happy news along the way. And you don't need 20 people texting 'hey, how did everything go today?' And when you're digesting information, you don't want to tell everybody certain things. So, I think I kind of regretted everybody. And then I was very quiet about it, and then everybody thought something was wrong and they didn't want to ask me anything, and I was ok with that because I didn't want to talk about it.

For Mary, as with other women who chose to disclose their (in)fertility early-on in the process, as treatment progressed and became more normalized, she began to regret her initial disclosure. Women began to be more reserved about their treatment, in an effort to keep prying minds at bay and reserve a sense of personal sanctity in the process.

However, it should also be noted that women who did not disclose early-on, but rather kept their treatment private, felt that they would have benefited from an earlier disclosure. As is evidenced in Figure 9, where edge width reflects the frequency of that connection, some participants sought out support more frequently than others. Julie, for example, has strong connections to her husband, family, and friends. However, Julie regrets not disclosing publicly earlier in the treatment process:

I wish that we had told people earlier. I mean, not like the whole world, not everybody needs to know my business. I don't want to make it sound like that but, people are a whole lot more understanding than I gave them credit for. And you know, some people still said some really hurtful things, but they recognized that afterwards and like tried to kind of switch up their language and stuff.

Julie initially avoided disclosure because she feared people would not deliver the appropriate type of support, however she finds people are more gracious than she anticipated. Similarly, Danielle avoided disclosing to anyone outside of her immediate family but, at the suggestion of her therapist, she eventually disclosed to a few of her close friends:

I was really frustrated, I was always letting them cry to me about various things, but then I wasn't getting any of the same support. So, I finally started—I was in therapy at the time and my therapist was like, “You're really angry with people who are your friends; what's going on with that?” We kind of talked about it and she was like, “What would happen if you did lean on them, and tried it out?” I was like, “Okay.” I did that, and that actually did help.

For Danielle, and many other women, not disclosing can create a sense of resentment when friends and family members make passing remarks that cause unintended grief. As is further

discussed in the next section, weak ties were often a vital source of support for gathering information and advice, venting anger, and finding empathy.

Disclosure also evolved as participants became more accustomed to the treatment process.

As Jillian describes, she instinctively became more public about her (in)fertility as time passed:

I would say for the first, more than a year, it was just a very small group of people who knew anything. And then only in the past, less than a year, six months or so, have I opened up to more people, because it just became such a huge part of my life that just seemed impossible to keep to myself, even though I'm a pretty private person.

(In)fertility is a totalizing event, and disclosure naturally occurs as a woman's attention becomes more fully enveloped in the treatment process. Support then, may not just vary by event, but evolve over time. Faith shares a similar sentiment:

I am talking about it more as the process has lasted so much longer than I thought it would. In the beginning where I wasn't really saying anything, now when it comes up, or I let it come up—you know, in my yoga classes I've mentioned, ok I'm going to be doing the chair yoga for a while because I'm doing an embryo transfer.

As infertility becomes an embedded facet of daily life, women are less hesitant to share the status of their treatment. Moreover, as the next section illustrates, as women more widely share their (in)fertility treatment they are able to access important informational and empathetic support from weak ties.

Importance of Weak Ties

Over the course of (in)fertility treatment, women develop and rely on new sources of support to access critical information, advice, and empathy. Figure 10 illustrates the different clusters of support source and type. Unsurprisingly online support groups, Internet resources, and

medical professionals often offer the most critical advice (highlighted in blue). As Allison describes, hearing the stories of real people in online forums helped provide a portrait of (in)fertility that she was not finding in her doctor's office:

Early on in the process when people would say, "Oh, a lot of people go through it, and you're not alone." I didn't find that helpful. But the longer that I'm experiencing it, I don't know, again knowing that I'm not alone, or just being able to hear other people's stories, experiences, validating some of the emotions along the way. Actually, I think just a blanket statement of like, "Oh, you're not alone," isn't enough for my support. But when you actually see those people virtually, or you hear them it makes it more real.

As has been discussed previously, the online groups serve as a critical source of resilience, helping to provide participants with a sense of hope and realism. These groups also offer new ideas and treatment protocols, as Abbey explains:

That's really what helped me the most was like finding on Facebook the people who have gone through it before and what all the options they could have gone through, so I knew to ask about progesterone levels, to ask about should we do a mock cycle, and when the doctor would then talk, I knew without her having to explain what stuff mean.

Similarly, many participants relied on (in)fertility podcasts to better understand the medical treatments recommended by doctors:

What I also found was that their podcast validated a lot of what my doctor was saying. So, like, my doctor explained to us that she actually calls it PGT testing and that there was this recent study that came out blah, blah, blah. And I was like, oh my God, I know about that because the podcast just talked about it and said you should talk to your RE about it. But then there definitely were some questions, I just felt slightly more empowered, like yeah, I'm not a doctor, but I feel like I know more of what's going on, I have a lay of the land. —Sarah

Online groups and podcasts are examples of weak ties, which only develop as participants become more embedded within the (in)fertility experience. These groups not only provide

treatment explanations, but so too can help participants find a reliable fertility clinic, explore more treatment options, and identify non-medical routes to fertility success.

A smaller cluster (highlighted in purple) involved pre-(in)fertility connections that were revitalized in a new way. For example, friends and work connections that had experience with (in)fertility provided a sense of empathy and normalcy. As Lisa describes, through an unplanned coincidence she happened to find someone at work who could empathize with her experiences:

I have a friend at work, she's actually not a close friend of mine and she was just somebody I worked with that I saw at a coffee shop everyday. And one day, she asked me how I was and I just started crying and I was like, "I just had my fourth miscarriage, and I don't know what I'm going to do." And then she started crying and she's like, "I've been trying to get pregnant for two years and nothings happening and I've done all these IUIs and nothings happening." And then we found out that we're actually seeing the same doctor. And she hadn't really talked about it with anybody. So, it was kind of great because I realized like, me opening up allowed her to open up and then I started doing IVF, and I was like, "You should try it." I was like, "I'm doing it, look, it's easy, you can totally do it."

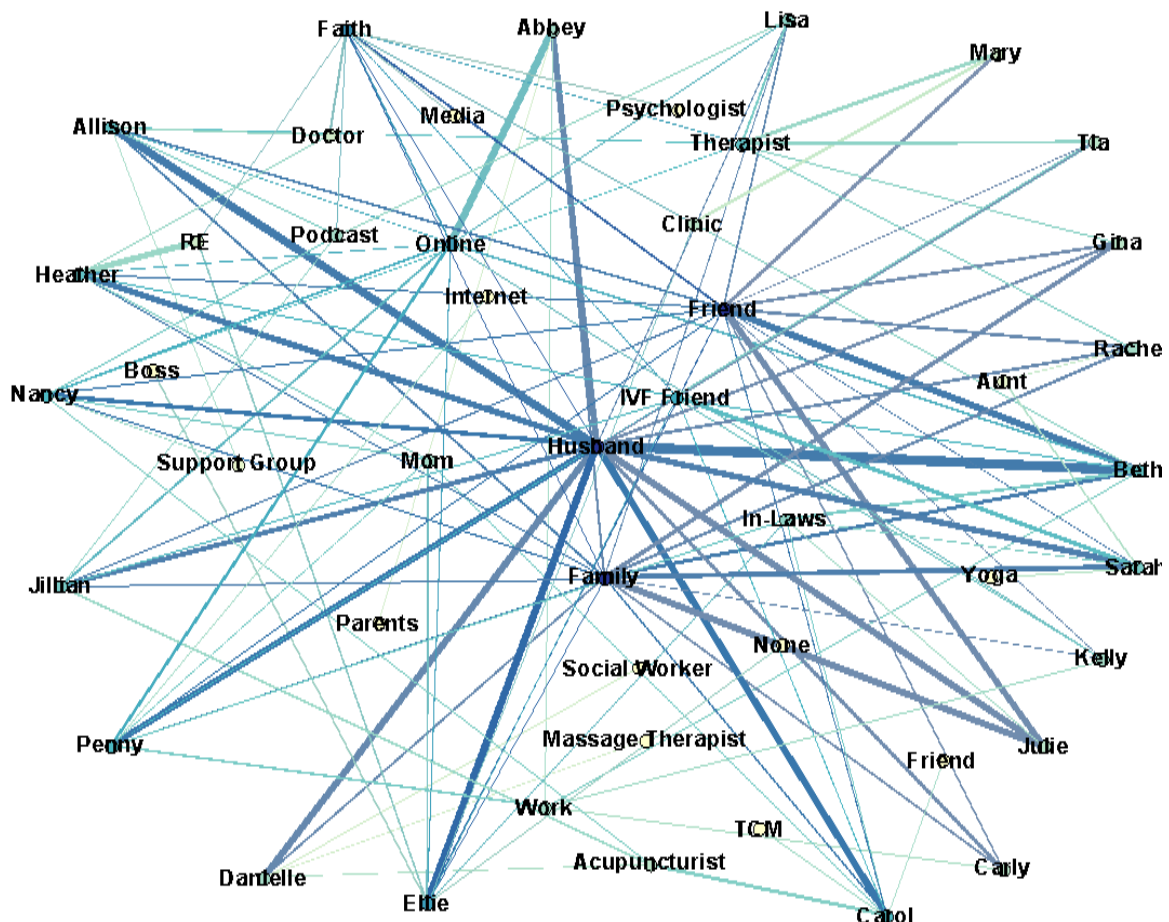


Figure 10: Participant's Most Frequent Sources of Support

Many participants bemoaned that lack of in-person support groups, however work colleagues who could relate to IVF often were a positive source of support. Finding (in)fertility support in work relationships proved a common experience among participants, as Rachel explains:

So, I have not shared with my employer that we're doing fertility treatments and I ended up sharing with a colleague when she—I don't know exactly how it came up, but—Oh, yeah. She was talking about her twins and I was like, "Oh, you have twins," and then she was like, "Yeah," and then she told me about IVF. Then I was like, "Well, I can't just not say that we're doing IVF as she's telling about it." So I told her about it and she's been really nice and supportive, but my employer does not know that we're doing this and at this point, I could probably tell them.

When part of the IVF community, work colleagues take on a new identity and offer critical information and support. When participants have someone to disclose to at work, for example, they can feel more secure in seeking out coverage and have easier access to information on insurance policy. Beth, for example, works in the healthcare field and on days when she had treatment, she would often seek out colleagues who could understand the nature of (in)fertility treatment to ask for coverage.

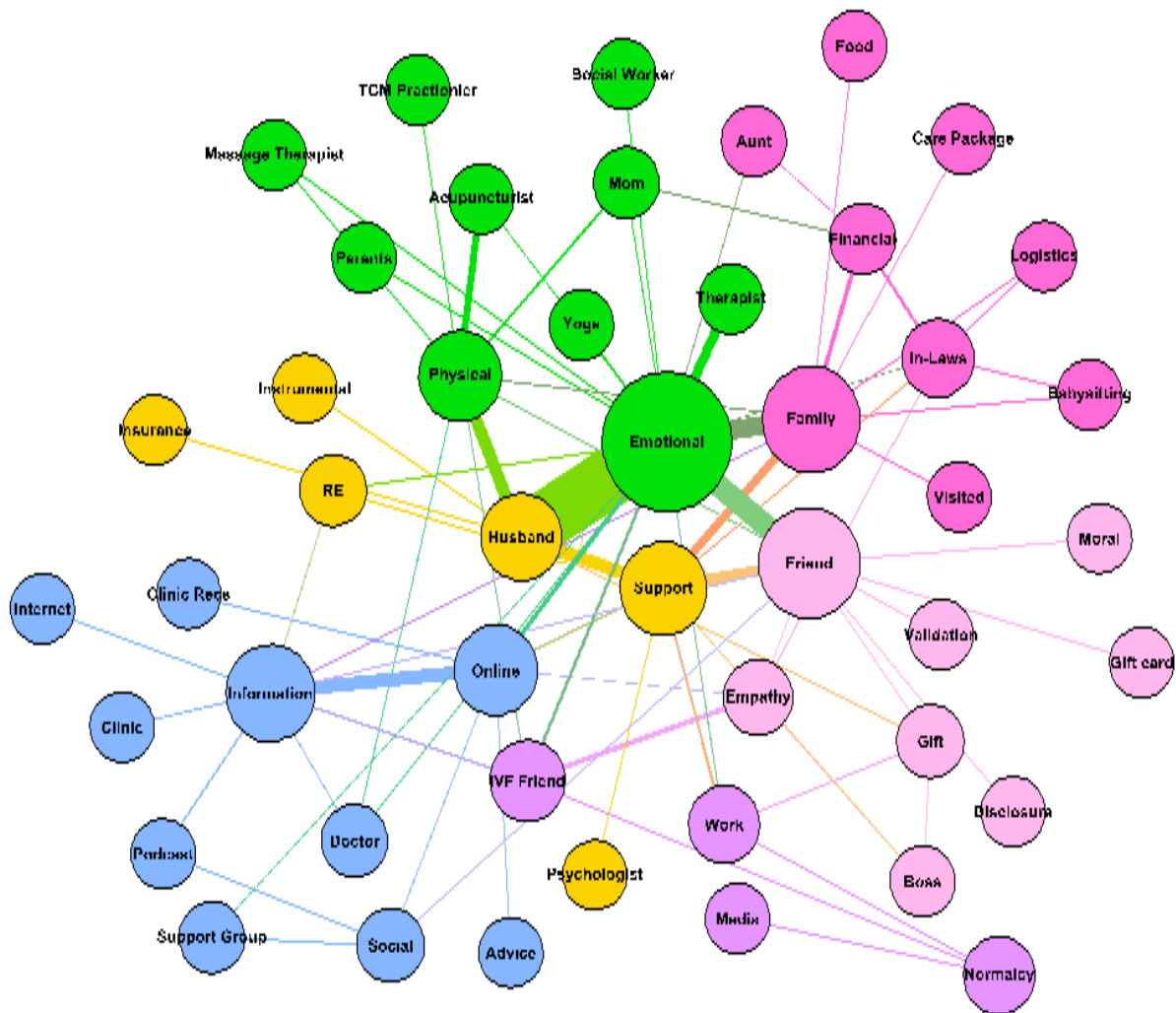


Figure 11: Clusters of Support

Work colleagues who were public about their (in)fertility treatment often provided participants with a sense of normalcy, which helped to reduce the stigma of treatment. At Penny's workplace, for example, nearly everyone had sought out (in)fertility treatment, which encouraged her to explore treatment options for herself:

I work with a group of people that have pretty much all gone through IVF, I think part of it just has to do with where I live, I'm just outside of [the city] so people tend to be career driven, focused sort of people so as a function of that they didn't get around to doing things until they were older. So, it was something that I had heard everybody talk about and wonder about. I was talking with a friend of mine, a colleague that I work with, she kept saying, "You know, you should"—and my husband and I hadn't thought about it at all—"you know, you guys should go, you should just go and get the initial consult and see where you are." Because I was like 38 at the time and she was like, "Because then you know how much time you have left." And I put it off, and I put it off, she had probably been after me for about six months or so to go. The part of calling and setting up the initial appointment was sort of a, it wasn't a big deal, it was the kind of thing everybody does like you schedule a hair appointment. And my husband and I had been trying, but not intensely, he had been working, we were newly married, he had been working out of state, we were, it was sort of a hit or miss thing. So, it was more about saying, well, realistically how much more time do we have to continue to not take this seriously. So, we went and found out we actually didn't have any time. And that part of it was hard. We jumped right in, but it took me a couple months to get over it. I think that was the part, like you were talking about identity, that was the moment that hit me. And so, you know I was fortunate enough because everybody around me had gone through it, it didn't seem in some ways that big of a deal. But in other ways it was like, oh, ok, how does this change things for me?

As Penny describes, (in)fertility was not viewed as an unusual experience and thus it allowed her to find the courage to seek out treatment options. Of course, for Penny, like many other women, it was not simply the act of seeking treatment that was unnerving, but more so accepting that her ability to conceive naturally may be ending. However, Penny had work colleagues who would willingly share their experiences with IVF, which helped her become more comfortable with the medical aspects of treatment. Similarly, Tia has a work colleague who she

lovingly referred to as her “IVF Guru,” and who helped her to understand the ins and outs of the treatment process.

Connections to the biggest node in Figure 11, “Emotional,” represents sources of emotional support. While strong ties, like family members, friends, and spouses provided continued emotional support, there were other, weaker ties, who also offered emotional support. For example, Jillian describes her acupuncturist as a vital source of emotional support because, regardless of how often she changed doctors, her acupuncturist remained consistent, *“I was going to an acupuncturist this whole time. I had started acupuncture back in August 2017 right away. My acupuncturist ended up becoming a really nice support because she’s been the only one whose been consistent throughout this whole process.”* Moreover, traditional mental health specialists, like therapists and psychologists, also provided invaluable emotional support. In particular, participants often sought out mental health experts who were familiar with (in)fertility. As Nancy reports her therapist was focused on helping people undergoing (in)fertility treatment and thus could more acutely understand the embodied devastation of a miscarriage, *“I started seeing a therapist after my fifth miscarriage and then also I was in the process of deciding to do IVF. And I found someone that does a lot of therapy with people that struggle with infertility around miscarriage, IVF, and adoption. So, that was really helpful because she’s very experienced in that realm.”* Similarly, for participants like Rachel, who suffered from depression, seeking out a psychologist who was familiar with (in)fertility provided her with the resources to access safe medication:

I found that there is a specialty in psychiatry called reproductive psychiatry. And these psychiatrists specialize in women's health issues, women's mental health issues including infertility and antenatal depression, postpartum depression and, yeah. I'm working with one of those, and she knows. I don't have to explain anything, she knows about all of these issues and she's been trained on what meds are safe to take in pregnancy. So that's a good thing.

In sum, weaker ties, like online groups, work colleagues, and new medical resources all served as a significant source of support for women during treatment. Of course, husbands, as the most central node in Figure 9, 10, and 11, cannot be ignored. Husbands were consistently cited as the greatest resource for emotional support and validation during (in)fertility. In the next section I further explore how women rely on their husbands for support.

Husbands

In each of the present figures, husbands serve as the most critical source of support during (in)fertility. While husbands most frequently provide emotional support, their support takes a myriad of forms as husbands serve various roles in the treatment process. As was discussed in Chapter 5, husbands often provide validation for women, which in turn helps to construct resilience during moments of loss. Additionally, participants reflect that their husbands are able to lighten the mood by providing humor. As Carol relays, her husband's jokes helped her relax while he administered her daily medication:

At the moment I'm doing progesterone shots and he gives them to me. So, I lie down on the bed on my stomach, so we always joke that he's stabbing me in the back to start my day every day. . . [He] makes a lot of jokes that lighten the mood for me, which makes it easier to go through with someone like him because if it's always bad news all the time and injections and medications that make you emotional, it's nice to have someone who can make you laugh.

Lisa similarly reflects that her husband's humor helped her to stay resilient during treatments:

I always have my husband come with me [to appointments] because he makes me laugh so much. And like, it's probably totally inappropriate because we're like in the waiting room and everyone is miserable and we're giggling. But he can make it more fun, just like we crack jokes together and it makes me feel like I can do it.

As Lisa articulates her husband's willingness to lighten the mood helped her to feel more empowered.

Figure 12 illustrates the unique type of support husbands offer. The 'General' node represents support that is rendered during the day-to-day, such as acts of validation, listening, and affirmation. This daily support is communicative in nature, and many participants remark that this support is often the most valuable. As Penny describes, her husband's constant presence throughout the entire process helped her feel more supported and less alone:

We were surprised by how much closer we got through the process, just in communicating. Like, my husband, we're fortunate enough that he has a fairly flexible work schedule, and he actually came to every single one of my monitoring appointments, and most of the time he would be the only husband there, or partner, or whatever. And that made a difference to me, it's not the same as being poked and prodded, but he also has to rearrange schedules and get appointments, I think that helped him empathize with me a little bit more in terms of understanding the process, and being there, and yeah, blood work and all that stuff every other day is a huge chore.

