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A Qualitative Overview of the Infertility Process in Women: Infertility Psychological Counseling*

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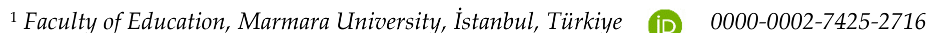
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ABSTRACT

It is important to examine women's experiences in the infertility process, as being a woman is perceived as a concept that overlaps with motherhood, and the woman herself is exposed to physical pain during the treatment. In this research, which was carried out with a phenomenological pattern, one of the qualitative methods, the experiences of married women diagnosed with infertility regarding the infertility process were examined, and it was tried to determine the themes that would help psychological counselors in the therapeutic process. The study group consists of 10 women selected by criterion sampling using purposeful sampling methods. The results of the research were discussed under seven headings: infertility experience, stress factors, acquired skills, social support resources, the role of the spouse, coping skills, and belief in the treatment. The theme of the infertility experience includes codes of negativeness, helplessness, frustration, and compelling; the theme of stress factors includes codes of expectations, pressure, uncertainty, the passage of treatment, personal conflicts, against his spouse's liability, failure, and the search for a solution; the theme of acquired skills includes codes of coping with the challenges, obtaining medical information, hoping, common share, body recognition, gender awareness, healthy eating, the theme of social support resources includes codes of, contact, spouse, family, friend, and counselor; the theme of the role of spouse includes codes of support; the theme of coping skills includes codes of, religious beliefs, social activities, the sense of common humanity, work and psychological support; the theme of faith for treatment includes codes of hope and despair.

Keywords:
Women, infertility, psychological counseling

1. Introduction

The family has a great role in raising people in accordance with social and cultural needs and ensuring the continuity of the generation (Dalaner, 2000). This role is performed by fulfilling the reproductive and fertility tasks, which are one of the basic instincts of mankind (Drosdzol & Skrzypulec, 2009). Almost every married couple makes family plans, but some couples have difficulties having children or having children (Sezgin & Hocaoğlu, 2014). This situation, known as infertility, is one of the most important problems concerning public health, but it is an economically challenging, physically uncomfortable event that damages relationships for every couple who wants to have a child (Stocker et al., 2016). Infertility is defined as the absence of pregnancy despite at least one year of unprotected and regular sexual intercourse (Sezgin & Hocaoğlu, 2014; Allan & Mounce, 2015, Peyromusavi et al., 2016).

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The incidence of infertility varies in each country and is increasing day by day in Turkey (Çavuşoğlu, 2015). It is stated that approximately 30% of infertility is caused by women or men, 25% is caused by women and men, and 15% is unexplained infertility (Fisher et al., 2008). In a study conducted in Turkey, it is seen that the rate of female infertility was 27%, male infertility was 25%, both couples were 13%, and the rate of unexplained infertility was 35% (Altıntop & Kesgin, 2018). Biological problems that cause infertility are explained by health problems such as inability to ovulate, malignant tumors, age, obstruction of the tubes, endometriosis, and thyroid (Deyhoul et al., 2017) for women, while age in men, problems related to the male reproductive organ, including inability to produce sperm and its function (Clinic, 2011).

Infertility, considered a life crisis, is a biological health problem and an important issue that negatively affects the mental health of couples and reduces their life and marital satisfaction (Daniluk & Tench, 2007; Orshan, 2008). In studies conducted with couples who are faced with infertility problems, it has been found that it affects not only the communication of couples with each other but also their social environment; however, it has been revealed that it affects the sexual lives of the spouses, their dreams and expectations for the future, their self-perceptions, and their body perceptions (Mousavi et al., 2013; Oskay et al., 2010; Schwerdtfeger, 2009). However, infertile couples can experience intense feelings of loneliness, helplessness, jealousy, and anger by feeling excluded by society (Watkins & Baldo, 2004). Although it is known that both couples experience depression, anxiety, and stress, since having a child is an important value for the family structure, and since being a woman is perceived as a concept that overlaps with motherhood and the woman herself is exposed to physical pain during the treatment, the infertility process affects women more negatively (Coleman et al., 2006; Drosdzol & Skrzypulec, 2009; Karjane et al., 2008; Noorbala et al., 2009; van Balen and Bos, 2004). In this study, women diagnosed with infertility were studied in this direction.