While (in)fertility can, and often does, cause stress in marital stress and dissatisfaction (Andrews et al., 1991; Onat & Beji, 2012), many participants described the treatment process as improving their communication with their husbands. As Carol describes, treatment forced her and her husband to have awkward conversations that they might not have had otherwise, *"It was initially a little awkward to be telling him about my period and you know signs in my body that maybe I was ovulating, like I didn't want to have to tell him those sort of things. But I've gotten comfortable with it, I feel it's made us closer."*

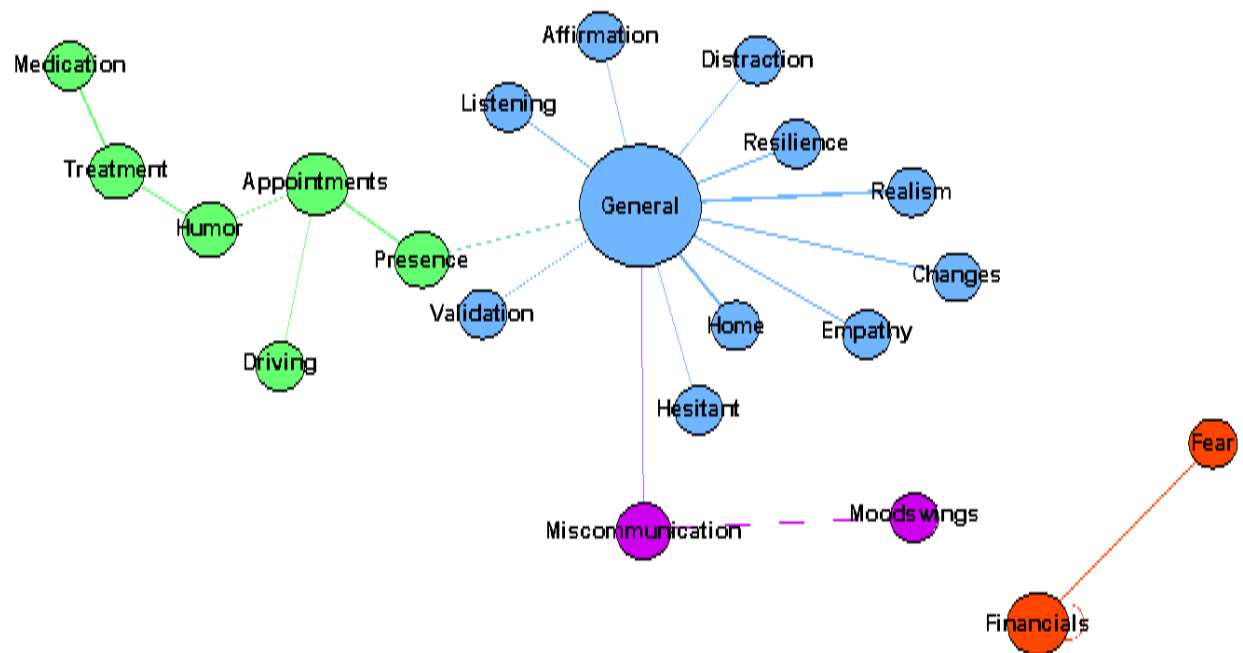


Figure 12: Network of Support Offered by Husbands

As Figure 12 illustrates, the physical presence of husbands, both during the day-to-day treatment and at appointments, is one of the most vital sources of support. In part, women appreciate their husbands' presence because, while he cannot undergo the treatment himself, it helps him to stay involved in the process. Ellie, for example, relies on her husband's presence as a constant source of support:

He's always there, he's never negative or criticizing anything, like oh maybe you did this or maybe we should have done this instead of this. He's just always there, like to hug and just, it's more of just being there, you know? Like, if I want to stay in, and I want him to stay in with me, and not face the world, he's good with that. He's good with like taking off work when he needs to and not being angry about it.

Many participants remark that empathy is built through a husband's willingness to be present at appointments, however participants also see their husbands' willingness to adopt lifestyle changes as empathetic. As lifestyle changes, like a healthy diet, exercise and weight loss,

and herbal medication are thought to improve fertility success, participants always appreciated when their husbands eagerly engaged in change.

Within (in)fertility treatment, husbands are uniquely removed from the reproductive process, thus they adopt certain measures to reassert their agency and value within the process. As is discussed above, husbands take extra care to attend appointments and enact lifestyle changes, but so too do they occasionally help with injections and take care of household chores. In an effort to divvy up the stress of (in)fertility, some participants begin to ascribe roles to their husbands, such as handling the financials or communicating with the clinic. As Abbey describes, her husband handles all of the bills that come from the clinic, which greatly reduces her stress, “*My husband handles all the financials because that was a big source of my anxiety. Since we live paycheck to paycheck to paycheck, it’s like, I can’t see our bank balance otherwise I will have a panic attack. So, I would just ask him, ‘Ae we ok?’ And he went ‘Yeah, we’re ok,’ and I would be like ok.*” While most husbands actively attended appointment, some participants, like Rachel, preferred her husband to take control of household chores:

My husband knows a lot of what I have been through, naturally. It has made me more vocal of what I want and need vs. what I don't want or need. That said, we have started couples counseling to make sure we stay in communication with each other and keep more important conversations in check.

My husband can't relate to my sadness - he's unfailingly optimistic and does not feel time pressure, as a man - but he's very supportive. Our communication has been good and I think we've gotten closer.

Figure 13: On Stronger Marriages

It was just easier for me to not have him there and then it was actually more helpful for him to take care of the animals and household things and let me go to the--Do that while I went to the appointments. So that was not--I never felt like he was peace-ing out. Then the shots, again, I kind of preferred to do them myself. It was just easier for me and less stressful, but he did the progesterone shots when we had to do that for the transfer, and he was actually amazing at it. So that was good because you have to do that in the butt.

While the husband's specific role in (in)fertility will depend largely on the interpersonal context of the marital relationship, these efforts showcase a desire for the husband to regain a semblance of control in an otherwise uncontrollable process.

Of course, (in)fertility does cause stress in relationships and husbands can be unhelpful and unsupportive. As Figure 12 illustrates, poor support develops around miscommunication and financial fears. Especially early on in (in)fertility, husbands often do not approach treatment with as much vigor as their wives, which can cause feelings of resentment. As Carol describes, her husband's initial hesitation to seek out a reproductive specialist was likely due to his fear about affording a family:

When we first started trying. . . I don't think he felt ready actually and I think that disconnect for him took him a while to get on board. So, he never wanted to talk about it at first, like for the first year and a half or so. And I ended up realizing that it was very, very much tied to the fact that he didn't have a very good job at first and he didn't feel like he could support us all financially if it worked.

Other participants remarked that their husbands were not very concerned about fertility and often wanted to continue trying on their own before going to seek medical advice. For example, Penny's husband was hesitant to attend a fertility consultation, so she made the appointment without her husband's knowledge:

I think he was still thinking we would be the lucky ones; it wasn't an issue. So, when I told him that I made the appointment, I framed it kind of like, hey I made this appointment, it's just information seeking, we're just starting, like, the window, we're not committing to anything, but so if we decide to do it I'm fortunate enough

that my health insurance covers 100% for three complete tries, so there's no expense, there's no whatever, it's just information so we'll know what we're dealing with.

In Penny's description, she tries to alleviate all of her husband's potential anxieties before they even entered the clinic; for instance, she considers his hesitance may be money-related, and thus she emphasizes her insurance policy. Eventually, husbands recognize the necessity of (in)fertility treatment, but most participants expressed feeling as though their husbands did not initially recognize the ticking pressure of a biological clock.

Throughout the course of the interviews, participants rarely disclosed any negative impact of (in)fertility on their relationship. However, some participants did concede that there were moments of stress and misunderstanding, especially when emotions were high. As Danielle describes, her relationship was challenged during the process because her emotions were at an all-time high:

You know, being on so many hormones you're super emotional—from side effects but you're also emotional because you're going through this horrible thing that is not natural. So, we have had moments where it's been, where we've fought, we've fought over things that are ridiculous. And there's also been things where, not pointing blame, but there's been times when I've been mad and taken it out on my husband because I'm going through all of this, even though there's nothing he could have done about it.

Other participants, like Faith, recalled similar emotionally fueled fights, that forced her husband to adapt to her mood swings. However, most often, participants were hesitant to disclose any negative influence (in)fertility has wrought on their relationships and focused most acutely on the positive support their husbands provide.

Synthesis

Support evolves as participants become more accustomed to the process of (in)fertility. Throughout the course of treatment, women continue to rely on stalwart sources of support, like their husbands and close family members to provide consistent emotional guidance. However, it is the weak ties support, found in online communities, work relationships, and casual friendships, which often fulfills a woman's desire to find in-person empathetic support. These weak tie relationships bridge the gap between the isolating experiences of (in)infertility and help women access new sources for information and advice. Support does not simply evolve overtime, but it is uniquely predicated on disclosure. Because (in)fertility is largely invisible, until women take the steps to share and seek out support, they are left with very few resources for encouragement.

Community Support

To better understand how support is communicated and effectively exchanged within the online support group, r/Infertility, I next engaged with the data gathered through the text mining and semantic network analyses to identify patterns of supportive communication. As the previous two chapters illustrate, support is frequently rendered ineffective if it comes from a source who does not fully understand the embodied experience of (in)fertility. Thus, relying on an aggregate of data collected from r/Infertility, I illustrate how supportive communication is enacted when it develops from a place of recognized, lived understanding. In this section I pay particular attention

to the ways in which this form of discourse functions as a macro-level representation of public discourses related to (in)fertility.

Online support groups are everything. I don't always participate in them but reading similar stories does make me feel better. I had a canceled cycle because of a cyst. Which I've gotten cysts my whole life, so I thought maybe this is a rare thing. Then I read several posts about the same situation happening to others and I was like, okay this is normal it just happens sometimes.

I think they can be a good outlet to find people who understand what you are going through. On the other hand, it isn't always the best place for medical advice. For example, PGS can be a hot button issue among some people. Some find it necessary to their overall treatment plan; others feel that it is a waste of money. That is a personal choice.

I feel much less alone with an online support group available. It makes me feel like, and know, I'm not the only one going through this, and I can always see info about the options in my treatment. I do often find that people are not quite like-minded. I often see posts about trying to diet during this process, for instance. I try to warn people about my experience - that I lost my period for months due to dieting. Doesn't help with fertility if you don't ovulate!

Figure 14: Support Groups

As was discussed in the Chapter 3, during initial analyses of the networks, I noticed three prominent clusters of discourse. Using these three dominant clusters as a guide, I refined the data in order to clearly decipher themes of each cluster (Figure 15) by performing second and third tier analyses. Through this process, I identified supportive communication as clustered around three phases of (in)fertility. First, the smallest of the three clusters (green in Figure 15) is related to diagnosis information. Second, the second largest cluster (light blue in Figure 15) is developed around outcomes of (in)fertility. And finally, the largest, most prominent cluster (dark blue in Figure 15) is constructed around the daily, lived experiences of (in)fertility. While there is certainty thematic overlap within each cluster, these three phases of (in)fertility—diagnosis, treatment, and

outcome—illustrate how supportive communication is organized within r/Infertility. Thus, within this section, I dive into each of these phases, investigating the nuances in the type of support offered and building an understanding of the organized culture of these online support groups.

Figure 15: Cluster Analysis of r/Infertility

Support During Diagnosis

As we're getting ready to begin IVF it was recommended to us that we have legal documents drawn up for the ownership/usage of embryos in the case of divorce, but more importantly death. Not something anyone wants to think about, but my job gives me a front row seat to the fragility of life. I think if my spouse were to suddenly die I would absolutely still want the option of transferring any embryos we're lucky enough to make together. Has anyone done this? Experience? Advice?

As this comment illustrates, participants look to the group for advice on how to move forward and suggestions on how to navigate the complexities of IVF. Building off of and exemplifying the features of an invitational community (Author, 2021), group members respond by sharing their own experiences as an example of situated, lived knowledge. For example, multiple responses confirm the normative nature of legalizing embryo ownership: *“This is pretty standard consent stuff and I actually question the reputation of any clinic that DID NOT have couples sign documents on their intentions. We chose that any embryos would be left with the surviving spouse to decide about. In the event of any other scenario our embryos go to donation.”* Within these groups, members often recognize the immanent value of lived experiences feeding into a core epistemological assumption of the group that knowledge should be fully grounded within lived experiences, instead of medical assumptions (Author, 2021).

Considering the initial illustration of the clusters (Figure 15) was sparse, I delved deeper into the smallest cluster to understand how support developed during the pre-treatment planning phase (Figure 16). Node size in Figure 8 reflects degree centrality, meaning these words are the most heavily connected words. Words like “male,” “issue,” “treatment,” and “plan” indicate that group members are often working towards identifying an issue and establishing a treatment plan. Comments within the group reflect this purpose; for example, this comment reflects a desire for more information *“Has anyone else experienced this? What was the treatment plan if we're under the assumption that I'm healthy? I'm wondering if it's going to be IUI first and then into IVF if*

that's unsuccessful. Google has been useless, and my appointment is so far away I'm just desperate for someone to give me info." In this instance, situated, embodied knowledge is viewed as more valuable within the community than the medical knowledge that members can access through their doctors.

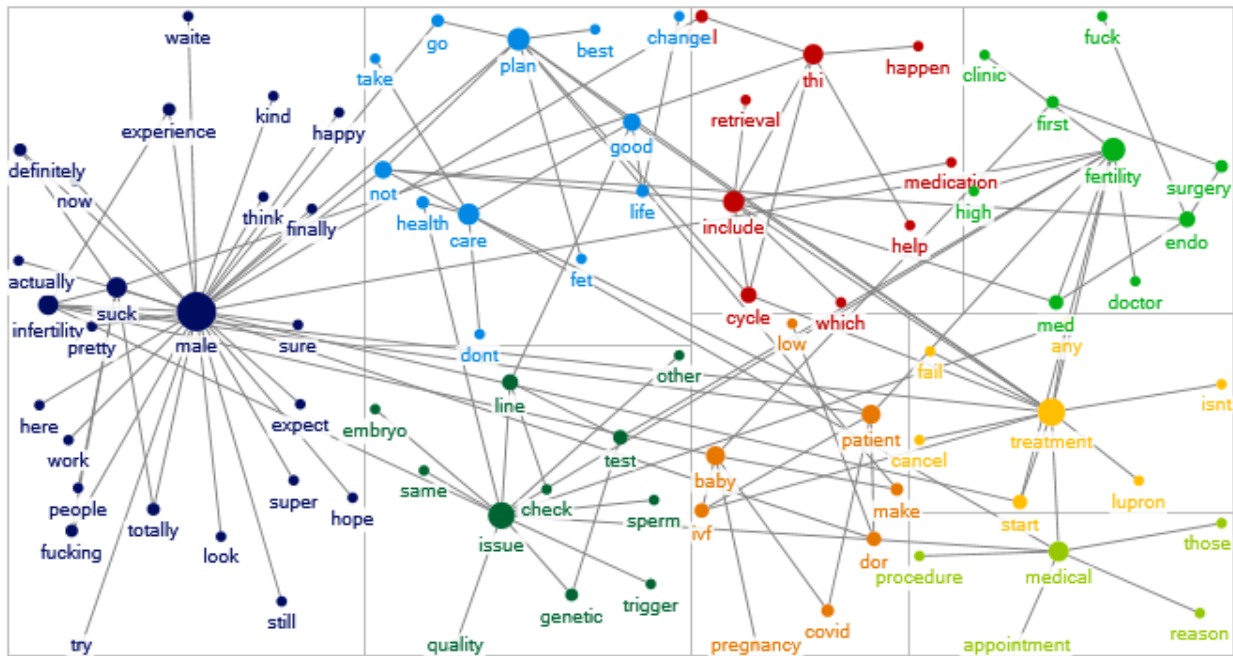


Figure 16: Support Related to Diagnosis

In Figure 16, connections between “embryo,” “genetic,” “issue,” and “sperm,” suggest that the community is designed as a place for members to disclose and receive advice on their medical conditions. The relationship between the “male” “infertility,” and “issue,” nodes suggests that male factor (in)fertility may be a common topic of conversation. Discussions within the group frequently involve references to male factor (in)fertility. For example, when one member created a thread to share her and her husband’s recent diagnostic results, she asked for suggestions on how to proceed. Specifically, she asked if she should pursue IVF, and if, in considering her husband’s

test results, it was likely her husband had male factor (in)fertility. Commenters rallied around her.

As one member wrote:

Yes you do by definition of The WHO parameters of sperm. . . Based on how high dna frag consider IVF with ICSI and Zymot/ picsi or TESE if super high. But lifestyle adjustments and first option should give some success hopefully without a TESE since you guys do have hx of success at least Bonus: And yes fuck everyone who always thinks it's the woman. I'll use this to curse further. Fuck 4 REs ignoring dna frag! Fuck for me having to basically get a fucking PhD in dna frag issues. And also- fuck dna frag and Varicoceles.

The reply is framed as a recommendation and offers the original poster multiple choices to pursue in the pathway to parenthood, from treatment options to lifestyle changes. Recommendations within this group are often geared towards empowerment by recognizing that members hold the final choice in their healthcare. Where doctors might not suggest lifestyle adjustments as the first option, these suggestions help reinstall agency into the process.

Support During Treatment

The largest cluster within Figure 15 was representative of everyday discussions and updates offered by community members. r/Infertility offers a place for members to post frequently on-topic (i.e., related to (in)fertility) and off-topic reflections. r/Infertility offers these on-and-off topic discussion posts twice daily, in the morning and in the evening. Recognizing the prevalence of these types of discussion threads in the dataset, it is not surprising that a majority of the conversation with r/Infertility is attuned to the everyday. Figure 17 represents a second-tier cluster analysis of the largest cluster.

The connections and prominence between nodes “treatment,” “cycle,” “retrieval,” and “transfer” indicate that community members are sharing updates. Within these daily update

threads, commenters do not ask for advice or suggestions, rather they simply offer an update on their condition, as this example illustrates:

Just got an update from the clinic. Out of 9 eggs retrieved, 7 were mature and 6 fertilized. Of those, 4 made it to day 5. Three of them are grade 3BA and one is an early blastocyst (I guess grades 1-2). They biopsied all 4 and put them on ice. The PGT results are expected in May as we are the first in the queue for the NGS sequencer. I am guessing it might be longer if there's a reduced flow of patients due to you-know-what over the coming weeks and months.

More often than not update comments like this one are not intended to generate much reaction or community conversation. However, when replies are generated, they are often congratulatory or supportive in nature. For example, in response to the above post, multiple people replied with general well wishes.