In the first studies on the effects of infertility problems on mental health, since studies on the diagnosis of the disease and the treatment process are insufficient, the causes of infertility have been tried to be explained psychologically. In this direction, the psychogenic infertility model was introduced in the 1930s (Benedek, 1952). According to this model, it is thought that women's irrational beliefs about motherhood and unhealthy maternal attitudes prevent them from becoming mothers biologically (Fischer, 1953). In men, it was thought that infertility problems were experienced due to mothers' controlling attitudes, men's unwillingness to be deprived of their mother's love, and superego-related thoughts (Belonoschkin, 1962). In addition to these studies, Covington and Burns (2006) state that women who have difficulty in coping with difficult situations cannot separate from their mothers, cannot express their negative feelings, are worried about pregnancy and motherhood, and their sexual life is not good, so they experience infertility. On the other hand, it is stated that struggling women cannot experience pregnancy because they can direct their competitive feelings toward their child when they have a child. Stanton and Dunkel-Schetter (1991) emphasized the importance of studies protecting couples' mental health in the United States in the 1970s, noting that developmental and stage models and psychological outcome approaches incorporating crisis and bereavement theory emerged in the 1970s. According to this approach, couples facing a crisis situation cannot complete the task of productivity development and enter the grieving process. Then, van Balen and Inhorn (2002) state that the cyclical psychology and psychosocial context models have been put forward. The circular psychology model emphasizes that couples who cannot have a child experience some changes in their bodies due to intense stress that negatively affect the treatment (Wischmann, 2003). On the other hand, the psychosocial context model states that the infertility problem is not only a problem between couples but also affects the family; at the same time, he emphasizes that the social and cultural structure also affects infertile couples.

Based on the approaches related to the infertility problem, it is possible to say that couples experience intense stress, especially caused by uncertainty, and face a crisis situation (Upkong & Orji, 2006). According to Stanton and Dunkel-Schetter (1991), it is important to examine stress and coping methods with infertile couples in depth Thus, it is believed that the psychological problems caused by the infertility treatment process make infertility counseling necessary. When examined, studies show that the counseling service positively affects the treatment process (Matsubayashi et al., 2003;¸van den Broeck et al., 2010). However, there are insufficient studies on the counseling service provided for couples in the diagnosis and treatment process of infertility. There are deficiencies in how a useful counseling process will be, and it has been revealed that intervention programs do not have clear and concrete content (Clapp & Adamson, 2006; Çoşkun et al., 2009).

In the research, being able to step into the infertility treatment process (Clapp and Adamson, 2006; Yılmaz and Oskay, 2015); making decisions about operations (Ramezanzadeh et al., 2006); being able to adapt to the subjects in which one is successful to protect one's self-esteem (Upkong & Orji, 2006); being able to remove negative emotions such as stress (Kaplan, 2018); increasing psychological resilience in the case of unsuccessful treatment (Yılmaz & Oskay, 2015); the ability to apply to social support resources and to provide physical relief by using relaxation techniques (Hsu & Kuo, 2002) are seen as important factors that make the individual strong. For this reason, it is thought that creating an intervention approach by including these issues in infertility counseling will positively affect the process. In summary, this study aims to contribute to the development of counseling services that can minimize the impact of infertility on couples by using therapeutic counseling models as mental health professionals at all stages of the treatment process. In this direction, the main question of the research is, "What are the opinions of married women diagnosed with infertility regarding the infertility process? The main question of the study was answered by seven sub-questions asked by women in the interviews;

1. Can you evaluate your feelings and thoughts about your infertility experience?
2. What are the factors that create stress for you about infertility and affect you negatively?
3. What skills have you acquired in the infertility process and what positive results have you experienced?
4. How do you evaluate your sources of social support in the infertility process?
5. How do you evaluate your partner's role in the infertility process?
6. What are your sources for coping with the problems and negative situations you experience during the infertility process?
7. How do you evaluate your belief in treatment?