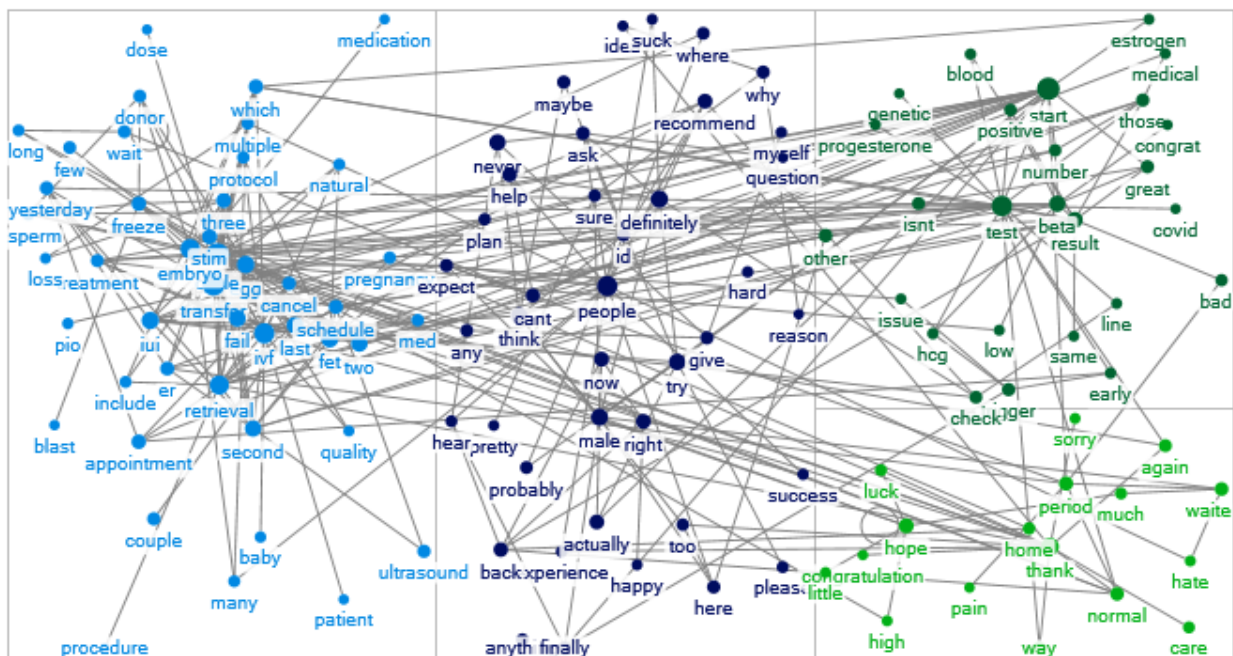


Figure 17: Support Related to Treatment

As the interviews reflect, women undergoing (in)fertility treatment often feel isolated and yearn for anyone to talk to about treatment, however, many women also believe that relying too heavily

on their offline connections may be a burden. These online support groups provide a safe, supportive place to post daily updates. Often times these posts allow members to air their grievances and vent their frustrations without reprimand, as this comment illustrates:

I've set up consultations with several clinics well in advance. One is local and two are about 6 hours away, so I set up telehealth appointments for those two consultations. It is impossible to call and reach someone on the phone at one of the clinics, so we set up the appointment via email. I was clear each time that I was interested in one particular doctor only. I get an automated appointment reminder call after hours yesterday to be told the appointment early next week is with the other doctor in the practice. I'm only interested in that doctor because he used to practice locally and was excellent as my RE. Now that I'm ready to get things started up again, I wanted to see if it was worth the 6 hour drive for continuing with him. I feel like the front office is kind of disorganized after repeated attempts just to get someone on the phone and an appointment set. I don't need the additional stress during a cycle. It's just disappointing, because the other two clinics were backups.

Commenters respond with sympathy, telling the original poster that they are “*so sorry*” for what she is experiencing. Commenters do not offer solutions or advice on how to navigate a disorganized clinic, nor do they insert their own experiences. As often occurs within these support groups, commenters will not offer direct advice, rather they will only provide empathy through recognition and understanding. Empathy serves as an organizational element of the groups and is instilled within the core principles of r/Infertility. For example, one of the six overarching rules of r/Infertility, “be compassionate” is listed, alongside the description that “*Infertility is stressful, and it is easier to step on people's toes than you might think. Please consider the emotional state of others during discussion here. Venting, jealousy and bitterness is to be expected.*” Through daily update threads, r/Infertility creates a space for venting, and instills compassion and empathy into the foundation of the group.

During the interviews, it became apparent that, for many participants, online support groups were the first time that they have utilized social media in this manner. As Sarah explained,

before her diagnosis participating and sharing in an online group was not a normal activity for her, but the groups have helped her find an empathetic community:

If I had questions, I would search the group for the topic coming up. I definitely felt like, anytime I saw anyone who had anything remotely similar to what I was going through, I would comment, which was pretty abnormal for me, I don't comment that much period, even amongst my friends. And like I would put my experiences out there if I felt like it was relevant or helpful, but mostly I just tried to click the love button for everyone that I could. I had felt a kinship in an online community that I had not before.

Jillian felt similarly, although she exclusively participates on Facebook, because she fears pseudonymous groups, like r/Infertility, might not be as empathetic:

I had never been part of a Facebook group before this whole thing, and now I am in, I mean there are a lot of things to be angry at Facebook about, but I am so thankful for these groups, I think it's been by far the best thing that Facebook does. And I think it works a lot better than online groups outside of Facebook because people are anonymous in those groups, so I don't think they behave as nicely in those groups when you're not as anonymous.

Clearly, online groups offer a unique and important form of support that women are unable to access in their offline social circles.

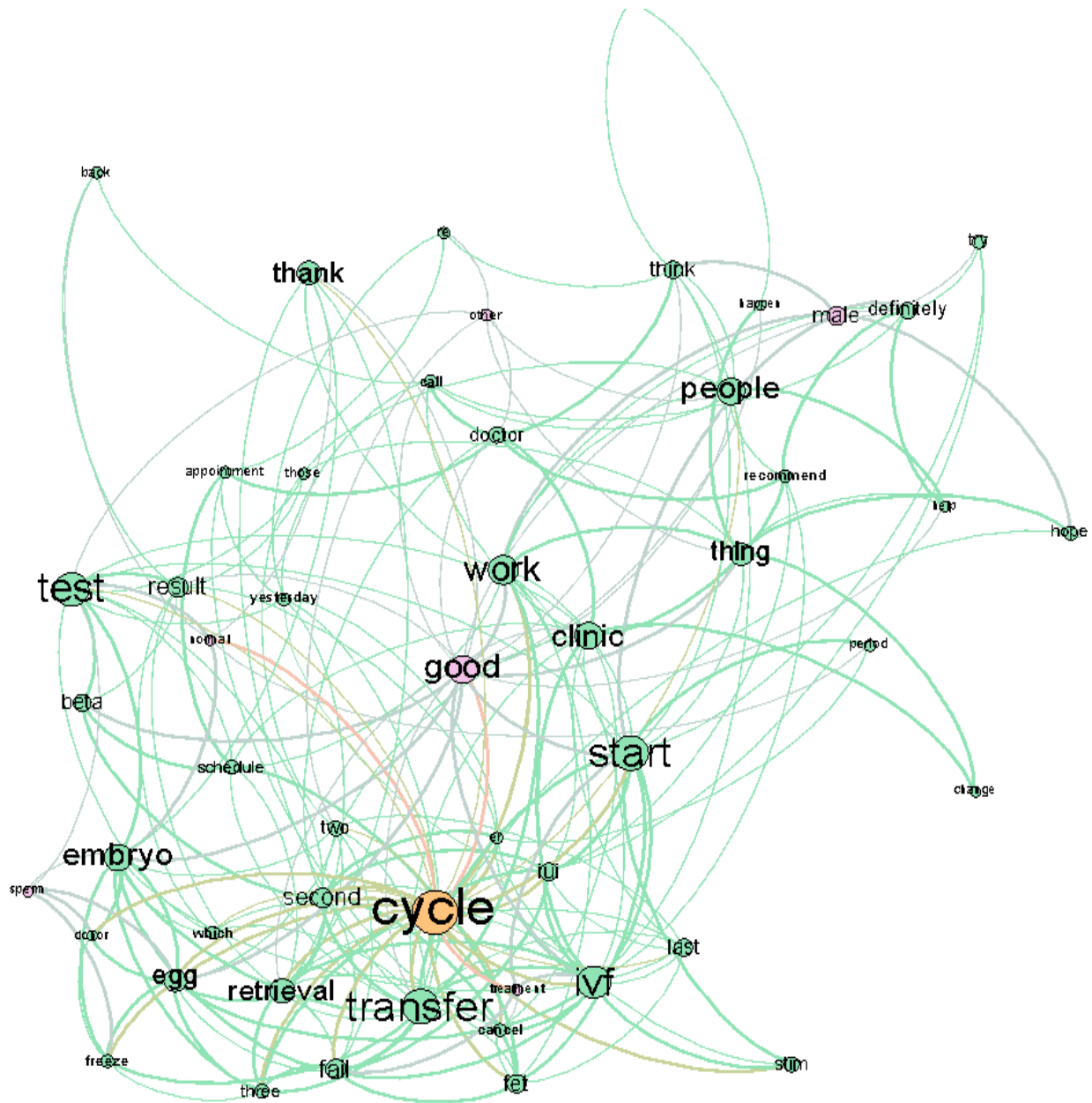


Figure 18: Alternative Visualization of Largest Cluster

Figure 18 visualizes a more refined version of Figure 17, enlarging nodes with the highest degree centrality and color-coding different clusters. As is evident in Figure 18, central conversations surrounding “embryos,” “stim,” and “transfer” coupled with frequent references to “start,” “period,” and “test” would suggest that participants are often discussing daily endurance

within the groups. For example, one member of r/Infertility wrote a quick update, “*Starting injections tonight. It’s been over a year since my last retrieval!*” and multiple members communicated support through a short message of “*Good luck!*” Other members simply use the group to navigate the seemingly endless waiting, as one participant wrote: “*Waiting *patiently* for my period to start so that we can prep for another egg retrieval.*” It appears that even when support is not written, it is nonetheless embedded within the community as members turn towards r/Infertility to feel a sense of connection during the monotony of treatment.

Support During Outcome

Finally, individuals turn to the group to receive support after treatment. Outcomes can be connected to test results (represented as “sperm,” “positive,” and “normal”) or positive news, like a pregnancy announcement (“pregnancy” and “congratulations”). Figure 19 illustrates nodes with the highest degree centrality by size, with color indicating second-tier clusters. The second-tier cluster analysis is more completely visualized in Figure 20. In both Figure 19 and Figure 20 “good” is the most central node. Group members are either wishing one another good luck (“*I’m sorry you are going through. Just know you aren’t alone. Good luck with your journey!*”) or as a means to report the outcome of test results (“*My HSG today shows everything looks good.*”). While the former is a frequent form of supportive communication, the latter is what connects “good” to “sperm,” “treatment,” and “cycle.” Members use the support group to report test results and receive affirmation or advice. For example, after one member posts her husband’s sperm test results, another member comments “*These [results] look pretty good!*” and goes on to suggest a specific subreddit (r/MaleInfertility) that might be better suited to answering her questions. Sharing test results help position group members towards information and allows them to relieve their anxieties.

Many commenters rallied around this story, not just to chastise the clinic, but moreover to denounce the idea that they should be happy and celebrate when receiving a positive pregnancy test. One person shared a similar experience, *“I got a positive (with a low beta!) one of the nurses at the clinic *insisted on congratulating me even after I asked her not to* and told her I was terrified. Sure enough, it ended up being another miscarriage. I’m so very sorry for your losses.”* Both comments also reflect an element of the liminality associated with pregnancy, which was highlighted in Chapter 4. Both comments emphasize their belief that they may never get pregnant and might never be able to accept a pregnancy until they are holding a baby.

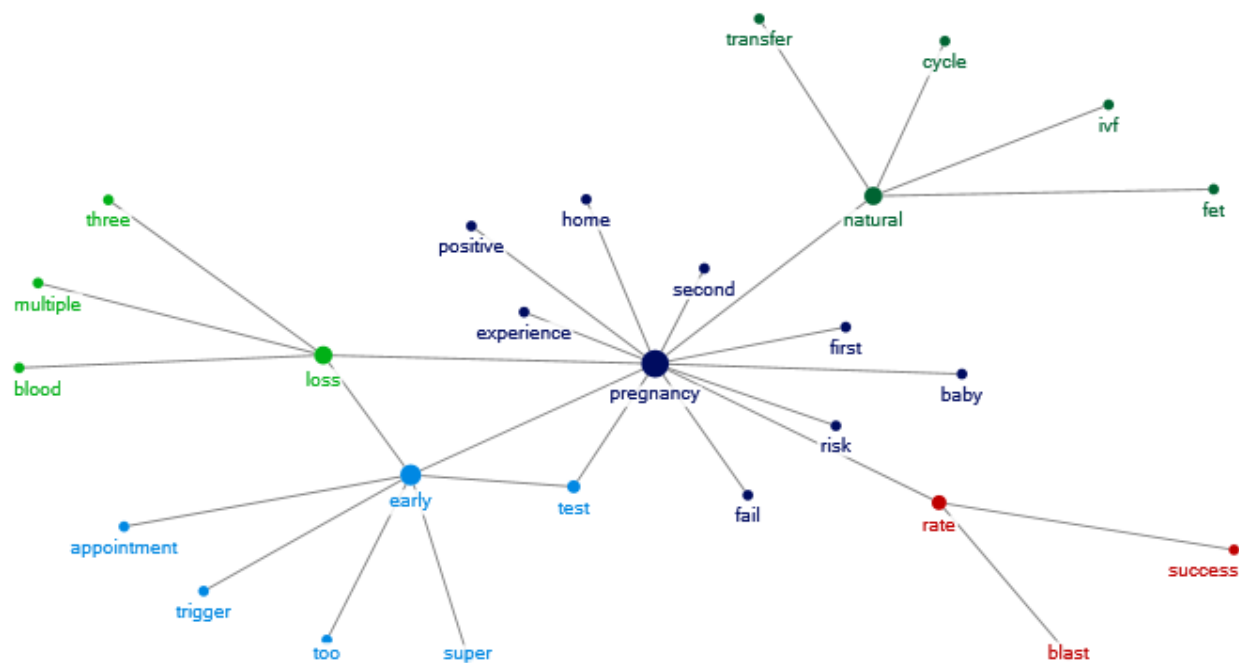


Figure 21: Discussion of “Pregnancy” in r/Infertility

However, while r/Infertility denounces blanket statements of congratulations, supportive congratulatory messages are still shared with extreme specificity. For example, when one member shared the results of an egg retrieval, a commenter encouraged her by saying *“Congratulations on so many eggs!”* Other congratulatory messages are shrouded in cautious optimism. Frequently,

members will share “*Cautious congratulations*,” recognizing the liminality of the experience. As one supportive commenter wrote, “*Holy moly that’s a great first beta! Cautious congratulations.*” These congratulatory messages reflect the recognized ambiguity of (in)fertility. Instead of promoting unimpeded positivity, r/Infertility promotes a culture of engaged nuance and supportive communication is thus structured through these shades of hope.

Synthesis

In analyzing networks of supportive communication on Reddit I engaged with an alternative online culture, one which includes partial anonymity through pseudonymous practices. While the engaged, supportive environment of r/Infertility reflects many of the same communicative elements as those highlighted in the interviews, the holistic approach to analyzing nearly 37,000 comments also highlights cultural elements structured into the community of r/Infertility. Notions of empathy, nuance, and liminality are enacted in the communication of r/Infertility through comments, discussion posts, and daily updates. Recognizing that topics of conversation typically fall within the three phases of (in)fertility, each phase likewise tends to emphasize a distinguished cultural feature. Taken together these phases and cultural elements provide a macro-level overview of the public discourse surrounding r/Infertility. Discourses found on r/Infertility are not anti-medical, they still include references and advice on testing, results, and prescribed drugs, but discourses are structured through support instead of medicalization. As the micro-level analysis of the interviews indicated, many women feel frustrated by the lack of emotional recognition in the clinic, whereas in the online groups, emotions are recognized as fragmented and nuanced and are fully embraced.

Interlude: Vulnerability

A few days after I begin my stim protocol, I post an update on my treatment to my blog. I am determined to provide consistent and regular updates because I used GoFundMe, the online crowdfunding platform, to partially fund my treatment. When I sought out financial support, I felt extremely uncomfortable. Still, to this day, I cringe at my choice to use others' money to fund my personal crisis. In the blog post I question my choice to be publicly vulnerable. I write:

When it comes to this blog, and my life, I am often wondering where the line is between vulnerability and over-sharing. If all this is just over-sharing, well, over-sharing is actually a specialty of mine. Ask my parents about that time during preschool show-and-tell where I pulled my dress up over my head to show off my cancer scar. Or, ask my boyfriend about the amount of personal information I disclosed the first night we met (spoiler alert: too much). For better or for worse, I have always loved to discuss the most intimate aspects of life.

But I realized something last week, after receiving an abundance of loving comments praising my ability to talk about infertility: *am I being too vulnerable? Is there a vulnerability limit and have I reached it? Have I maxed out on the limits of my emotional sharing?*

I cherish each and every message of support I get. I love the compliments of my strength because I love writing and, being able to communicate my emotions this way is sometimes the only way I am able to communicate at all. This is why, for example, my parents did not fully understand my experiences with infertility until I started writing them down—my strength lies in the written word, rather than in a spoken syllable. In so many ways this blog has proven extremely therapeutic for me and I'm happy that it can provide consolation for others along the way.

But here's the thing—part of the reason I think people are so happy (impressed? surprised? I don't really know the correct verbiage to use here) that I'm openly talking about infertility is because so few women (or men) do. As I've talked about, there is a lot of stigma and shame attached to infertility. There is also a lot of ambiguity surrounding treatment (the success rate of an IVF cycle is maybe about 40%... this is a complete and utter conjecture backed up by minimal-to-no actual facts), which may ultimately inhibit people from disclosing their status. People do not want to share that they are trying for a baby when in all reality they might not get pregnant. It makes sense why people don't talk about it—we're dealing with scary stuff and frightening realities.

As I thought through the many reasons people don't disclose, I began doubting my own voice. I wondered if one day, when I unfreeze these eggs of mine and pop them back into my body, I could still fail to have a baby. And if this happened, would I feel differently about being so open about infertility. Would I also regret basing my career around a topic so personal? No one likes failing, especially publicly on the Internet.

Also, I have so much love and so, so much gratitude for the people who financially supported my upcoming treatment. And while I know this is crazy, there is a little bit of guilt attached if I fail to produce enough eggs, or if I am unable to get pregnant when the time comes. I try not to think about those things too much because I do not want to enter fertility treatment with even an ounce of tension, pessimism, or negativity. I want to be all optimism, all gratitude, and all positivity.

In part, I write out my insecurities because the guilt is mounting. I received so much money, I am so grateful, but I nonetheless wonder how much of my medical information I owe to my donors. I wonder, *if I never get pregnant will they think they wasted their money? Should I tell them how many eggs I retrieved?* I willingly engage in public disclosure both on my blog, in my academic work, and in casual conversation, and in doing so I continually navigate the bounds of vulnerability. *How much do I owe to a public that I've invited into my life?*

Autoethnography prompts us to be vulnerable and in doing so we invite readers to be vulnerable with us (Behar, 1996; Ellis, 1999), and yet I question the value of that shared vulnerability. In committing myself to vulnerable research I unanticipatedly became an outlet for others to be vulnerable, yet when they became vulnerable their vulnerability lacked empathy. On Memorial Day weekend, for example, about a month before I begin IVF, I am sitting around a picnic table with the other girlfriends of my boyfriend's friends. I am annoyed and uncomfortable at the weird gender boundaries at play. On the drive over, I tell my boyfriend, "I know what's going to happen, you and all your friends will gather around the grill, and I'll be stuck sitting with those girls who I don't know and who I'm pretty sure don't like me."

He tries to quell my fears, "You can stand with me if you want, it's not a big deal."

“No,” I say, “you’re wrong. If I stand with you, instead of sitting with the other girlfriends, I’ll be looked at as controlling and clingy. They already think I am overbearing; I’m not going to give them ammo.”

And so, I find myself sitting around a picnic table, searching for a conversation topic, when one of the other girlfriends leans over to ask me what I do in graduate school. I tell her I study (in)fertility. I disclose that I am preparing to begin a cycle of IVF in the coming weeks, explaining that my (in)fertility is a direct result of my childhood cancer treatment. I go into explicit detail, connecting my dwindling AMH to the radiation I received as a child. Midway through our conversation she pauses, looking incredibly troubled, she asks, “Should I be worried?”

“Well,” I say, choosing my words carefully, “You’re young, I mean, you’re 24, right? That’s pretty young, even in the (in)fertility world, and my (in)fertility is really because of my cancer treatment. So, I’d be aware, but not overly concerned.”

A similar conversation ensues a few months later when I present my initial dissertation results at an academic conference. During the break, a younger graduate student approaches to thank me for my presentation. “This was really great,” she says, “but I wonder if I should be worried, I’m almost 26.”

“Well, the thing is, you really can’t know what your fertility is without talking to your doctor,” I say, trying to ease the looming annoyance, “and as I mentioned, my (in)fertility is a direct result of my cancer treatment.”

I am patient and empathetic with their concerns. I believe young women should be cognizant of their fertility; however, I also recognize my (in)fertility as uniquely situated. I share not only the connection between my (in)fertility and my cancer treatment, but moreover describe the expensive, painful, and invasive pathway to treatment. And yet, when young women that I

barely know try to empathize with me through drawing connections to their own fertility I am nonetheless frustrated. Their attempts at empathy eclipse my pain. Their vulnerability is understandable, and yet their tactics to communicate vulnerability come across as dismissive of my lived experiences.

Disclosure of (in)fertility demands vulnerability. The ambiguity surrounding the success of (in)fertility combined with the otherwise intimate nature of conception means that individuals may be less inclined to publicly acknowledge their condition. However, what I have learned through disclosing my (in)fertility is that often this vulnerability is accompanied by immense pressure; pressure to succeed, pressure to endure, and pressure to be positive, despite the hardships. Vulnerability implies publicity; it stands to showcase our willingness to publicly state our weaknesses.

CHAPTER 7: IMPLICATIONS

I just think that as women, and men for that matter, we're just left in the dark about this part of our health and especially for women when there's this timeline, just nature. Like you were saying, you talked to women who were in their forties and fifties, there's just a reality there that it would just be helpful to have the information as I plan my life, not that I would even make any other decisions than I made, but just to have all the information.

—*Rachel*

At its core, this dissertation was designed to address a central question of inquiry, one which has not been fully explored by organizational communication researchers: *Can a health crisis, experienced by an individual, function as an organizing event?* What I have illustrated, through narratives of loss, hope, and networks of support, is that (in)fertility is an organized experience. In building these theoretical and methodological contributions, I drew on a variety of qualitative methods to address four research questions.

First, I analyzed a combination of personal and organizational narratives in order to examine how narratives contribute to the organizing of (in)fertility. Engaging narratives on the micro- and meso-levels, I found that (in)fertility is construed through narratives and networks of loss, empowerment, and support. Through these three processes, (in)fertility is constructed to privilege the embodied experience, rather than the medicalization of the clinic.

Second, I looked to understand how identities are communicated as potentially tenuous, liminal, or challenged. Specifically, I found that identities can be lost and changed during the process of (in)fertility as women cope with an ambiguous future; however, so too can identities be considered a source of strength and empowerment. Within online groups, members share narratives that structure identities as both challenged and strengthened; through this collaborative exchange, members begin to recognize the commonalities in their experiences.

Third, I sought to model how resilience is developed during (in)fertility. Resilience can be a powerful construct, which allows women to continue forward, envision a happy future, and validate their emotions and experiences. Resilience is entangled with hope, as women most frequently find resilience through reflexive and intra-personal communication. (In)fertility illustrates the embodied nature of resilience. Resilience ebbs and flows throughout (in)fertility; women are not always able to actualize and draw on resilience, nor do they consistently see themselves as resilient, rather resilience is discursively constructed as a process to sustain forward-thinking and continued action.

Fourth, I traced the evolution of social support, investigating how networks of support contribute to resilience. On the individual level, support evolved as individuals became increasingly comfortable disclosing their (in)fertility status. Support is not always positive; friends and family members can err in the manner through which they deliver support, and some women shy away from disclosing precisely because they fear the awkward exchange and potentially unintentional, yet hurtful, messages. More frequently, women turn to online support groups for support. On the meso-level, online support groups offer a safe space for women to discuss the specificities of (in)fertility, exchange resources, and foster empathetic engagement. While disembodied in nature, online support groups re-center the women's body and emotions as central to the (in)fertility experience.

In the remainder of this chapter, I introduce the theoretical, methodological, and practical contributions, before turning to the limitations and future areas of research.

Theoretical Contributions

This dissertation contributes to communication research in three meaningful ways. First, this dissertation highlights the multilevel organizing of (in)fertility through an antenarrative

approach (Boje, 2001, 2011). Second, this dissertation extends organizational communication theory by theorizing *embodied organizing*. And third, this study builds on the Communicative Theory of Resilience (Buzzanell, 2018) through situating resilience as an intrapersonal, embodied, and hopeful process. In the following sections, I present these contributions.

Multi-level Antenarrative & Emergent Organizing

The narrative and networks analyzed in this study highlight the multi-level organizing of (in)fertility. At the individual, micro-level, friends, family members, and medical resources organize around women suffering through (in)fertility in order to raise her endurance for treatment, help her to cope with the trauma of loss, and foster optimism and hope. At the meso-level, public discourses found on Facebook, Reddit, and within other niche online communities are designed as safe harbors for women undergoing (in)fertility treatment. These communities promote a culture of empathy, nuanced understandings of (in)fertility, and create a space for vulnerability. Woven together through the meso-level, the organizing of (in)fertility as a lived and embodied experience runs as a counter-discourse to the macro-level discourse(s) of medicalization.

This project showcases the micro-and-meso-levels of (in)fertility d/Discourse, complexifying the already existing literature on the social construction of (in)fertility, which addresses the macro-level of d/Discourse (Becker & Nachtigall, 1994; Griel, McQuillan, & Slauson-Blevins, 2011; Jensen, 2015, 2016; Jensen & Blumling, 2018; Teman, 2003), but rarely considers the micro- or meso-levels. The macro-level understanding of (in)fertility is medicalized, evidence of this can be found in medical textbooks, cultural understandings, and ideological interpretations of what (in)fertility signifies and how it should best be treated. Medicalization suggests that a disease is objective, evidence-based, and best treated by experts (Griel & McQuillan, 2011); yet as the narratives and networks highlight, many (in)fertility patients do not

consider (in)fertility as a disease per se, rather (in)fertility is a side-effect of a pre-existing health condition, prior illness, or, in many cases, a facet of nature. Medical definitions, including that of the World Health Organization and International Committee for Monitoring Assisted Reproductive Technologies (WHO-ICMART, 2020) regard (in)fertility as “a disease of the reproductive system defined by the failure to achieve a clinical pregnancy after 12 months or more of regular, unproductive sexual intercourse” and as “the inability of a sexually active, non-contracepting couple to achieve pregnancy in one year.” These definitions position (in)fertility as not merely a disease, but as a condition unique to the hetero-sexual couple, and as one which should be treated by medical intervention. Jensen (2016) suggests that it is through medicalization that, “fertility must be understood in terms of biochemical variability of heterosexual couples; that scientific progress will inevitably lead to the realization of a state of artificial fertility that exceeds what is possible through nature alone; and, that the establishment of fertility requires the guidance of technical experts” (p.72). In short, the over-reliance on a macro-discourse of (in)fertility has produced a public perception as (in)fertility as something to be perfected through science, disregarding not only the unique situatedness at which women arrive at treatment, but so too constructing a portrait of (in)fertility as always treatable.

Throughout the interviews and network analyses, it became obvious how notions of medicalization and cultural perceptions of (in)fertility as stigmatized pervaded the micro- and meso-levels of discourse. Women almost always entered treatment unendingly optimistic, believing that IUI, IVF, or any combination of fertility-enhancing drugs would successfully lead to a live birth. These hopeful expectations were quickly lost, and many participants described the process of becoming increasingly hopeless and exceedingly more vulnerable as treatment wrought its toll on their emotional, physical, and financial well-being. Likewise, participants described the

undue pressure of revealing their (in)fertility treatment to others and the burden of navigating expectations of success. Participants described instances of disclosure in which they were greeted with a hearty ‘congratulations,’ as if they were already pregnant. Many participants connected well-intentioned, but misdirected congratulatory messages as indicative of broader misunderstandings regarding (in)fertility. Participants felt incredible pressure to deliver happy news to friends and family members, while simultaneously enduring the pessimism that develops with continued losses. The challenges of disclosure served only to further stigmatize and silence many women’s (in)fertility experience. Discourses and assumptions of medicalization were inherent throughout individual narratives and evident in the networked data as participants described the false, but broadly accepted, assumption that medical treatment would lead to success.

Alongside the evidence for medicalization however, narratives and networks also organized against medicalization. Women pushed back against the conception of (in)fertility as a disease, support groups advocated for alternative pathways to parenthood beyond the biological, and women found ways to retain agency and control in a process designed to dehumanize the women’s body. Participants constructed an identity of empowerment, utilized control as resilience, and planned for a future without children. The online support communities, to which many women frequently turn, served as an important resource for receiving medical advice not routed in traditional forms of expertise, but rather developed through lived experiences and situated knowledge. Thus, as much as medicalization imbues the micro- and meso-levels of (in)fertility, so too do the micro- and meso-levels work against macro-conceptions of medicalization.

Recognizing how this understanding of multi-level organizing is built through the interplay of partial narratives and fragmented semantic networks, this multi-level organizing is conceptualized through attention to the antenarrative analysis. Traditional narratives are

constructed as linear, with a clearly defined beginning, middle, end, forcing an obsession with coherence (Boje, 2008; Boje & Durrant, 2006). An antenarrative analysis positions stories as fragmented, unconstrued, and boundless (Boje, 2001; Derrida, 2004). Antenarrative repositions the emphasis on the historical conditions and circumstances in which the story develops, evolves, and changes, rather than locating the emphasis solely with the narrative. While antenarrative positions away from the individual narrator, Jorgensen and Boje (2009) suggest an antenarrative inquiry can increase the narrator's consciousness of how she is affected by organizations, societies, and cultures. Antenarrative is embedded within context, it is the interplay between the everyday stories and the master narratives of ideologies and taken-for-granted assumptions (Rosile, Boje, Carlon, Downs & Saylor, 2013). Antenarrative is part method, part practice, but as this study's interactive, poly-vocal inquiry illustrates, antenarrative can be extended to understand theoretically how organizing occurs through fragmented, dynamic, yet interconnected, storytelling.

Where traditional narratives are oriented towards the past via retrospective sensemaking (looking backward; Weick, 1995), Boje (2011) conceptualizes antenarrative as oriented towards the future, through prospective sensemaking (looking forward). The 'ante' in antenarrative refers to a "a bet" and "a before," signifying a bet on the future, before narrative cohesion is fossilized in the past. Retrospective sensemaking situates the story within past events, stabilizing the living, dynamic nature of storytelling. For participants in this project, the majority of whom were still in the midst of treatment, sensemaking is an on-going process, one which is continually shaped by and through their prospective, future-oriented hopes for a successful pregnancy.

Because of their prospective nature, antenarratives open up a space to enact change (Boje, Rosile, & Gardner, 2004; Boje, 2008), create actionable knowledge, and invite a reinterpretation of past events to allow for new, future possibilities (Boje, 2008; Jones, Moore, & Walton, 2016).

Considering the progressive value of antenarratives, they are further well suited to exploring the organizing enactment of (in)fertility. That is, as this project highlights, micro- and meso-level d/Discourses of (in)fertility showcase an enactment against the macro-level d/Discourses of medicalization, which currently persists. Micro- and meso- d/Discourses highlight that (in)fertility treatment is ambiguous, depressing, and, more often than not, unsuccessful despite medical intervention. Contrary to medicalized notions, which position (in)fertility treatment as the dominance of science over nature, experiential-based narratives of (in)fertility frame nature as working in tandem with medicine. As is evident in the interviews, while many doctors may direct a woman to a healthier lifestyle, the doctor will frequently ignore ‘alternative medicine’ as placebo medicine. And yet, despite this medicalized assumption, women frequently turn to Chinese herbal medicine, acupuncture, and other methods of self-care, and position these alternatives to medicine as contributing to their success.

Antenarratives are self-organizing story networks, assembled through fragmented plots, contextual relationships, and emerging stories (Boje, 2011). Antenarratives are built through a relational exchange, constrained by the ‘official’ or ‘grand’ narrative, which in the case of (in)fertility is the macro-level d/Discourses of medicalization. Grand narratives surrounding (in)fertility are embedded into medical textbooks and dogmatic, clinical assumptions surrounding (in)fertility. As participant narratives attest, oftentimes these assumptions are then articulated through the voice of their doctor. RE’s will encourage patients to continue through treatment, despite the odds; doctors will minimize the significance of a miscarriage and display a lack of empathy in considering the emotional toll of treatment. This macro-level discourse is embedded into the patient experience and shapes the way that others interpret the significance of (in)fertility, and yet through relational sharing of experiences on Internet forums, individual stories provide an

important complexity to the definition of (in)fertility. As antenarratives these collections showcase the polyphonic nature of networked storytelling (Belova et al., 2008) and illustrate how multiple, diverse logics work together (Boje et al., 1999).

Antenarratives construct collective identity through linking every day, living stories with grand narratives (Boje, Haley, & Saylor, 2016). Identity, in this instance, is recognized as on-going and evolving in tandem with lived experiences (Carlsen, 2006; Weick, 2012). Identity is constructed through continued social interaction and a simultaneous recognition of the antenarrative and grand narrative (Johnson, 2014). As an identity related to (in)fertility emerges it does so through the fractured and fragmented experience of treatment. Some participants continually express mourning as they seek to negotiate their lost, previous identities with those they have adopted during treatment. Similarly, other participants continue to see themselves as retaining a core sense of self, despite the trauma of loss. In recognizing the multivocality and situatedness of experiences, an identity related to (in)fertility is not cohesive nor uniform, but rather built through the continued tensions of the multi-level d/Discourses. Participants are exposed to the grand narrative of medicalization during treatment, but they also turn to the online support groups to understand the social experience of (in)fertility and to get advice on navigating losses emotionally. Participants understand themselves as both strong and weak, resilient and hopeless. Where medicalization may shift women to feel disembodied, and a cultural rhetoric of motherhood may tell women that their lack of a child makes them failures, the support groups and individual support networks include supportive comments and praise. (In)fertility, and the varied identities associated with it, are built through on-going, unending tensions.

It is through this perspective of antenarratives as contributing to a storytelling network and the formation of a collective identity, that I situate (in)fertility as emergent organizing. Conceiving

organizing as emergent process positions the organizing effort as emanating both from the previously occurring context and history and the forward-thinking possibilities of the current state (Boden, 1994; Mintzberg, 1988; Goldstein, 1999; Taylor & Van Every, 2000). Thus, much like antenarrative, emergent organizations consider the retrospective past as much as the prospective future. Emergent organizations develop through the interplay of these dialectical tensions as organizational members seek to make sense of conflicting versions of reality. Much like the networked foundations of antenarrative, emergent organizations develop through continuous interactions between organizational members (Truex, Baskerville, & Klein, 1999). As members continue to engage in online support groups and share their experiences with friends and family members, (in)fertility emerges as an organizing process.

Emergent, alternative organizing (Cheney, 2014; Parker et al., 2014) examines how organizations develop as an ongoing, precarious process, one which is constituted by and through communication (Cooren et al., 2011). Organizing is shaped by concerns of culture (Cruz, 2017) and equality (Webb & Cheney, 2014), and is often a feminist endeavor (Buzzanell, 2000; Buzzanell et al., 1997; Cheney, 1995; Parker et al., 2007). (In)fertility is discursively organized through the narrative and antenarrative interplay, emerging as women navigate the medical texts and discourses alongside their lived, embodied experiences.

Understanding this project as contributing to the organizing of (in)fertility, can link antenarrative as a methodology that works in tandem with crystallization (Ellingson, 2009). Antenarratives point to disjointed stories, as Boje (2001) notes, “rather than reified plots, there are fragments of stories, bits, and pieces told here and there, to varying audiences, so that no one knows a whole story” (p.5). Antenarrative points to a collective nature of storytelling, wherein each participant contributes to an emerging story, creating plot twists, new narrative pathways,

and complexifying details (Boje, 2001). However, what we should recognize through an antenarrative approach, is not just the way in which situated knowledge contributes to organizational sensemaking and emergent organizing, but so too that shared narratives and networked stories will continue to exist long after this study is published. Rather, antenarrative opens up our understanding of emergent organizing to consider how stories continue to reaffirm with and dissent from the official, macro-level grand narrative.

Embodied Organizing

This project's findings consistently highlight the embodied nature of (in)fertility. Despite medialized discourses that reduce the body to a machine, participants found creative ways to reassert agentic authority over their body through practices of self-care and emotional vulnerability. Participants centralized their body, and paid heed to the painful yet significant trauma it endured over the course of treatment. While health communication scholars have considered and theorized the role of the body in research (i.e., Ellingson, 2006, 2017; Ellingson & Borofka, 2020; Heath, 2002; Lende & Lachiondo, 2009), organizational communication scholars continue to devalue the significance of the body in contributing towards the material-discursive process of organizing. Despite this, as the findings from this project illustrate, (in)fertility is an embodied experience, and through shared narratives and networks of support, (in)fertility emerges as organized through a process of embodied organizing.

Theorizing on embodiment positions the body as produced through a material-discursive entanglement by considering the social and material experiences of individuals as they navigate wellness and illness (Miedema et al., 2000; Thomas-MacLean, 2005). Materiality refers to the physical elements of an experience, including the signs and symptoms of health (i.e., pain, bruises). For example, participants in this study self-administered medication and, as a result, their bodies

changed and swelled over the course of the stimulation process. All participants endured near-daily internal ultrasounds and underwent the process of egg retrievals and embryo transfers. Not only did (in)fertility render an embodied transformation as participants' bodies responded to the medication, but so too did (in)fertility leave behind material and biomedical actants (Ellingson & Borofka, 2020). Leftover needles and empty syringes were a lesser discussed but nonetheless assumed reality of (in)fertility.

Moreover, (in)fertility is materialized through concrete aspects of health. For example, participants narrated the financial pressures of (in)fertility. While medicalization encourages women to never give up (in)fertility treatment, many women were cognizant of their financial realities and recognized that they could not endlessly pursue treatment. While no participant in this study went into debt because of (in)fertility, news outlets report that many couples are entering significant financial debt as a result of treatment (Young & Dickler, 2019). In other words, income, health insurance, and other available financial resources interactively influence the production of (in)fertility.

Giving voice to the material actants and conditions that produce (in)fertility as emergent, embodied organizing also highlights the inherent privilege that underscores the (in)fertility experience. (In)fertility is grounded within raced and classed structures, which often limit the access women of color have to medical treatment. Colen's (1995) theorizing on 'stratified reproduction,' describes how reproduction is bounded by social and cultural conditions, which serve to empower some women while concurrently disempowering less privileged women. Black and Hispanic women, in particular, are more likely to be overrepresented among people with (in)fertility yet underrepresented among those who seek medical treatment (Greil et al., 2011). However, it is not simply the material conditions of income, private insurance, and education

which disempower women of color from seeking treatment options (de Nooljer, Lechner, & De Vries, 2003; Jovanic, Lin, & Chang, 2003). The disparity in (in)fertility is also organized through social values that reflect larger cultural systems of belief about who deserves to be a mother (Roberts, 1997; Solinger, 2005). Media images depict white, middle-class women as most frequently accessing (in)fertility treatment, implicitly construing poor, non-white women as hyper fertile (Bell, 2009; Sandelowski & Lee, 2002). In this way, (in)fertility is organized around material-discursive bounds of inclusion/exclusion.