2. Methodology

2.1.Research Model

This study is a qualitative descriptive study created to examine the experiences of women diagnosed with infertility regarding the infertility process. Willis et al. (2016) state that qualitative descriptive studies aim to describe the thoughts or opinions of individuals about an event or phenomenon. Phenomenological design, one of the qualitative research methods, was used in the research. Phenomenology is a qualitative research method that allows people to express their understanding, feelings, perspectives, and perceptions about a particular phenomenon or concept and is used to describe how they experience this phenomenon (Rose et al., 1995). In this direction, the views of women on the phenomenon of infertility were examined in this study. In this study, the "semi-structured interview" technique was used to determine the experiences of married women diagnosed with infertility regarding the infertility process.

2.2.Research Sample

The study group consists of 10 women selected by criterion sampling using purposeful sampling methods. In this sample, the inclusion criteria for the women participating in the study were: volunteering to participate in research; being married for at least three years; and being diagnosed with infertility by a gynecologist. Information on women is presented in Table 1

Table 1. *Information About the Participants*

W	Age	Educational Status	Profession	Duration of Infertility	The Cause of Infertility	Treatment Process
1	27	Y. Undergraduate	P.Advisor	13 months	Polycystic ovary	Vaccination
2	31	Undergraduate	Officer	5 years	Low AMH	IVF
3	35	Undergraduate	Teacher	3 years	The reason is unexplained	IVF
4	43	Secondary school	Worker	4 years	Age, Uterine Fibroids	IVF
5	30	Undergraduate	Officer	5 years	The reason is unexplained	IVF
6	34	High school	Teacher	6 years	The reason is unexplained	IVF
7	29	Y. Undergraduate	P.Advisor	1 year	The reason is unexplained	Egg Tracking
8	33	High school	Housewife	5 years	Low AMH	IVF
9	29	Postgraduate	Academician	4 months	Polycystic ovary	Egg Tracking
10	31	Undergraduate	Teacher	20 months	The reason is unexplained	Vaccination

The women participating in the study are between 27-43 years old, and their average age is 32.2. 1 of the women is a secondary school graduate (10%), 2 of them are high school graduates (20%), 4 of them are undergraduate graduates (40%), 2 of them are graduates (20%), and 1 of them is a doctoral graduate (10%). The time elapsed after women are diagnosed with infertility is in the range of 4 months and 6 years.

2.3.Data Collection Tools and Procedure

Within the scope of this study, the "Personal Information Form" was used to obtain the demographic data of women, and the "Semi-Structured Interview Form" was used to conduct the interviews. The experiences of women regarding the infertility process were obtained through semi-structured interviews. An interview is a process of mutual and interactive communication based on the style of asking and answering questions, which is predetermined and made for a purpose (Yıldırım ve Şimşek, 2016). The use of semi-structured interviews here is useful because they are quite flexible, and therefore, new questions can be asked depending on the process during the interview (McLeod, 2014). In addition, it is thought that the validity of the research increases in terms of the interviewer's ability to ask for explanations from the other party and determine the direction of the interview (Szombatová, 2016).

Before preparing the questions to be directed to the women, the current information about the infertility diagnosis and treatment process, psychological needs, and current articles in the related literature were examined, and the topics of the interview were formed. While creating the research questions, questions were prepared by considering the characteristics of the developmental period of women and the literature on infertility psychological counseling, social support, coping skills, and hope concepts. Based on the objectives of the study, the questions to be asked by the researchers in the interview were planned. In this process, the opinions and information of three field experts were consulted, and changes were made based on their feedback. Ten questions were prepared with expert support and used in interviews.

The "Personal Information Form", which is used to obtain the demographic data of women, consists of age, education level, occupation, the status of having a child before, how long they want to have a child, the diseases that cause infertility, and the treatment during the infertility process.

Before the data collection process, ethics committee approval was obtained from a state university's Social and Human Sciences Ethics Committee (Meeting No. 2022.01). In addition, no information regarding the identity of the participants was collected within the scope of the research. In the consent form, information about the purpose of the study and the people conducting the study was shared, and it was stated that the participant's information would be kept confidential and that they could quit the study at any time. Participation in the study was on a voluntary basis. Participants were informed about the purpose and process of the research and that they could leave at any time. Semi-structured interviews were conducted after obtaining written and verbal informed consent from the women who participated in the research. Informed consent was given to the women in the form of informed consent that the interviews with the women would be recorded on a voice recorder, and they were recorded with a voice recorder after obtaining their verbal and written permission. Afterward, the recordings were played to the women, and they were informed that the sentences they did not find appropriate would not be included in the study.

2.4. Data Analysis

A descriptive analysis was performed in the analysis of the data obtained from the research. Descriptive analysis is an analytical technique in which the data obtained are summarized and interpreted according to a predetermined theme, direct quotations are used to reflect the views of the interviewees strikingly, and the results are interpreted in the context of the subject (Yıldırım & Şimşek, 2016). When performing descriptive analysis in the research, a framework for descriptive analysis was first created. The previously established conceptual framework and themes are discussed here. In the second stage of the analysis, reading, editing, and processing of data obtained from children according to the themes determined were carried out. In the coding part of the data in the second stage, the coding type mentioned by Corbin and Strauss (1990) was used according to the previously determined concepts. In the third stage, the findings obtained were defined by quoting directly, and in the fourth stage, the findings obtained were interpreted. During the data analysis, the MAXQDA computer software program was used to help the researcher systematically evaluate and interpret qualitative texts (Yakut-Çayır & Sarıtaş, 2017).

According to the ethical principles of qualitative research, the names of the women participating in the study were not included, and each woman was listed in (W) format and quoted. However, the label in the middle of all the figures in the findings shows the theme, while the other labels show the codes. The circles belonging to the labels show the women expressing that code.

2.5. Validity and Reliability

In order to ensure validity in the research, first of all, the study's theoretical framework was formed by scanning the literature on the research topic. It explains how the semi-structured interview questions, the qualitative pattern of the research, and the qualitative data collection tool were created. In order to collect appropriate and sufficient data during the data collection phase, it was aimed to make participants participate in the study by using the purposeful sampling method and the criteria established. In order to reach the correct information at the end of the research, it was stated that the identity information of the participants would be kept confidential and that their participation in the research was voluntary. In order to avoid data loss during the data collection phase of the study, an audio recording was made with the approval of the women. The data collection process for the research and the analysis of the data are also described in detail. In the data analysis, first of all, the researchers deciphered the audio recordings. The research method section reports the research model, study group, data collection tool, data collection, and analysis time in detail. After the interviews were conducted, the audio recordings were deciphered, and the interviews with each woman were transcribed and forwarded to them. The accuracy of what the women said was confirmed again, and the study's internal validity was ensured. None of the women participating in the study requested changes.

In order to ensure reliability in qualitative analysis, the themes and their codes were checked by each researcher separately (Creswell, 2016). In addition, in order to ensure its reliability, the data obtained from the interviews were reviewed and checked by the researchers at different times. Similarity, which is the consensus among the coders, is calculated using the formula: Confidence/Percentage of Agreement = Consensus / (Consensus + Disagreement) X100, . The consensus among coders should be at least 80% (Miles & Huberman, 1994). In this study, the percentage of consensus was determined to be 90%. Again, the codes and themes created to ensure reliability were examined by 2 faculty members who are experts in the field of psychological counseling and then checked to see whether the codes fit the themes.

2.6. Ethical

This research was carried out with the permission of Marmara University Social and Humanities Ethics Committee dated 25/01/2022 and numbered 2022/01.

3. Findings

In this study, it is aimed to examine the experiences of women regarding the infertility process. Considering the purpose of the research and the interview questions, the opinions of women were analyzed under seven main themes determined in advance. The identified themes are listed as follows: 1) the infertility experience; 2) stress factors; 3) acquired skills; 4) sources of social support; 5) the role of the spouse; 6) coping skills; and 7) belief in the treatment. These themes have been framed for the purposes of the research. The themes related to women's infertility experience are shown in Figure 1.