Embodied theorizing positions the body as produced through a material-discursive process, influenced by environment and context, and inscribing and inscribed by subjectivities (Burns, 2003; Perry & Medina, 2011). Thus, when considering the absence of non-white voices in this study, we too should consider the social and individual factors that prevent women of color from seeking medical treatment for (in)fertility. Among these, women of color are more likely to distrust medical institutions (Ojeda & Bergstresser, 2008), have a lack of spousal support (Inhorn et al., 2009), and perceive a greater stigma that may delay help seeking and lessen compliance with treatment protocol (Golberstein, Eisenberg, & Gollust, 2008). In contrast, the primarily white and Asian women interviewed in this study professed trust in the medical process, a rigid compliance with treatment regimens, and consistent support from their husbands. Thus, just as this project centralizes the body as contributing to the organizing of (in)fertility, so too does it reaffirm existing exclusionary conditions that stratify (in)fertility through implicit and explicit raced and classed bounds.

Shilling (2012) suggests bodies are bounded by a cultural system of particular norms and values, such as capitalism and neoliberalism; however, what this research illustrates is how bodies so too are circumscribed by medicalized discourses, clinic experiences, and networked support.

Bodies are produced relationally, as people make sense of their own experiences intersubjectively, relying on online support communities and conversations with doctors to value and/or devalue their body (Ellingson & Borofka, 2020). Within the context of this study, women exchange information and advice related to treatment protocols and effects. Participants turned to the group to joke about the size of suppositories and ask questions on administering medicine. Online groups prompted a new level of vulnerability for many women, who felt they could not easily find answers to such deeply embodied questions in their off-line social network. However, as the findings reflect, some women felt their clinic did not recognize or appreciate the emotional and embodied toll of treatment. Women described feeling pressured by doctors to pursue treatment, or to continue forward with treatment even after complex and continued losses.

Recognizing (in)fertility as bounded by material-discursive conditions, I propose *embodied organizing* as the dynamic, ongoing, and interactive process aimed towards coordinating and transforming activities and knowledge through engagement with the body. Drawing on definitions of organizing offered by Cooren and colleagues (2011), Ashcraft and colleagues (2009), and Kuhn and Corman (2003), I position embodied organizing as innately ambiguous, heterogeneous, and indeterminant. That is, as this project illustrates, narratives and networks coalesce around a shared understanding and experience, knowledge is built and construed as participants exchange advice, collaboratively construct knowledge, and communicate the material-discursive realities of (in)fertility. And yet, despite the coming togetherness of narratives and networks, participants also recognize the diversity of (in)fertility. Participants recognize the situatedness of their experiences and offer advice from a wholly local standpoint.

Embodied organizing is a relationally networked process, as individuals share narratives and contribute to a broader, in-depth, lived understanding of (in)fertility. Shilling (2012) positions

bodies as produced through “a complex network of material, technical, natural, and ideational phenomena” (p. 76, original emphasis). Embodied organizing is similarly produced through a network of discursive-material social production, in which meaning develops provisionally and is temporally situated.

Through reconfiguring (in)fertility as embodied organizing, so too can we recognize embodiment within other facets of this study. Identities, for example, and identification with (in)fertility become embodied as participants expressed optimism and eagerness at starting treatment. Participants willingly took on the physical, emotional, and financial toll of (in)fertility treatment, recognizing it as a pathway to their larger goal of starting a family. Of course, identification with (in)fertility does not necessarily reflect an active adoption of an (in)fertility identity, rather it may reflect an engagement with (in)fertility through embodied organizing. Participants join support groups and talk with other women in their off-line networks to learn more about (in)fertility, share their perspective, and gain an outlet for expressing their emotional journey. Through this collaborative network of communication, women construct an identification with the (in)fertility community, regardless of whether or not they are identifying with the (in)fertility diagnosis. Most acutely, resilience becomes embodied through endurance. Unlike the adaptive-transformative processes highlighted by Buzzanell (2010/2018), endurance, the embodied process of resilience, takes into consideration how the body engages in resilience and orients towards productive change.

Extending Resilience

Finally, this study builds upon the Communicative Theory of Resilience (Buzzanell, 2010/2018) by highlighting the ways in which intrapersonal, embodied, and organized communication complexifies and deepens our understanding of resilience as a process. As the

interviews reflect, resilience ebbs and flows as women going through (in)fertility face unanticipated obstacles and celebrate small victories. Through investigating the evolution of resilience, this project extends current theorizing on resilience in two ways: (1) resilience is constructed through persuasive, intrapersonal appeals and (2) resilience is embodied through endurance, a material-discursive process. In the following section, I discuss these two theoretical contributions in greater detail.

Intrapersonal Resilience

Throughout the interviews, participants reflected upon their perceived resilience, often situating resilience through an intrapersonal dialogue. Participants utilized personal mottos of strength and positive reminders of faith in order to instill within themselves forward-thinking possibilities. In this sense, resilience served as a means of self-persuasion, wherein participants enacted agency in modifying their own beliefs to help enhance forward-thinking optimism (Burke, 1970; Cunningham, 1992). This intrapersonal, self-oriented persuasion, however, was codified through a mix of personal and organizational stories, which often allowed participants to recognize the wealth of diverse experiences possible through (in)fertility.

While conceptions of intrapersonal communication and self-persuasive rhetoric have received markedly little scholarly attention, these theories orient persuasion as innately epistemic and dialogic. Hikins (1977) positions self-persuasion as occurring when two competing arguments are present and, as an individual weighs both arguments, they will change their viewpoint and alter their attitude. That this process occurs within the individual mind, rather than through collective sensemaking, suggests that as individuals navigate this tension they are actively altering and adopting new systems of thought. Narratives collected from women undergoing (in)fertility treatment highlight a similar tension-ridden process, wherein women experience competing and

conflicting cultural, medical, and social discourses, which only serve to heighten the ambiguity, anxiety, and anger of (in)fertility. For example, many women assert that their doctors are optimistic in treatment, communicating the high probability of success. Optimism developed through medical discourse can create a false sense of hope and left many women feeling even more depressed and frustrated when they failed to quickly conceive. On the other hand, women also turn to online support groups and are often affronted with the reality of unending loss. Within online support groups, members will read stories of painful losses and begin to understand that their doctor's optimism may not be accurate. Through these conflicting messages, women construct resilience through intrapersonal mantras of guarded hope, reminding themselves both that treatment can be successful, but regardless of outcome their lives will be fulfilled.

Mantras of hope serve as persuasive, resilience-laden communicative strategies that help women to construct future-oriented optimism during moments of hardships and heartbreaks. For example, participants who experienced multiple, devastating miscarriages, may still maintain an intrapersonal belief in their opportunity for success by reading narratives of other women who have had success after repeated loss. These women, in turn, may recall these inspirational stories during their own losses as a way to build hope and remain oriented towards the future. For example, during the interviews, participants might reference a story they read in an online group and use that to justify their own belief system. These stories took on the effervescent quality of folklore. While the similarities between folklore and the narrative paradigm have not fully been explored within the communication discipline, Roberts (2004) offers a communication-centered approach to folklore studies which centers the social processes that underlie the traditional aesthetic, poetic quality of fabled storytelling. Since the first scholarly inquiry into folklore, these stories have been rooted in the visages of peasant, minority, and otherwise non-mainstream culture (Wordsworth,

2003). In many ways, the stories shared within the (in)fertility support group serve as folkloric narratives designed to communicate support for alternative pathways to parenthood, motherhood, and in/voluntary childlessness. As folklore, these narratives depart from conventional assumptions of natural, easy conception to enliven understandings of the minority of women who struggle with (in)fertility.

While many researchers have correctly situated folklore as developing through interpersonal and group communication, Bard (1992) argues that folklore can serve as a form of intrapersonal narrative as well. Consciously or unconsciously, Bard (1992) suggests, individuals engage in an internalized narrative process in which they memorize people and events and use these stories as a plan for and prelude to action. As becomes evident through the examination of personal narratives and organizational semantic networks, women read narratives of others online, internalize the experience, and shift thinking about their own condition through the context of that narrative. For example, one participant continually reflected on the story of another group member who, after years of loss, successfully became pregnant but because of underlying, pre-existing mental health diagnoses, the woman terminated her pregnancy. The participant summarized this story as a means to convey the pressure inherent within (in)fertility as a means to understand, and normalize, her own anxious, depressive thought patterns. Importantly, the folkloric narratives are not innately negative. While some women will become disheartened and fearful when reading the story of another group member who has suffered through multiple, recurrent miscarriages, so too will a woman become hopeful and resilient when reading about a group member who successfully gave birth after years of misfortune. These narratives scale up to take on significance beyond the group and contribute both to an organized form of resilience within online communities and also a thoughtful engagement with intrapersonal resilience, grounded within hopeful mottos.

On the other hand, for women who do not have access to optimistic stories, they may instead draw on their own identity to construct resilience. Some participants, for example, reminded themselves of all the other types of hardships and ambiguity they had endured, and through this process they were able to recognize their own buoyancy and strength. For example, one participant continually reminded herself that in her early 20's, long before she entered (in)fertility treatment, she doubted herself and her ability to find success, but eventually she found success in her career. This participant used this story from years prior to remind herself that things in her life have worked out and that she has never been truly alone. These stories of hope, gathered through disparate online groups and personal memories of strength, become part of the intrapersonal dialogue a woman holds with herself. Thus, while this intrapersonal approach to resilience is constructed through interpersonal or organizational messages, it is nonetheless crafted internally, as women find hope by repeating mantras and recalling memories during dark or devastating moments.

Previous research has suggested that an ability to manage negative self-talk, while foregrounding positive self-talk, is a strategy of resilience (Foster et al., 2018). Through finding ways to reframe previously stressful experiences, like a painful injection, through positive frames of reference individuals can improve self-image, self-esteem, and self-agency (Mak et al., 2011). Communication research is far less attuned to how positive self-talk can contribute to resilience. Yet, talk, regardless of whether it is interpersonally networked or routed in the intrapersonal, can create and sustain resilience.

It is through recognizing the important nature of intrapersonal self-talk that I conceptualize embodied resilience. Specifically, the spatial, temporal, and bodily dimensions associated with self-talk prompt a reflexive recognition of the varied and nuanced processes of resilience that

emerge as participants centralize their identity in a medical treatment that often objectifies (Jensen, 2016; Sekimoto, 2012). This study's findings reveal that as participants engage in positive self-talk, attain agentic authority, and hail material actants, they more readily able to soldier forward, despite of loss or pain. Moreover, participant narratives highlight the ways in which resilience is processed in situ; rather than developing extraneously, resilience is built internally. Thus, I further complexify existing literature and theorizing on CTR by turning to a conceptualization of embodied resilience.

Embodied Resilience

The second way in which this project extends the Communicative Theory of Resilience (Buzzanell, 2010/2018) is to consider the embodied nature of resilience through conceptualizing endurance. I position endurance as the embodiment of resilience, a physical exertion towards productive and positive change. Previous research (Buckley, Punkman, & Ogden, 2018; Caldero, 2016) has considered the embodied aspects of resilience through analyzing the benefits of dance and movement on resilient perspectives, but by integrating a communicative approach to understanding both the body and resilience, I position resilience as an embodied process. In this sense, the body is central to reconfiguring resilience.

Buzzanell (2018) positions the key to the communication theory of resilience as the ability to “foreground productive actions while backgrounding unproductive behavior or negative feelings” (p. 16). Yet, stressful health events may inhibit one's ability to remain optimistic. In breast cancer, for example, patients are often encouraged to remain hopeful, joyful, and proud, despite the severity of their illness (King, 2010). As participants endured the hardships wrought by infertility treatment, they occasionally did so by privileging the unproductive. Foregrounding unproductive actions and negative emotions is a critical element of understanding embodiment

within health communication. In her ontological theorizing on health communication, Zook (1994) suggested that biologically negative behaviors, such as drinking or smoking, may actually serve as ontologically positive functions. This assumption not only underscores the idea that all behaviors profess ontological value, but that individuals do not merely behave to stay alive. In the same way that Zook (1994) argued alcohol may assist socially anxious people in overcoming their inhibitions, the results highlight how women undergoing the stressful process of infertility may make large and small changes to reduce the pressure of treatment, even if it slightly diminishes their chances of success.

Just as feminist theorizing positions embodiment as nuanced and ambiguous (Barral, 1969), so too does this study underscore embodied resilience as contradictory, multivocal, and privileged. For example, while the physical manifestation of infertility treatment—the shots, the bruises, the medical waste, and the hefty bills—all caused varying levels of grief, physical pain, and mental anguish, these efforts were nonetheless oriented towards productive and positive change that are overwhelming offered to primary white, heterosexual, and middle-class women (Bell, 2010). In other words, as women adopt a sugar-free diet, attend acupuncture appointments, and endure another shot in an already bruised and bloated stomach, they do so from an intrinsically advantaged position. Just as this project positions infertility as embodied, it further suggests resilience is built through embodied privilege.

Ultimately, however, for the women in this study, the physical manifestation of (in)fertility treatment are all oriented towards the productive, positive change that Buzzanell (2010/2018) configures as central to resilience theorizing. Just as this project positions (in)fertility as organized through embodiment, so too does it suggest resilience is built through embodied action. Rather than give up treatment, participants continue to endure the embodied trauma of treatment,

recognizing the ways in which these painful moments may help catapult them towards motherhood. In configuring resilience as an adaptive-transformational process (Buzzanell, 2010/2018), so too does endurance engage in a process of adaptation to the shifting social and medical contexts of (in)fertility. Participants engage in physical actions in an effort to transform their realities, hailing new possibilities through decisive action. Many participants, for example, began acupuncture after starting (in)fertility treatment. While doctors do not necessarily endorse acupuncture as a causal solution for (in)fertility, women nonetheless vehemently advocate for acupuncture, believing that acupuncture has the possibility to transform their chances of (in)fertility success. Through acupuncture women engage in an embodied process of endurance; while acupuncture may not instill hope or optimism in them, they nonetheless engage in the forward-thinking possibilities by utilizing their bodies in a productive manner that will, hopefully, lead them to motherhood.

Methodological Contributions

This study makes two methodological contributions, including integrating the significance of crystallization, particularly within network sciences, and revealing new methods for aggregating participant resonance.

First, this project builds methodological insight on the qualitative continuum of research through crystallization. In engaging multiple forms of qualitative data, including participant interviews, timeline maps, social networks, text mining and semantic networks, as well as autoethnographic and cyber ethnographic observations, I drew a more holistic, yet still thoroughly partial and limited, portrayal of (in)fertility. As Ellingson (2014) makes clear, among the many benefits of crystallization is its ability to engage diverse publics, including, community members, research participants, and other stakeholders, like doctors, in conversation. The varied and

dispersed forms of data necessarily make possible the ability share these findings with a variety of stakeholders, including women undergoing (in)fertility treatment.

In particular, integrating network science into this study allowed for a more critical application of a feminist-interpretivist approach to a traditionally post-positivist methodology. In this study I utilized the Qualitative Structural Analysis (QSA; Herz et al., 2015) approach to interrogate actor and structure composition. The QSA offers an opportunity to examine the embeddedness of specific relationships through a focus on the social structures of actors (Coleman, 1958; Wellman, 1988). Actors in a network are always operating within distinctive social and cultural systems that necessarily shape worldviews (Vaisey & Lizardo, 2010). In the context of network science and theory, culture refers to what is found/revealed in both publicly available texts, objects, and artifacts (Geertz, 1973) as well as a broad orientation towards “meaning and values” (Spillman, 1995, p. 131). As the findings indicate, network composition is heavily influenced by perceptions of stigmatization and attitudes towards disclosure.

Network science has rarely been considered as a facet of the qualitative continuum of research highlighted (Ellingson, 2009). Yet, network science, including but not limited to the QSA, makes important contributions to the investigation of multi-level, embodied organizing. Relying on both self-reported network data and narratives, a qualitative approach to networks offers an important contribution of ethnographic research. By considering networks as embodied, this research recognizes the significance of social organizing during stigmatized and traumatic life events. For example, women in the study who chose not to disclose their (in)fertility treatment expressed less resilience than women who were able to openly seek support from friends and family members. In making the resilient choice to seek support, women engage in embodied acts of disclosure, wherein they center the body as a component of (in)fertility.

Second, this project relied on resonance pull-out-boxes in order to evaluate members' interpretations of results. Combining the community resonance evaluation of Reily (2013) and the pull-out-box strategy of Linabary (2017), these empathetic validity evaluations enhanced the findings by offering both confirmatory and opposing viewpoints. Moreover, this strategy offered the opportunity to check in with participants, as nearly all of the participants were actively seeking treatment during our interview, and a number were in the midst of the two-week-wait or early stages of pregnancy. At least one participant participated in the resonance survey and reported that she had successfully given birth to a healthy baby 4 months prior. The resonance pull-out boxes provided an engaged, yet ancillary, perspective on these findings and helped reaffirm the partial, fragmented nature of this research.

Practical Contributions

Whenever I present my research, I am asked by concerned husbands, boyfriends, and family members how they can better serve the women in their lives who are struggling with (in)fertility. There is no easy answer because, as this research has highlighted, not only are (in)fertility experiences diverse, but so too are the women who undergo treatment. Some women desire blanket honesty, rather than optimism. For example, as one participant described, she wanted her husband to reaffirm that their marriage would be a happy one even without a child. Other participants desired optimism and hope, but only through the context of an (in)fertility support group where they are able to discover hope grounded in shared identities. However, despite the diversity, in the following section I present recommendations for how those who interact with women undergoing (in)fertility can communicate, support, and assist.

First, husbands and partners were consistently cited as the most relied upon source of support during treatment. A lack of spousal support during (in)fertility can lead to increased

depression and anxiety (Matsubayashi et al., 2004; Ogawa et al., 2011). Foremost, husbands should respect and admire their partner's endurance and resilience. Participants expressed happiness when their partner recognized the physical and emotional toll they were undergoing. Because different women will seek different forms of support from her partner, partners should engage in open and necessary communication, asking "what do you need?" or "how can I support you?" Some women, for example will feel supported when their husbands join them at every appointment, are present for every injection, and see the (in)fertility process as a joint experience. Other women, however, gained a sense of empowerment from attending appointments alone and handling their own injections. Husbands, in these instances, provided critical physical support by attending to household chores or by serving as an empathetic cheerleader, yet did not share in the explicit burden of (in)fertility.

Second, parents, siblings, and other family members should recognize (in)fertility as a vulnerable health problem. As one participant aptly reported, "I wouldn't tell them if we were trying the old-fashioned way, so why would I tell them now?" That being said, many women felt that their family members offered an important source of support. Parents especially should refrain from putting pressure on their daughters or daughters-in-law to have babies.

Third, friends and co-workers should be cognizant of the pain or jealousy some women experience when witnessing *another* pregnancy announcement, even when it is that of a close friend or sibling. Baby showers, in particular, are a triggering event for many women suffering from (in)fertility and, as a result, these women often chose not to attend. Colloquially, many women appreciate when pregnancy announcements are shared through email, or other forms of asynchronous communication. Email allows the women grieving her (in)fertility to compose her thoughts and emotions before sharing her congratulations. Unlike synchronous and face to face

communication, email does not demand a woman react instantaneously, instead she is able to mourn her jealousy without marring a friend's good news. Friends can also offer an outlet for women to express their frustrations, especially in instances where a husband or partner is not emotionally capable of empathizing with the fractured reality of (in)fertility.