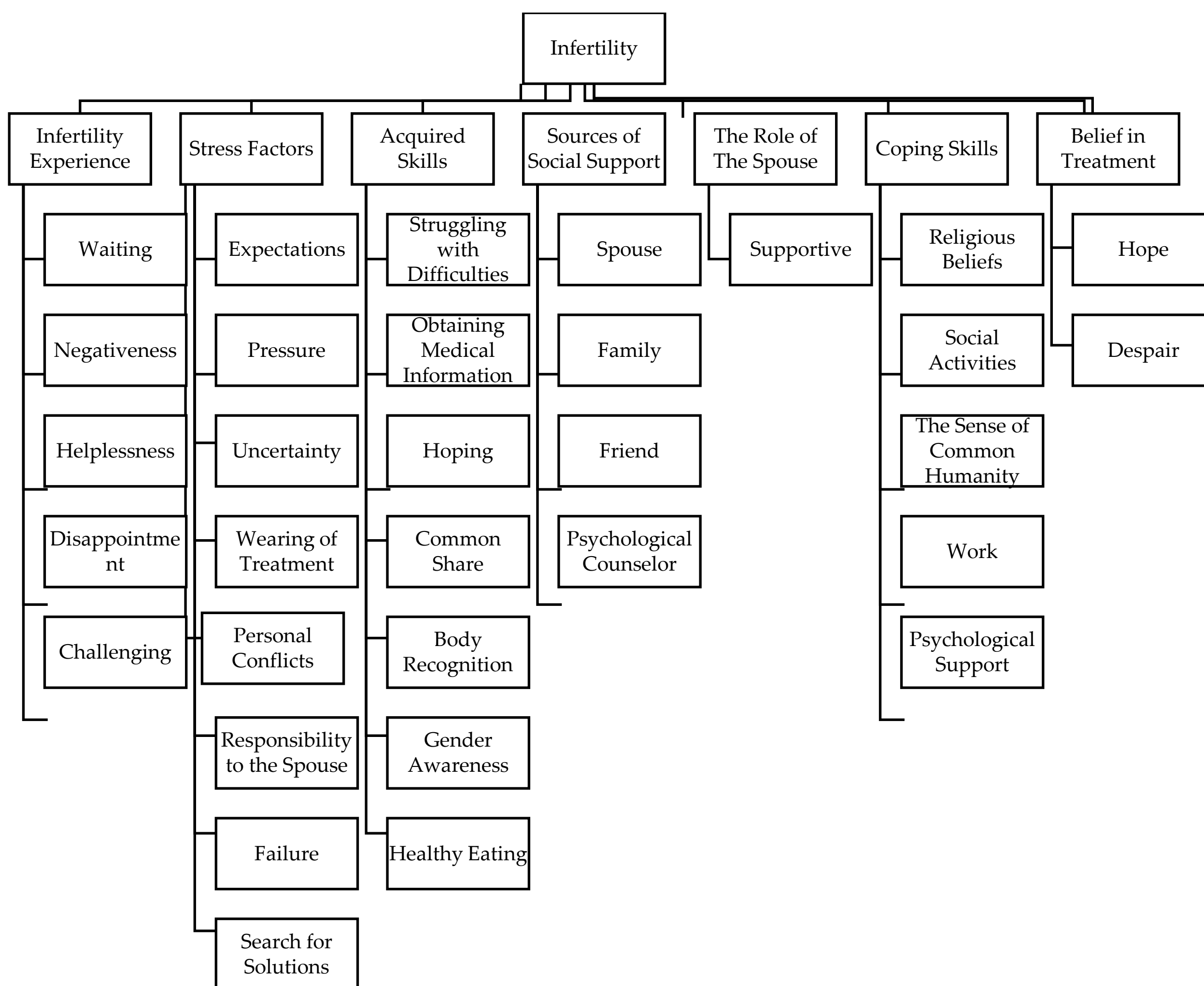

Figure 1. *Themes Related to Women's Infertility Experience*

As shown in Figure 1, the themes are covered in seven topics: infertility experience, stress factors, acquired skills, sources of social support, the role of the spouse, coping skills, and belief in the treatment. The theme of the infertility experience includes codes of negativity, helplessness, frustration, and compelling; the theme of stress factors includes codes of expectations, pressure, uncertainty, the passage of treatment, personal conflicts, failure, and the search for a solution; The theme of skills gained includes codes for tackling the challenges: obtaining medical information, hoping, mutual sharing, body recognition, gender awareness, healthy eating, The theme of social support resources includes codes of contact, spouse, family, friend, and counselor; the theme of the role of spouse includes codes of support; the theme of coping skills includes codes of religious beliefs, social activities, the sense of common humanity, work, and psychological support; and the theme of faith for treatment includes codes of hope and despair.

3.1.Infertility Experience

As a result of the interviews conducted to examine women's experiences regarding the infertility process, the first theme that emerged as a result of the interviews was "Infertility Experience." The infertility experience theme consists of waiting, negativeness, helplessness, disappointment, and challenging codes. The following are the findings related to these themes and codes:

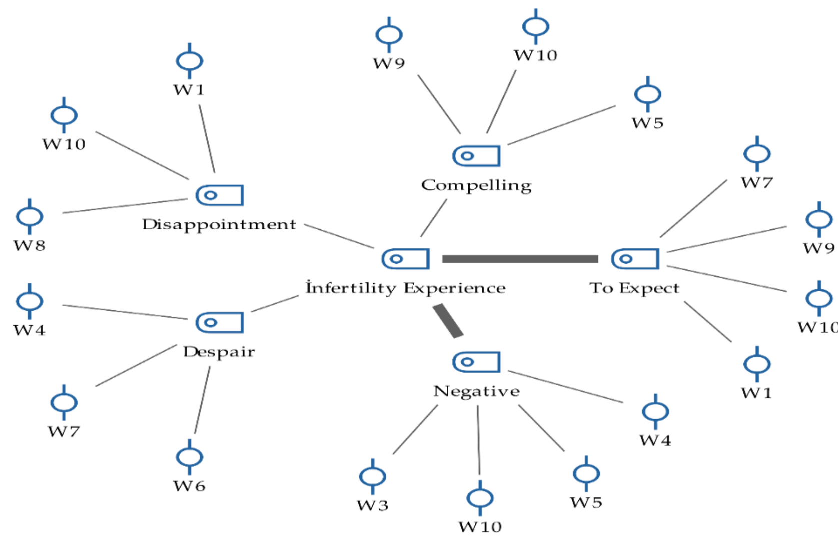

Figure 2. *Code Map on the Theme of Women's Infertility Experience*

As shown in Figure 2, the women participating in the study expressed their infertility experience as a process that includes negative experiences (f=4) and waiting (f=4). However, women reported that the infertility process was disappointing (f=3), helpless (f=3), and challenging (f=3). Examples of such statements by women are as follows:

W4: "The situation of not having children is a very difficult process. The person feels helpless and unhappy. You are thinking about what kind of research you are going to get into and trying to find a cure".

W5: "It is a difficult, patience-demanding process in which intense negative thoughts prevail at the slightest negativity, which makes me extremely difficult, especially in the social environment."

W10: "I wish I had never experienced it. It's a very tiring and stressful process. It's like life has gone by, and I stayed behind it for a year and a half. It is very tiring to experience the same disappointment every month. I was so afraid it would become an obsession. But it has come".

3.2.Stress Factors in the Process of Infertility

As a result of the interviews conducted to examine women's experiences regarding the infertility process, the second theme that emerged was "Stress Factors." The theme of stress factors consists of expectations, pressure, uncertainty, the wearing of treatment, personal conflicts, responsibility to the spouse, failure, and the search for solution codes. The following are the findings related to these themes and codes.