Fourth, medical professionals, doctors, and nurses should recognize and pay heed to the emotions of (in)fertility. While patients do not expect their doctors to be their therapist, many participants in this study desired a more empathetic relationship with their doctors. Patients desire honesty from their doctors. Many women were left even more hurt when their doctor falsely predicted quick treatment success. Likewise, many women reported feeling discouraged by seeing a busy and 'by the numbers' fertility clinic, doctors and staff should keep in mind that women enter (in)fertility often despondent and vulnerable. However, if nothing else, what medical professionals should clearly be attuned to is the vital significance of online support groups. Online support communities—those designed specifically for women undergoing (in)fertility treatment—are an incredible resource and can help provide important emotional engagement for patients when social workers or therapists are not available.

Fifth, what unites almost all women dealing with an (in)fertility diagnosis is the loss of an easy future. All members of a social support network should recognize that most women are raised in a system and culture that privileges pregnancy as the assumed path for women. As women, we are raised to believe pregnancy is easy; we are taught about the importance of preventing pregnancy when we are young and that assumption implies that achieving pregnancy is inevitable and easy when we are older. Recognizing how closely tied fertility is to one's gender, members of a support system should use empathy to communicate their support and never assume success is achievable.

And finally, what has been the most significant implication of this research has been its ability to foster and build community among women suffering through (in)fertility. Recently, women have messaged me on Facebook, having read about my research in various forums. Rather than looking for advice, many of these women are just looking to hear that they are not alone; that someone else gets it. I frequently offer to share my dissertation, suggesting readers skip through the heavy academic language that pervades the first few chapters and instead read my autoethnographic reflections and my findings, sometimes directing them to specific passages that align with their own personal experiences. Through reading the narratives of the women I interviewed, these women are, in turn, integrated into the very (in)fertility organizing that this project theorized.

Limitations

All research includes limitations, and this project included two major points of weakness that nonetheless offer avenues for future research directions.

First, as was discussed in the theoretical implications, participants in this study were primarily white, Western, middle-class, highly educated, and heterosexual. Raced and classed boundaries persist within (in)fertility, and this study does not offer significant moves in debunking the assumption that (in)fertility patients are white, middle-classed women. Black and Hispanic women continue to be underrepresented among IVF recipients, despite race being an unexplained marker of prognosis (Green et al., 2001; Seifer Frazier, & Grainger, 2008; Wellons et al., 2008). Additionally, members of the LGBTQ community experience pregnancy and parenthood on a spectrum (Luce, 2010; Walks, 2007), yet all participants to this study were heterosexual, cisgendered women. Raced, classed, and gendered borders reduce the representation of this study. Moreover, participants in this study were recruited from a single Facebook group, which limited

the diversity of the voices included. My ethnographic observations revealed the Podcast Group includes women and men who are college educated; a number of my participants held terminal degrees and worked in highly lucrative professions. Of course, this only further serves to emphasize the homogeneity of representation within this study and, more broadly, within the social perception of the normative (in)fertility patient.

Second, this study relied on a mix of narrative and network data, however the networks were not uniform, and some participants provided more detail than others. The diversity in responses reduced how much I could rely on incomplete ego-network data. Instead, I shifted focus to visualize patterns across alters and events. While this approach offered new and exciting methodological insights, the lack of focus on ego-network data did limit this project's ability to portray evolving changes to networks over the course of treatment.

Future Directions

The theoretical, methodological, and practical contributions of this study also introduce additional avenues for future research. In the following section, I highlight four areas that should be of particular interest to organizational and health communication scholars and qualitative researchers.

First, among the many future directions for the embodied organizing of (in)fertility, future research should be attuned to the diversity of experiences. In particular, there are nascent opportunities to explore how (in)fertility is experienced by members of the LGBTQ community. Transwomen, for example, are rendered infertile after hormone therapy, consequently they must not only mourn the loss of their own fertility, but the disembodied connection between their gender identity and fertile capabilities. Likewise, while this project was attuned to the experiences of women, men also experience (in)fertility and likely experience an even greater stigmatization

(Culley et al., 2013). Like women, men congregate in online forums (Malik & Coulson, 2008); further research into men's participation in online forums may be an excellent avenue through which to continue towards a holistic understanding of health as organized.

Second, as this study illustrated, (in)fertility is organized across macro-, meso-, and micro-levels of material-discursive communication. While researchers have explored the macro-level communication as it develops from medical textbooks (Jensen, 2015), few studies have explored how this macro-level discourse is rearticulated in the clinic. Future studies should examine how doctors, nurses, and other medical professionals working within (in)fertility, appropriate or disengage from medicalized assumptions. Examining the Discursive construction of (in)fertility, as well as the discursive, everyday talk of treatment could provide important insight into how patients come to understand (in)fertility as medicalized.

Third, future research should continue to investigate how antenarrative and embodiment contribute to the emergent organizing of health, or any number of other solitary, yet shared, experiences. There is an abundance of research available that speaks to online communities, online identity formation, and online support groups, however few have considered the potential for joining together these theoretical approaches.

Fourth, crystallization offers an exciting and endless expanse of opportunities for building and challenging current qualitative methodologies. Recognizing the fragmented nature of most qualitative research, future research should consider how network theory and science can be engaged qualitatively. While most descriptive network research explains network structure through a relational approach, an engaged qualitative approach to network science offers an avenue through which to explore the socio-cultural influence on network structure. Future researchers

should continue to consider how networks can inform and contribute to embodied, engaged, feminist research.

Conclusion

To conclude, this project identified the multi-level organizing of (in)fertility through a cohesive analysis of narrative and networks. Using a combination of participant interviews, comments aggregated from an online forum, auto-ethnographic interludes, and survey responses for resonance, this study revealed ongoing identity tensions, empowering resilience, and networks of support. Taking a crystallization approach to examine the theoretical construction of (in)fertility through identity, resilience, and support, this study's findings shed light on the antenarrative and embodied organizing of (in)fertility. Thus, this project builds on existing theory related to emergent, narrative, and embodied organizing through considering the material-discursive construction of micro- and meso-level understandings. This study aims to help friends, family members, and medical professionals engage with and promote resilience for women undergoing (in)fertility treatment. Future researchers are encouraged to interrogate the raced, classed, and heteronormative bounds of (in)fertility, adding a necessary diversity to the current representation of this project.

Interlude: Revisions

Last week, my mom shared a photo on Facebook from our 2013 family reunion. In it my dad's brother and sister, my mom's brothers, their wives, and their children, and my grandmother and her nieces, all smile lovingly up at the camera. It is 2013, my second-cousins, Helen and Lindsey, have flown from Colorado to visit my grandma. My grandma is living in an assisted living facility but her dementia has not quite reached the levels it has today; she can still talk in

complete sentences with words other than gibberish, she can remember how to chew, and she still gets her nails manicured twice a month at the same salon that she has gone to for the last 30 years. My brother is a senior in high school, he is athletic and popular and happy; in two months he will move to Rhode Island to start college. He has not yet experienced the trauma associated with pledging a fraternity; he has not yet been forced to drop out of college; he is supremely confident. It is the last time I can recall my dad's older brother and sister being together; it is certainly the last time my grandmother and her nieces gathered. In 1948, when my grandmother was only 16 years old, she was shipped off to Colorado for the summer to babysit her two young nieces. Her oldest brother had run off to Colorado, and her sister, Helen, had followed suit. Helen fell in love with a cowboy; I still have their love letters saved.

I love this photo, the calmness of an early June day in Massachusetts, gathered with loved ones. But in the back row, standing behind me, is my ex-boyfriend. In less than a month I will break up with him after years of emotional manipulation, for stifling my progressiveness, and for his alcoholic tendencies. I knew I would break up with him, I had already tried to break up with him multiple times that previous year, but he always found a way to worm his way back into my life. I tell my mom, "I don't want him in our family photo, he shouldn't be in it," but my mom is kind and generous, she insists he should be included. And so, every time I see that photo, I am reminded of a happy day marred by his presence.

Last week, seven years after the reunion, my mom shares the photo on Facebook, writing "This was the best day!" and I comment, "Can we photoshop my ex-boyfriend of it?" At the time, I'm half-joking, but the more I think on it the more I realize it could easily be done; I could revise the memories of that day, until I no longer see him, but only see the love of my family. I find a

website, submit the photo and describe my request. I pay \$15, and 24 hours later I have a revised history.

We are ceaselessly, unendingly revising our histories. As I write this there are nationwide protests demanding accountability for police brutality and a growing recognition of systemic racism against Black Americans. Suddenly, across the world white citizens are redefining their relationship to racism; it becomes common to hear the phrase, ‘While I know I’m not racist, I now realize I have been complicit in racism by not actively being anti-racist.’ People are redefining their past actions in recognition of a cultural awakening; people are revising their histories.

Historical revisionism is a methodological approach of historiography; it involves challenging the established account of a historical event, altering older beliefs, and introducing new evidence (Krasner, 2019). Historical revisionism is used to analyze big events, yet it is frequently referred to as meaningless because it is so often adopted by neo-Nazis (Howe, 2000; Morris, 1990). However, psychologists point to ‘flashbulb memories,’ as the autobiographical memory that individuals recall when reflecting on an especially emotional or consequential event (Brown & Kulick, 1977; Conway, 2013; Conway et al., 1994; Talarico & Rubin, 2003). Flashbulb memories are our personal account of historical events. But, as research has consistently shown, flashbulb memories are fallible (Bernsten & Thomsen, 2005; Winograd & Neisser, 2006). Individuals will rewrite and revise their personal narratives; memories will deteriorate over time even as they continue to be experienced with vividness and self-assuredness (Day & Ross, 2014; Neisser et al., 1996). In other words, we can be supremely confident in our recollection of key events, while simultaneously failing to accurately depict said event.

In (in)fertility we are constantly revising our histories and reinterpreting our relationship to motherhood and pregnancy through a new lens, one which has endured trauma and loss. How

do we communicate these revisions not only to others, but to ourselves? How do we allow these revisions to broaden the scope of what we envisioned our lives to be, constructing a new narrative that is optimistic and fruitful? Throughout this dissertation I have sought to illustrate the ongoing, retrospective, and prospective changes myself and other women make as we come to accept the changing narrative of our life.

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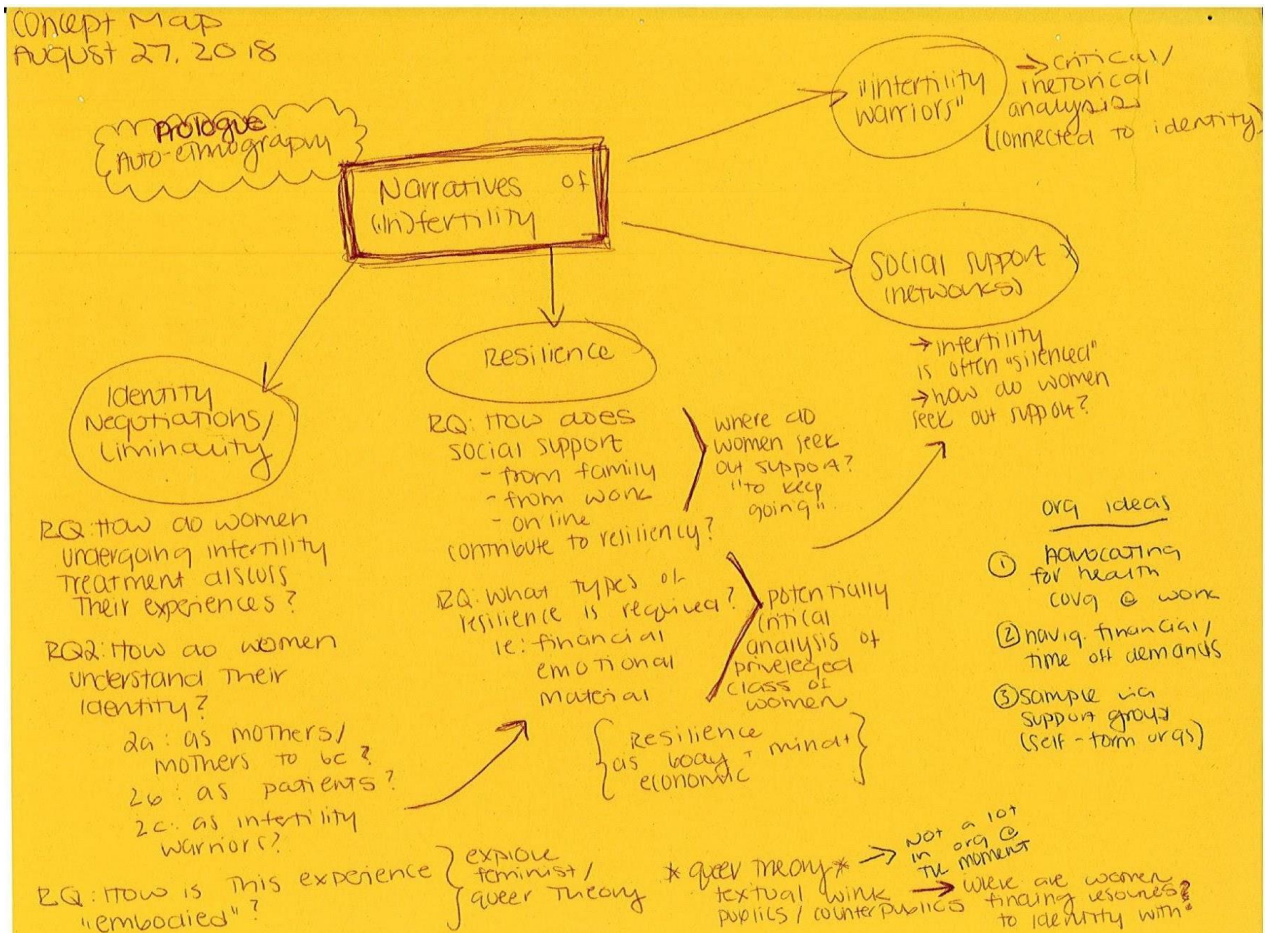
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APPENDIX A: INITIAL CONCEPT MAP



APPENDIX B: PARTICIPANT CHART

| Participant Pseudonym | Summary of Experience and Standpoint |
|-----------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Abbey | Abbey was in her late 20's when she starts trying to get pregnant. She has one miscarriage and begins seeking help from a RE after an insurance mandated year of trying. Her infertility is largely due to a blocked right tube from childhood appendicitis. She successfully had a baby after one retrieval and three transfers. |
| Beth | Beth is from Canada and in her mid-30's, she and her husband have male factor infertility. Her husband had a testicular injury when he was in his 20's and later, during their years of IVF, had testicular cancer. She successfully gave birth after her second retrieval, third frozen embryo transfer. At the time of our interview, Beth was preparing for her fifth cycle in hopes of a second child. Beth's IVF experience has involved traveling to Greece. She has suffered two miscarriages and a chemical pregnancy. |
| Carol | Carol is from Canada and 39 years old. She and her husband tried for two years to become pregnant before going to a fertility clinic. She started with timed and medicated intercourse but, after four cycles, she moved on to IVF. She has done two retrievals, two fresh transfers (chemical pregnancy), and one frozen transfer, all have failed. At the time of our interview she as preparing for her second FET and considering donor eggs from her sister. |
| Danielle | Danielle is from Canada and in her mid-30's. Her infertility is due to male factor issues, so she and her husband started with IVF. She has had 3 retrievals, one fresh transfer, and two frozen transfers. She switched clinics after her first retrieval because of miscommunication and a lack of transparency. She suffered a miscarriage after her first FET. At the time of our interview she has received a positive pregnancy test with her second FET. |
| Faith | Faith, age 49, and her husband, age 50, started IVF two years ago using donor eggs. At the time of our interview she had just completed her third frozen embryo transfer and was in the midst of the two-week wait. |

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| Ellie | Ellie is 37, living in the United States. Her infertility is likely due to uterus scarring from an endometriosis surgery she received three years prior and a blocked tube. Her doctor recommended going straight to IVF but while waiting to start IVF she became pregnant on her own. This pregnancy had to be terminated in the second trimester because of fatal chromosomal abnormalities. She then did one retrieval and two FETs, both failed. At the time of our interview she was preparing for her second retrieval, had reached her insurance maximum, and was considering surrogacy. |
| Heather | Heather is 25, but started trying to conceive at 23, and is Canadian. She and her husband did two rounds of monitored cycles with oral medication, three rounds of IUI, and one round of IVF with a fresher transfer. The transfer ended in an ectopic pregnancy that necessitated the removal of her left fallopian tube. At the time of our interview she was recovery from the surgery and taking a break from IVF. |
| Jillian | Jillian started IVF two years ago at age 35. After being diagnosed with a low AMH, she and her partner tried on their own but suffered a miscarriage. After the miscarriage she learned she had a uterus anomaly in which she only has one fallopian tube. At the time of our conversation she had just completed her third retrieval (fourth stim cycle) and was preparing for a transfer at her clinic in California (she lives in the mountain west). |
| Sarah | At the time of our interview, Sarah is 8 months pregnant after a successful frozen embryo transfer. Sarah has endometriosis, which caused cysts to grow on her fallopian tubes. Both of her fallopian tubes were removed during surgery, which meant IVF was the only course of action for her and her husband. |
| Julie | Julie is 8 months pregnant through embryo adoption. She and her husband made the decision to pursue embryo adoption, instead of IVF, after going through four unsuccessful IUI cycles. Julie's infertility is unexplained, although she does suffer from endometriosis and PCOS. |
| Lisa | Lisa is 36 and has unexplained infertility. Although she is able to get pregnant easily, she suffers early miscarriages. Before starting infertility treatment, she suffered from five miscarriages. She has done one round of IVF and has had two failed FETs. |

| | |
|--------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Kelly | Kelly is in her mid-30s and has a low AMH; she has undergone two IUIs and two IVF cycles. Kelly became pregnant after her first FET and successfully gave birth to her first child. A few months after she gave birth, she spontaneously became pregnant with her second child. At the time of our conversation, she was trying for a third child through IVF. |
| Nancy | Nancy's infertility is caused by male factor problems (her husband had a reversed vasectomy and low mobility) and by diminished ovarian reserve, low AMH, and pre-menopause. She has had two IVF retrievals, two unsuccessful transfer, and one FET that resulted in a miscarriage. At the time of our interview she was preparing for her second FET using donor eggs. |
| Mary | Mary is 41 and 11 weeks pregnant. After previously trying to donate eggs and being told she was too old at age 31, she froze her eggs when she was 35. She retrieved 22 egg, and 6 years later she selected a sperm donor. Of 22 eggs, only one egg made it to embryo status and tested for normal. |
| Rachel | Rachel began infertility treatment when she was 35 years old. Her need for treatment was caused by low AMH and MFI. She has done two retrievals and had two failed FETs. |
| Tia | Tia is in her mid-30's when she and her husband seek out help from an RE. Their cause is mostly MFI. She has undergone 3 failed IUIs and 3 IVF retrievals. She has had one failed FET and suffered two miscarriages. |
| Penny | Penny is in her late 30's. She has done 8 cycles of IVF. Two of those cycles were converted to IUI because of a poor response. She has had one failed fresh transfer and two FETs. The two FETs resulted in miscarriage. |
| Gina | Gina is 36. Her infertility is medical, including PCOS and endo. After two miscarriages, she started with three unsuccessful rounds IUI, and then progressed to two rounds of IVF. After her third miscarriage (during IVF), she pursued an alternative pathway in naprotechnology. Napro fits within her religious belief system. She concived her son through the naprotechnology method and is currently trying for a second child through napro. She has done 9 cycles with napro. |

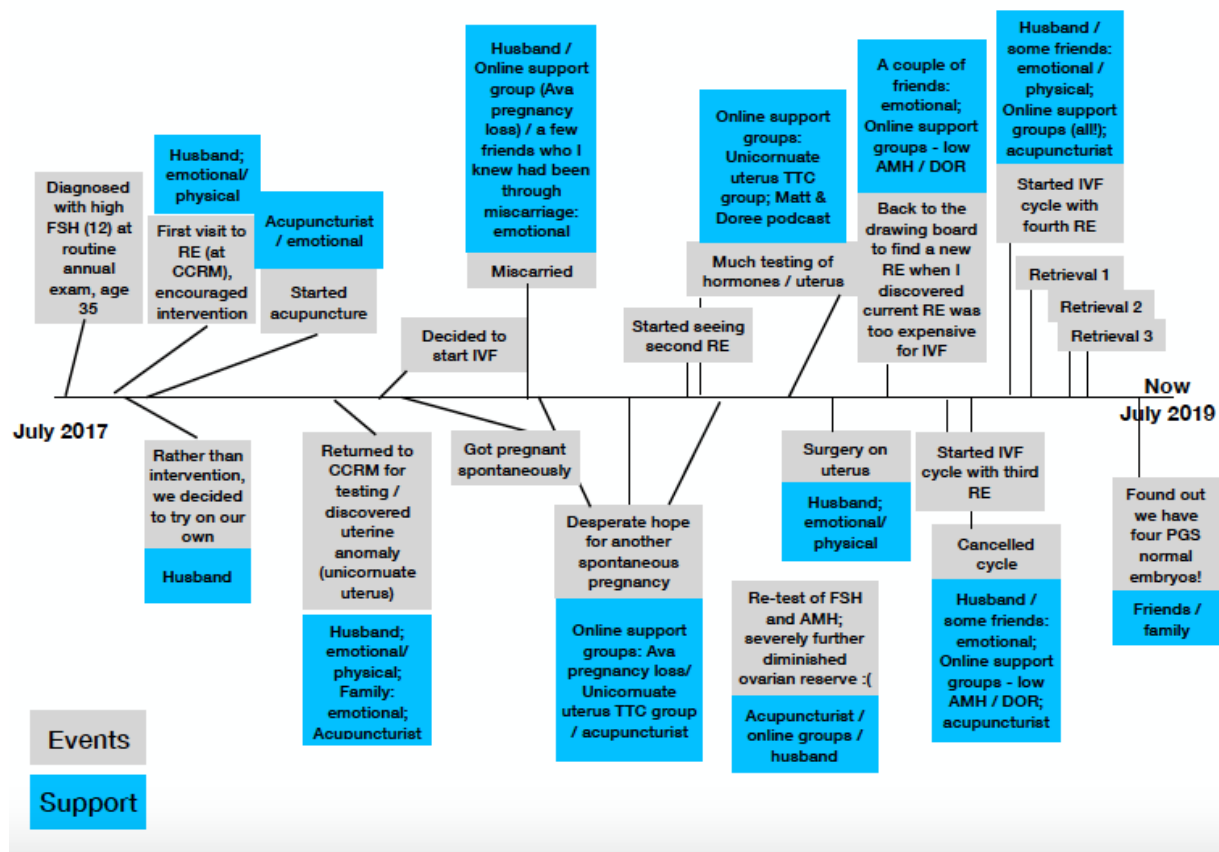
| | |
|---------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Allison | Allison has endometriosis. She has undergone 8 failed IUIs, and 2 IVF retrievals. She has done two fresh transfers, but one resulted in a miscarriage. At the time of our interview she is preparing for her first FET. |
| Carly | Carly is 34 years old and began IVF two years ago. She is doing a shared-risk cycle with her clinic. Her infertility is likely related to MFI. She has undergone one, unsuccessful IVF retrieval. |

APPENDIX C: OPTIONS OF TIMELINE MAP DESIGN

Using the chart below, outline a timeline of the key moments, or turning points, of your experience with infertility. You may begin, for example, with your first visit to a fertility specialist or the first moment you realized you would need to receive treatment. You are more than welcome to use additional pieces of paper. After, please go through a note people who supported you during these key moments (i.e., emotional, physical, financial, or social support). You are more than welcome to add boxes as you see fit! Please bring this timeline chart to our interview or email it beforehand (Jarvis10@Purdue.edu). Thank you!

| What month and year did this event happen? | Briefly describe what happened? | During this time, who supported you? What type of support did they provide? |
|--------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|
| June 2017 | After over a year of actively trying to get pregnant on our own, we were referred to an infertility specialist. | Husband, supported by attending appointments. |
| August 2017 | After a monitoring cycle at the infertility specialist, and testing we discovered that my husband had low sperm count, low morphology and motility. We were told by our RE that the only chance we had of getting pregnant was by IVF with ICSI. | Husband and I supported each other. Went to appointments together, made lifestyle changes, including financial planning to budget for IVF. |
| September 2017 | Had communication issues with our fertility clinic. Nurse gave me the wrong dosing information, leading to taking the incorrect dose of a medication. | Husband had a discussion with the nursing manager. |
| October 2017 | 1 st egg retrieval, which yielded 14 eggs, but no embryos. Mild OHSS | Husband – physical support, stayed home from work to assist in recovery |

Option 1: Table with directions for participants to list key event, description, and source of support. The majority of participants selected this option. This example comes from participant, Danielle.



Option 2: Participants had the opportunity to complete a visual timeline map, wherein they noted the passing of time on a blank line. Participants were provided with the same direction as option 1. This example comes from Jillian.

APPENDIX D: INTERVIEW PROTOCOL

Retrospective Interviewing

1. Let's begin by making a map that chronologically organizes your fertility journey.
 - a. Can you walk me through your experiences with fertility?
 - b. When did you first learn you may have fertility challenges?
 - c. What were some points in your map that represent a key moment for you?
2. Now that we have a map, let's go back and discuss each point. Beginning with the earliest moment, can you tell me about it?
 - a. How did the doctor discuss this?
 - b. How did you and your partner discuss this?
 - c. How did this moment make you feel?
3. As you were going through these experiences how did you discuss them with other people?
 - a. Can you tell me a story about telling a friend about fertility treatment?
 - b. Can you tell me a story about telling a family member about fertility treatment?
4. Can you tell me a story about your partner's involvement with fertility treatment?
 - a. Has your relationship changed or been challenged?
5. Can you tell me a story about being at work and dealing with fertility treatment?
 - a. Have you spoken to anyone in HR or a superior as you've dealt with this?

Identity & Resilience

1. Can you tell me a story about challenges have you faced you faced during treatment?
 - a. Consider emotional, physical, financial challenges, or any other forms.
 - b. What did you do? How did you try to overcome these challenges?
 - c. What changes did you make when you faced a difficult time?
2. Have there been times when you've wanted to end treatment?
 - a. How did you stay motivated to keep going?
3. As you think back on your experiences of (in)fertility, what advice would you give to someone entering into the process?

4. When you think about yourself at the beginning of this process, versus now, how have you changed?
5. Has infertility challenged your sense of self?
 - a. How so?
 - b. What did you do to overcome this, if anything?
6. How have your conceptions of motherhood changed? Can you provide a story that exemplifies this?

Social Support

1. What has been the most beneficial source of support?
2. Let's begin by making a list of all the people you've turned for support or comfort during your infertility experiences.
 - a. Can you tell me a story about each of these people? A moment that shows their role in your life.
 - b. What source of support did they provide?
3. Next, let's make a list of anyone you've felt uncomfortable talking to about this process.
 - a. Can you describe a moment where you remember feeling they were unsupportive or not understanding?
4. Is there anyone at work who you feel you can talk to?
 - a. Or anyone at work you feel uncomfortable talking to?
5. Have you participated in any social groups, whether online or in real life?
 - a. What sort of things did you discuss?
 - b. How was (in)fertility discussed?
6. Infertility has a high expense and often requires a high knowledge of the insurance. Has this been something you've dealt with?
 - a. Who do you talk to about this?
 - b. Who has provided advice? (please make a list)
 - c. Are there any organizations that have helped?

APPENDIX E: FIRST LEVEL CODING

So, because I'm on there so much, it felt very strange to never be able to talk about it on there, when it's such a big part of my life. And I think it was on Mother's Day this year when it really, I was like 'I think I need to post about how I am feeling' because most—I mean I'm 39 now—most of my friends have kids, almost all of them, pretty much all of them who want kids have kids. Most of my friends are done having kids now, and so Mother's Day is just a big FB feed of 'I'm so grateful for my children for blah blah blah' and it's hard, it was really hard for me, this was the hardest year for me to see that knowing that I could have 2 by now, I could be done, if I'd gotten pregnant quickly when we started trying we could have had our family complete by now, we've had enough time. And it still hasn't worked, I know people must wonder, like we've been married for 2 years, 'aren't you going to—isn't the clock ticking? Like aren't you getting on that?' like 'yes, we are.' So, it felt really important to finally just say something, so I did. And it was kind of, it was helpful for me to just share that it's a really difficult day for some people and to also kind of say 'if anyone else is out there and struggling with this and doesn't have anyone to turn to, you don't have to comment here but you can turn to me because I have become an accidental expert.' A lot of people reached out.

C: Oh, that's awesome. So, you received a lot of empathetic support or other types of support through posting about it on Facebook?

P: Yes, and then I also put one on Instagram too; I made a post, which I think was less noticed because I don't use Instagram so much. But, yeah, definitely got some messages. Like, a few supportive comments and also some private longer messages from people who had been through the same stuff and never said anything, and I had no idea. So, it was nice to find some of those sisters in the journey.

C: And did that help you at all in keeping going with—it looks like after you did that you just had

holidays, especially Mother's day rep. very hard reminder

I motivated by embryo

re-exhibit the control over the narrative

when they move on people prompt to scroll

APPENDIX F: SECOND LEVEL CODING

Urgency

- I think I feel more urgent for other people than they do for themselves because you don't think that it's going to be you until it's you. –Rachel

Timeline

- If they're trying and it's not working, do not wait to go to the doctor because [time] can be invaluable. If I could get some of those years back when we were not working with a clinic, and we could have done these treatments sooner, maybe they would have worked because maybe I would have had more, better quality embryos. So, the value of time when you're getting older is like so important. –Carol
- Sometimes I do tell my friends, because some of them are married, I tell them, 'you know, if you want kids you might as well just, not trying, but not preventing it from happening. It's always a good idea to just get tested.' I feel like I do educated them on that infertility could happen to anyone at any age, it doesn't really matter. –Heather
- I had another AMH and FSH test in October that showed that my everything had decreased terribly. It looked really bad. So, that was kind of a low point because I knew we weren't really making any progress because I was waiting for the surgery and I was watching my ovarian reserve plummet. –Jillian

Diagnosis highlights broader community

- The miscarriage was probably my first realization that there was this larger community out there. I blogged about my experience. . . I had a WordPress blog and I wrote about what I was going through because at the time I was the only one I knew that had a miscarriage, but as soon as I posted, everyone came out of the woodwork. Like, parents of my high school friends, like this is why this son is so much older than the other son, we had a miscarriage in between, here I'll send you these books and then like a few months later I found some high school friends had had miscarriages. One of my friends had secondary infertility and it was just like, it was a lot of stuff we don't talk about. –Abbey
-

APPENDIX G: THIRD LEVEL CODING

RQ1: How do personal narratives of (in)fertility contribute to the organizing of the (in)fertility identity?

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|---------------------------------|--------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Organized around turning points | Age pressure | <p>I was 32 at that point, so I still felt not terribly old, but like, I knew I was getting to that point of being older. And <u>so</u> I read that if you're under 35, is either try for a year, and if you're over 35, then it's six months. And my husband being older, I decided in July to go in, and do an initial this appointment to see if anything was concerning. —Allison</p> <p>The real defining moment of the whole journey for me was in February 2018—that was my birthday month, so I turned 38, and they had told us a number of times that there is a big fertility drop-off at 35 and another one at 38—and I was just crushed. We didn't have a lot of the things—we felt very stuck in our lives in general—but we didn't have a lot of the things that we wanted for the way we had envisioned our lives progressing. . . I had a horrible birthday, everybody was like, 'what do you want to do for your birthday,' and I was like, 'nothing, I want you all to leave me alone and let me just wallow.' —Carol</p> <p>Through a work program I got to live and volunteer in West Africa for a year or so. . . Now, when I was there, I seriously probably would have come home with four kids. I turned 35 when I was there, and you have women that will just, "here please take my baby back to America to give it a better life." So, I kind of looked into adoption agencies there, and they ended up stopping out of country adoption while I was there. . . And so then I'm like, ok, I'm 35 years old and I need to do something and that's kind of when I said, "ok, I'm going to go to the fertility clinic." Now, truthfully, I went out of strong emotions. —Mary</p> <p>So, we have been back on the meds, this was my 9th cycle back on the meds, and I haven't been responding to them as well this time. So, this past month was the first month that we found the right dose this time, which instead of ten <u>milligrams</u> that we conceived my son on, this was 25 <u>milligrams</u>. So, more than double the dose was needed, but now I'm almost 37, I'll be 37 in November, and there's a big difference between 34 and 37 in fertility. —Gina</p> |
| | Initial loss | <p>I think that first transfer and miscarriage was probably another turning point moment because they had all assured us this is a PGS normal embryo, it's a 50/50 shot that it will implant and if it implants because it's a PGS normal embryo you have less than a 10% chance of miscarrying, because we know that 90% of embryos miscarry due to genetic stuff and we know your genetics are fine. And that, once we got past the implantation and everything had been going well, my betas were going really high, it was a bit of a shock when the hemorrhage happened. And we went into the hospital and the hospital was like, yeah, this is done, we're sorry. And I called the clinic, and they were like, hospitals are wrong some time, you should come in tomorrow. The hospital had said, there was no fetal pulse, there was not heartbeat.</p> |

APPENDIX H: NETWORK CODING

| | A | B | C | D | E | F |
|----|----------|------------|--------|-------------|--------------|---|
| 1 | Ego | Alter | Date | Event | Type | |
| 2 | Abbey | Husband | 16-Apr | Miscarriage | Emotional | |
| 3 | Abbey | Family | 16-Apr | Miscarriage | Emotional | |
| 4 | Abbey | Work | 16-Apr | Miscarriage | Flowers | |
| 5 | Abbey | Online | 16-Apr | Miscarriage | Support | |
| 6 | Beth | Friend | 15-Oct | Miscarriage | Emotional | |
| 7 | Beth | Family | 1-Oct | Miscarriage | Emotional | |
| 8 | Beth | Friend | 15-Oct | Miscarriage | Gift card | |
| 9 | Beth | Online | 15-Oct | Miscarriage | Empathy | |
| 10 | Beth | Husband | 15-Nov | Miscarriage | Instrumental | |
| 11 | Beth | Clinic | 15-Nov | Miscarriage | Information | |
| 12 | Beth | Husband | 15-Jan | Miscarriage | Emotional | |
| 13 | Beth | | 19-Apr | Miscarriage | | |
| 14 | Danielle | Husband | 18-Sep | Miscarriage | Emotional | |
| 15 | Danielle | Family | 18-Sep | Miscarriage | Food | |
| 16 | Danielle | Family | 18-Sep | Miscarriage | Visited | |
| 17 | Faith | RE | Feb-19 | Miscarriage | Emotional | |
| 18 | Faith | Husband | Feb-19 | Miscarriage | Emotional | |
| 19 | Faith | Friend | Feb-19 | Miscarriage | Emotional | |
| 20 | Faith | Media | Feb-19 | Miscarriage | Normalcy | |
| 21 | Faith | Online | May-19 | Miscarriage | Information | |
| 22 | Jillian | Husband | | Miscarriage | Emotional | |
| 23 | Jillian | Online | | Miscarriage | Emotional | |
| 24 | Jillian | IVF Friend | | Miscarriage | Emotional | |
| 25 | Nancy | Husband | May-17 | Miscarriage | Emotional | |

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Sheet1
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Ready

APPENDIX I: PROTOCOL FOR RESONANCE SURVEY

Directions: Last summer I conducted interviews with 20 women at various stages of infertility. In particular, I attempted to understand how identities and sense of self were challenged, how resilience was communicated, and how social support evolved over the course of fertility treatment. Summaries of the findings are listed in this survey; as you read through please take time to describe if, and how, these findings resonate with your own experience. I am also eager to hear if you do not agree with a statement, please explain why. If you ever feel uncomfortable responding to a statement and/or that you cannot comment on the statement, you are able to leave a response blank.

- Findings showed that participants often felt their RE's office and fertility clinic ignored their whole person. Some participants felt clinics valued neutrality, depersonalization, and commodification, and ignored the emotions of infertility. For example, clinics might encourage women to keep going through treatment regardless of the financial costs. How has your experience with the clinic aligned with, or diverged, from these statements? Can you provide a story that explains this?
- Women attempt to reassert control in the fertility process by making lifestyle changes, trying herbal remedies, and seeking out acupuncture. Do you see these changes as an effort to gain control in an uncontrollable process?
- Women who successfully had a baby through fertility treatment often had difficulty accepting their pregnancy as real, often because of the trauma of previous miscarriages. These women felt as though they were 'waiting for the other shoe to drop.' Other women reported that even after birth, they felt alienated from mother's groups, where women had not undergone IVF to become pregnant. If you have had a baby through treatment, do these statements reflect your experience? If possible, please include a brief story that describes this.
- Online support groups were a vital source of support, where participants looked to find like-minded individuals, vent their frustration, and find new information about medical treatment options. Can you think of a time when the online support groups did or did not exemplify these uses?
- Participants also cited negative experiences with online support groups, including feeling alienated if they went an alternative route to IVF or if you were older/younger than the majority of participants. Some participants felt that the comparison that happens within

online support groups can be negative to their mental health. Do these statements align with your experiences? Why or why not?

- Some women reported that undergoing infertility treatment was empowering. Do you feel empowered? Has this experience positively changed you?
- Some participants felt as though they had lost who they were pre-treatment. Do you feel as though treatment has negatively changed you?
- Many participants noted that while there were challenges in their marriage, overall, they're marriage had been strengthened because of this experience. Participants felt that they had increased intimacy and communication with their partners. Does this reflect your experiences?
- Last year, between June and October 2019, did you participate in the 2-hour interviews?

If yes:

- If yes, how are you now?
- Reflecting back on the interview experience, how do these findings resonate with you?
- Reflecting back on the interview, did it change how you thought of your own infertility journey?

If no:

- In the space below, please share a little bit about your own infertility journey. You could, but are not required, to include your diagnosis, how long you have been trying to conceive, any failures or success you've experienced, and anything else that you think is important.
- Would you be interested in participating in a follow-up email for potential participation in a brief, 30-minute phone call concerning your experience with resilience and online support groups and/or the effects of COVID-19 on your treatment plans?
 - If yes, please enter your name and email address:

VITA

Caitlyn M. Jarvis

EDUCATION

Ph. D. Purdue University, Brian Lamb School Communication, West Lafayette, IN

Expected Graduation: August 2021

Major Area: Organizational Communication

Minor Area: Computational Social Science Research

Dissertation: *Narratives (In)Fertility: Organizing and Embodiment in Silence and Stigma*

Advisor: Dr. Stacey Connaughton

Committee Members: Dr. Seungyoon Lee; Dr. Laura Ellingson (Santa Clara University);

Dr. Elizabeth Williams (Colorado State University); Dr. Cheryl Cooky (Sociology)

M. A. Colorado State University, Department of Communication Studies, Fort Collins, CO

M. A. Communication Studies Awarded: May 13, 2016

Advisor: Dr. Carl Burghardt

Committee Members: Dr. Elizabeth Williams, Dr. Kirk Hallahan (Public Relations)

Master's Thesis: *"The Season from Hell": The Genre of Corporate Sports Apologia*

Graduate Teaching Certificate, The Institute for Learning and Teaching

B. A. Saint Anselm College, Department of Politics, Manchester, NH

B. A. Awarded with Honors: May 17, 2014

Major: Politics

Minor: Communication Studies

Undergraduate Thesis: *The Political Philosophy of Thomas Jefferson*

Honors Societies: Pi Gamma Mu, Pi Sigma Alpha, Delta Epsilon Sigma

PUBLICATIONS

- Jarvis, C. M. & Welch, J. R. (*Forthcoming*). “The year of the cheerleader lawsuits”: Paradoxical Sensemaking and Postfeminism in Reporting on Gender-Based Harassment. *Communication, Culture, & Critique*.
- Jarvis, C. M. (*Forthcoming*). Supportive communication through medicalization: Semantic network analysis of supportive messaging on an online infertility support group. *Women’s Reproductive Health*, 8(4).
- Jarvis, C. M. (2021). Invitational rhetoric in epistemic practice: Invitational knowledge in infertility support groups. *Rhetoric of Health and Medicine*, 4(1).
- Jarvis, C. M. (2021). Navigating the public-place/ private-market tensions: Toponymic and material reading of Broncos Stadium. *Sport in Society*, 24(3), 473-489.
<https://doi.org/10.1080/17430437.2019.1678589>
- Jarvis, C. M. & Eddington, S. M. (2021). Disentangling antifeminist paradoxes: Alternative organizing in antifeminist online spaces. *Management Communication Quarterly*, 25(1), 96-126. <https://doi.org/10.1177/0893318920972649>
- Lee, S., Benedict, B. C., **Jarvis, C. M.**, Seibeneck, L., & Kuenanz, B. J. (2020). Support and barriers in long-term recovery of Hurricane Sandy: Improvisation as a communicative process of resilience. *Journal of Applied Communication Research*, 48(2).
<https://doi.org/10.1080/00909882.2020.1797142>
- Seibeneck, L. K., Schumann, R., Kuenanz, B. J., Lee, S., Benedict, B. C., **Jarvis, C. M.**, Ukkusuri, S. (2020). Returning home after Superstorm Sandy: Phases in the return-entry process. *Natural Hazards* 101, 195-215. <http://doi.org/10.1007/s11069-020-03869-1>

Manuscripts in Revision

Jarvis, C. M. (*Revise & Resubmit*). Endurance: Embodied resilience as a material-discursive process in health crises. *Journal of Applied Communication Research*.

Jarvis, C. M. & Eddington, S.M. (*Revise & Resubmit*). "My freedom doesn't care about your fear. My freedom doesn't care about your feelings": Postmodern and oppositional organizing in #OpenAmericaNow. *New Media & Society*.

Manuscripts Under Review

Eddington, S. M., **Jarvis, C. M.**, & Buzzanell, P. M. (*Under Review*). Affective and disembodied male rage: A semantic network approach to understanding the communicative construction of online identity in a men's rights community. *Organization*.

Lee, S., Seibeneck, L. K., Benedict, B. C., Yabe, T., **Jarvis, C. M.**, Ukkursuri, S. (*Under Review*). Patterns of social support and trajectories of household recovery after Superstorm Sandy. *Natural Hazards Review*.

Manuscripts in Progress

Jarvis, C.M., Eddington, S.M., & Betts, T. (*In Progress*). Constitutive conspiratorial communication and contra-resilience: Populism and post-truth in coronavirus conspiracy on Reddit. To be submitted to *Convergence*.

Jarvis, C. M. (*In Progress*). #InfertilityWarriors, affective medicalization, and heteronormative whiteness: Visually and discursively rendering the ideal patient on Instagram. To be submitted to *Social Media & Society*.

Jarvis, C. M. (*In Progress*). The personal is professional: Affective negotiating specificity and generalizability. To be submitted to *The Journal of Autoethnography*.

Eddington, S. M., & **Jarvis, C. M.** (*In Progress*). Exploring the discursive framing of #WhyIDidntReport. To be submitted to *Journal of Communication*.

Eddington, S. M. & **Jarvis, C. M.** (*In Progress*). Adaptive and transformative online communities of practice: #AcademicTwitter as an institutional response to COVID-19. To be submitted to *Media and Communication*.

Eddington, S. M. & **Jarvis, C. M.** (*In Progress*). Intractable conflicts, difference, and contradictions: An exploration into identity negotiations of male college educators' feminist identities. To be submitted to *Gender, Work, & Organizing*.

BOOK CHAPTERS

Jarvis, C. M. (*Forthcoming*). Social media and social identities. *Wiley International Encyclopedia of Health Communication*.

Eddington, S. M., & **Jarvis, C. M.** (*Forthcoming*). Mitigating political polarization in the future workplace. *The Routledge Research Companion to Business with a Conscious*.

COMPETITIVE CONFERENCE PRESENTATIONS

Jarvis, C. M. & Eddington, S.M. (*Under Review*). "My freedom doesn't care about your fear. My freedom doesn't care about your feelings": Postmodern and oppositional organizing in #OpenAmericaNow. Paper presented in the Organizational Communication division at the annual conference of the National Communication Association, Seattle, WA.

Eddington, S. M., **Jarvis, C. M.**, & Buzzanell, P. M. (*Under Review*). Affective and disembodied male rage: A semantic network approach to understanding the communicative construction of online identity in a men's rights community. Paper presented in the Organizational Communication division at the annual conference of the National Communication Association, Seattle, WA. **TOP PAPER.**

Lee, S., Siebeneck, L. K., Benedict, B. C., Yabe, T., **Jarvis, C. M.**, & Ukkusuri, S. V. (*Under Review*). Patterns of social support and trajectories of household recovery after Superstorm Sandy. Paper presented in the Applied Communication division at the annual conference of the National Communication Association, Seattle, WA. **TOP PAPER.**

Jarvis, C. M. (2021, March). Endurance: Embodied resilience as a material-discursive process in health crises. Paper presented in the Health Communication division of the Eastern Communication Association, Virtual. **TOP PAPER.**

Jarvis, C. M. (2021, March). Interdependent systems of resilience: Publicly promoting resilience during and after COVID-19. Competitively selected panel presented in the Eastern Communication Association, Virtual.

Jarvis, C. M. (2020, November). Engaging shared identities of infertility: The radical specificity of a dissertation project. Paper presented in the Ethnography division of the National Communication Association, Indianapolis, IN, Virtual.

Jarvis, C. M. (2020, November). Sensemaking processes in organizational crisis: A case study analysis of the NFL Cheerleaders' Lawsuits. Paper presented in the Sports Communication division in the National Communication Association, Indianapolis, IN, Virtual.

- Jarvis, C. M. & Eddington, S. M. (2020, November). Choosing the patriarchy: Women's paradoxical organizing in antifeminist online spaces. Paper presented in the Organizational Communication division at the National Communication Association, Indianapolis, IN, Virtual.
- Eddington, S. M. & **Jarvis, C. M.** (2020, November). Exploring the discursive framing of #WhyIDidntReport. Competitively selected research escalator presented in the Organizational Communication division at the National Communication Association, Indianapolis, IN, Virtual.
- Eddington, S. M. & **Jarvis, C. M.** (2020, November). Spontaneous organizing for resilience: #AcademicTwitter as an online community of practice. Competitively selected research escalator presented in the Organizational Communication division at the National Communication Association, Indianapolis, IN, Virtual.
- Jarvis, C. M. (2020, November). At the crossroads of adaption and transformation: Multi-level resilience as a response to COVID-19. Competitively selected panel to be presented at the National Communication Association, Indianapolis, IN, Virtual.
- Jarvis, C. M. (2020, May). Supportive communication in loss: Imbuing a rhetorical epistemology into semantic network analysis. Paper presented in the Health Communication division of the International Communication Association, Gold Coast, AU, Virtual.
- Jarvis, C. M. (2019, April). Shared identities and self-reflexive research: Praxeological engagement of embodied research. Competitively selected panel to be presented at the Central States Communication Association, Chicago, IL, Cancelled.
- Jarvis, C. M. (2019, November). Minority patterns of discourse in a patriarchal movement: Examining semantic networks of r/RedPillWomen. Paper presented in the Organizational Communication division at the National Communication Association Conference, Baltimore, MD.

- Jarvis, C. M. (2019, November). Invitational rhetoric in practice: Negotiating triggers in online support communities. Paper presented at the National Communication Association Conference, Baltimore, MD.
- Jarvis, C. M. (2019, October). Narrating (in)fertility: Developing resilience with tenuous identities. Research presented at the Organizational Communication Mini Conference, Urbana-Champaign, IL.
- Siebeneck, L. K., Schumann, R., Lee, S., Benedict, B. C., & **Jarvis, C. M.** (2019, October). I felt so lost: Returning home after Hurricane Sandy. Southwest American Association of Geographic Conference, Fort Worth, TX.
- Lee, S., Benedict, B. C., **Jarvis, C. M.**, Seibeneck, L., & Kuenanz, B. J. (2019, May). Networks of support in post-disaster recovery over time: A quantitative analysis of personal networks derived from interviews and timelines. Paper presented in the Organizational Communication division of the International Communication Association Conference, Washington D.C. **TOP PAPER.**
- Jarvis, C. M. (2019, April). Divisive discourses: Inter-institutional rhetoric in the case of the NFL versus President. Paper presented at the Eastern Communication Association Conference, Providence, RI.
- Jarvis, C. M. (2019, March). Dialectical tensions and rhetorical framing in labor negotiations: NFL versus cheerleaders. Paper presented at the International Association for Sports Communication's Annual Summit on Communication and Sport, Idaho State University, Boise, Boise, ID.
- Jarvis, C. M. (2018, October). Stakeholder identity negotiations for an organization in crisis: Fan perceptions of the National Football League. Paper presented at the Organizational Communication Mini-Conference, Rutgers University, New Brunswick, NJ.

- Jarvis, C. M. (2018, April). The transcendental ideograph: <Family> in the NFL's domestic violence crisis. Paper presented at the Central States Communication Association Conference, Rhetorical Theory and Criticism Division, Milwaukee, WI.
- Jarvis, C. M. (2017, November). How do you measure the soul of a city: Value negotiation at Mile High Stadium. Paper presented at the National Communication Association Conference, Dallas, TX.
- Jarvis, C. M. (2017, March). Speaking to stakeholders: Analyzing the NFL's response to the domestic violence crisis. Paper presented at the Eastern States Communication Association Conference, Boston, MA.
- Jarvis, C. M. (2016, October). Calling on the courts: The rhetoric of due process in the NFL's domestic violence scandal. Paper presented at the Global Summit on Politics, Sports, and Civic Engagement, Emerson College, Boston, MA.
- Jarvis, C. M. (2015, February-March). Intersecting attributed blame and news media genre: A case study of reporting on the Ray Rice scandal. Paper presented at the Western State Communication Association Conference, San Diego, CA.
- Jarvis, C. M. (2015, February-March). The violence paradox: Analyzing the NFL's response to domestic violence. Paper presented at the Western State Communication Association Conference, San Diego, CA.

RESEARCH GRANTS & AWARDS

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|-------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 2021 | <p>College of Liberal Arts Fellowship (\$43,000) <i>Competitively selected research fellowship awarded to support research interrupted by COVID-19.</i></p> <p>Alan H. Monroe Graduate Scholar Award <i>Awarded by the Brian Lamb School of Communication, Purdue University.</i></p> |
|-------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

2020

Brian Lamb School of Communication Doctoral Research Grant (**\$9,200**)

Competitive research funds awarded by Purdue's Lamb School of Communication to support independent research by doctoral students.

Promise Award (**\$1,500**)

Awards funded by the College of Liberal Arts to support international conference travel.

2019

Purdue Research Foundation Grant (**\$23,000**)

Competitively selected year-long research grant awarded by Purdue University and the College of Liberal Arts to support dissertation research.

Brian Lamb School of Communication Doctoral Research Grant (**\$7,700**)

Promise Award (**\$500**)

Awards funded by the College of Liberal Arts to maximize innovation and scholarly excellence in graduate student research.

Charles J. Stewart Doctoral Grant (**\$500**)

Competitive research funds awarded to doctoral students to support independent research projects.

Research Assistant, 2017-present

Critical Transitions in the Resilience and Recovery of Interdependent Social and Physical Networks. *Critical Resilient Interdependent Infrastructure Systems and Processes (CRISP) program, National Science Foundation. Co-PI: Seungyoon Lee.*

ACADEMIC APPOINTMENTS

Primary Instructor

Purdue University, West Lafayette, IN
Communication

Brian Lamb School of

COM 423—Leadership, Communication, and Organizations

Spring

2021

Through this course, students learn a variety of approaches and theories to leadership communication, conducting various case study analyses and developing their own leadership philosophy. Students engage in a semester-long research/service project of their choosing, working with groups or individually to engage in leadership practices.

COM 411—Communication and Social Networks

Fall 2020

This course introduces students to a variety of social network theories and advanced social network research methods using computational software. Students use software to collect, visualize, and analyze social network and communication data, gaining marketable experience in big data analytics. *Course rating: 4.6; Instructor rating: 4.9*

COM 328—Rhetorical Approaches to Diversity at Work

Fall 2018; Spring

2021

This course focuses on different philosophical conceptions of work as well as how to communicate the need for diversity at work. As the sole instructor for this course I developed the course syllabus, course lectures and activities, and provided feedback on student assignments. *Course rating: 4.1; Instructor rating: 4.3 (Fall 2018)*

COM 325—Interviewing: Principles and Practices

Spring 2020

This course is designed to introduce students to interviewing as a research method and as an important component of the employment process. Students gain practical experience through phone interviews, learn to conduct employment interviews, lead focus group research, and participate in field research. *Evaluations not completed because of COVID-19.*

COM 324—Organizational Communication

Spring 2018

This course serves as an introduction to theories and topics in organizational communication, with special attention paid to workplace and non-profit communication. As the sole instructor for this course I developed the syllabus, led in-class activities and lectures, and provided feedback on student assignments. *Course rating: 4.6; Instructor rating: 4.8*

COM 114—Introduction to Presentational Speaking

Fall 2017—Summer

2018

This course is a requirement for all Purdue students, with 25 students per section. This course typically has a wide variety of student majors. In this class I emphasize activity-based-learning and develop interactive, creative lessons. I provide feedback on student presentations. I taught two sections per semester and one summer section (5 sections total). *Course rating: 4.3; Instructor rating: 4.4*

Graduate Teaching Assistant

Purdue University, West Lafayette, IN
Communication

Brian Lamb School of

COM 204—Critical Perspectives of Communication Theory
2019

Fall 2018—Spring

This is a large lecture course designed as a pre-requisite for all Communication students and as a writing intensive course for all other students. As a teaching assistant, I attended lectures (taught by Dr. Josh Boyd), graded student assignments, and independently led two recitation sections each semester. During the semester I also led lecture for 100+ students.

Primary Instructor

Department of Communication, Media, &

Culture

Coastal Carolina University, Conway, SC

COMM 150—Media, Self, and the World
(Distance)

Fall 2020

Through this course, students are introduced to theories of media literacy. Through a variety of applied assignments, students gain a history and appreciation for media literacy and apply it to their own consumer behavior. This course was taught online.

COMM 274—Organizational Communication
(Distance)

Fall 2020

Through a case study approach, students are introduced to organizational communication theories. At the end of the semester, students produce a case study analysis of an organization of their choosing, critically interrogating the communication processes.

Primary Instructor

Emerson College, Boston, MA
Studies

Department of Communication

CC 100—Fundamentals of Speech Communication

Fall 2016—Spring 2017

This is an introductory speech course designed to embolden students to think creatively about presentations. In this course I provided activities that encouraged students to develop research and organizational skills and aesthetically pleasing visual aids. I taught this course 7 times at Emerson, on a 3 / 4 load.

Primary Instructor

Colorado State University, Fort Collins, CO
Communication

Department of

SPCM 200—Public Speaking
2016

Fall 2014—Spring

As instructor on record, I developed course content and graded student assignments. This course is designed as an introductory speaking course for all Colorado State students. Typically, I taught 2 sections per semester (6 sections total).

Graduate Teaching Assistant

Colorado State University, Fort Collins, CO
Communication

Department of

SPCM 433—Organizational Communication
2016

Spring

This course is designed to explore theories, perspectives, and approaches to organizational communication. As a teaching assistant I graded student assignments, met with students, and had the opportunity to lecture. Dr. Elizabeth Williams was the instructor on record.

SPCM 479—Communication Capstone

Spring

2016

This course is designed as the ultimate course for Communication majors to assist them in seeing the value and marketability in their degree. This course typically has 125+ students enrolled per semester. As a teaching assistant I graded student assignments and met one-on-one with students to help them prepare for the job market. Dr. Elizabeth Williams was the instructor on record.

SPCM 335—Gender and Communication

Fall

2016

This course is designed around a series of topics and theories to understanding the relationship between gender and communication. As the teaching assistant I graded student assignments, met one-on-one to supervise students' projects, and developed exam questions. Dr. Jen Bone was the instructor on record.

SERVICE & ENGAGEMENT

Service to the Community

Strategic Communication & Community Engagement Officer

Colorado River Fire Rescue, 2020 – present

Service to the Department and University

Purdue University

Purdue Cooperative Conversations Initiative, 2020 – present

Purdue Policy Research Institute, 2020 – present

Purdue Graduate Student Association, 2018 – 2019

Brian Lamb School of Communication, Purdue University

Teaching Mentor, 2020-present

Welcome Weekend Mentor, 2017– 2020

CGSA Graduate Student Representative, 2018 – 2019

CGSA Logistics Chair, 2018

Service to the Discipline

International Journal of Disaster Risk Reduction, Reviewer

International Journal of Sports Communication, Reviewer

New Media & Society, Reviewer

International Association of Communication and Sport

Reviewer for 2019 Summit

National Communication Association (NCA)

Reviewer for Applied Research Division, 2021

Reviewer for the Student Section, 2018, 2019

Reviewer for the Communication and Sport Section, 2018

Central States Communication Association (CSCA)

Reviewer for Graduate Student Caucus, 2018

Memberships in Professional Organizations

National Communication Association (NCA), 2016-2021

International Communication Association (ICA), 2017; 2020-2021

Eastern States Communication Association (ESCA), 2016; 2019; 2021

Central States Communication Association (CSCA), 2018; 2020

Western States Communication Association (WSCA), 2015

Presentations, Guest Lectures, and Colloquia

Jarvis, C. M. (2018, February). Divisive discourses: Inter-institutional rhetoric in the case of the NFL versus President. Paper presented at the Communication Graduate Student Association Conference, West Lafayette, IN.

Jarvis, C. M. (2015, February). The violence paradox: Analyzing the NFL's response to domestic violence. Paper presented for department colloquium, Department of Communication Studies, Colorado State University, Fort Collins, CO.

Jarvis, C. M. (2015, November). Intersecting attributed blame and news media genre: A Case study of reporting on the Ray Rice scandal. Poster presented at the 2015 Colorado State University Graduate Student Showcase, Colorado State University, Fort Collins, CO.

Jarvis, C. M. (2016, September). Guest class lecture. Presented on the relationship between gender and sports, focusing on dualisms in mediated depictions of male and female athletes. Colorado State University course SPCM 335: Gender and Communication.

Jarvis, C. M. (2015, February). The framing of post-feminist rhetoric: Parody as a tool to combat feminist thought. Poster presented at the 2015 Colorado State University Graduate Student Showcase, Colorado State University, Fort Collins, CO.

REFERENCES

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100 N. University Street
West Lafayette, IN 47907
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Beering Hall, Room 2168
100 N. University Street
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