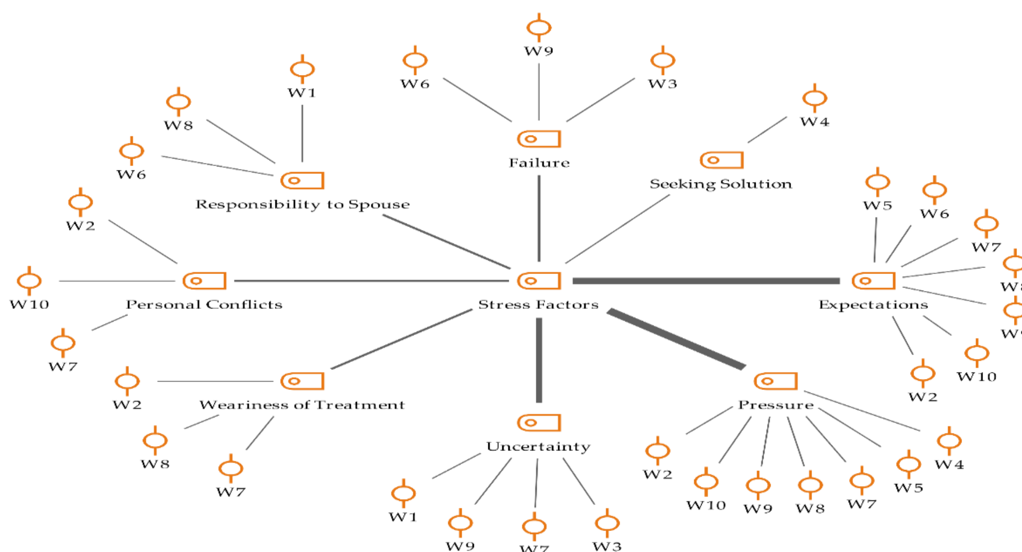

Figure 3. *Code Map for the Theme of Stress Factors*

Figure 3 shows that women experienced the most stress due to pressure (f=7) and expectations (f=7) during the infertility process. However, women also noted that factors such as uncertainty (f=4), wearing of treatment (f=3), personal conflicts (f=3), responsibility to the spouse (f=3), failure (f=3), and the search for a solution (f=1) also create stress. Examples of such statements by women are as follows:

W2: "Prejudiced, questioning opinions from the environment. Pressures that are made in the family, albeit slightly. Personal psychological conflicts and the fact that the process is exhausting".

W7: "It is a long-term process, full of uncertainties; we take tests every month and wait for the result. Not being able to share this situation with everyone. Social pressures, expectations, and longing for a baby".

W9: "Also, of course, expectations from the environment, people's asking, 'When do you think about children?' etc., cause stress because I do not want to tell about the treatment process except for my relatives. I hope it's for the best; I'm avoiding it by saying that at the best time".

3.3.Acquired Skills in the Process of Infertility

As a result of the interviews conducted to examine women's experiences regarding the infertility process, the third theme that emerged was "Acquired Skills." The acquired skills theme consists of struggling with difficulties, obtaining medical information, hoping, sharing, body recognition, gender awareness, and healthy eating codes. The following are the findings related to these themes and codes:

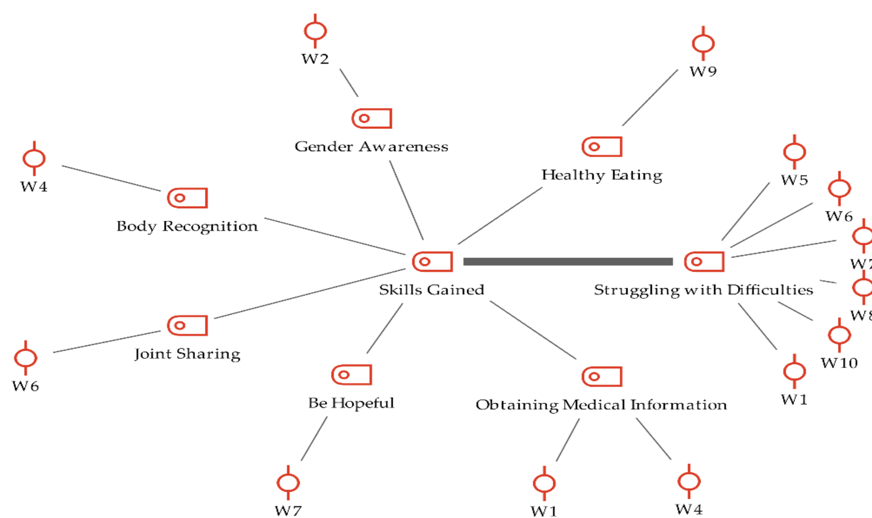

Figure 4. *The Code Map for the Theme of Acquired Skills*

As can be seen from Figure 4, women acquired the most ability to struggle with difficulties in the infertility process (f=6). On the other hand, women were able to acquire the skills of medical information (f=2), hope (f=1), sharing (f=1), body recognition (f=1), gender awareness (f=1), and healthy eating (f). =1) Examples of such statements of women are as follows;

W1: "I have learned a lot about obstetrics and gynecology. I'm learning to fight failure".

W6: "I think I have matured even more. I start creating solutions after a certain period of facing negatives. I am able to exchange ideas with friends who are experiencing the same situation as me".

W8: "I can approach my daily problems and family problems more moderately and maturely. I don't mind everything".

3.4.Social Support Sources in the Process of Infertility

As a result of the interviews conducted to examine women's experiences regarding the infertility process, the fourth theme that emerged was "Sources of Social Support." The theme of social support resources consists of spouse, family, friend, and psychological counselor codes. The following are the findings related to these themes and codes.

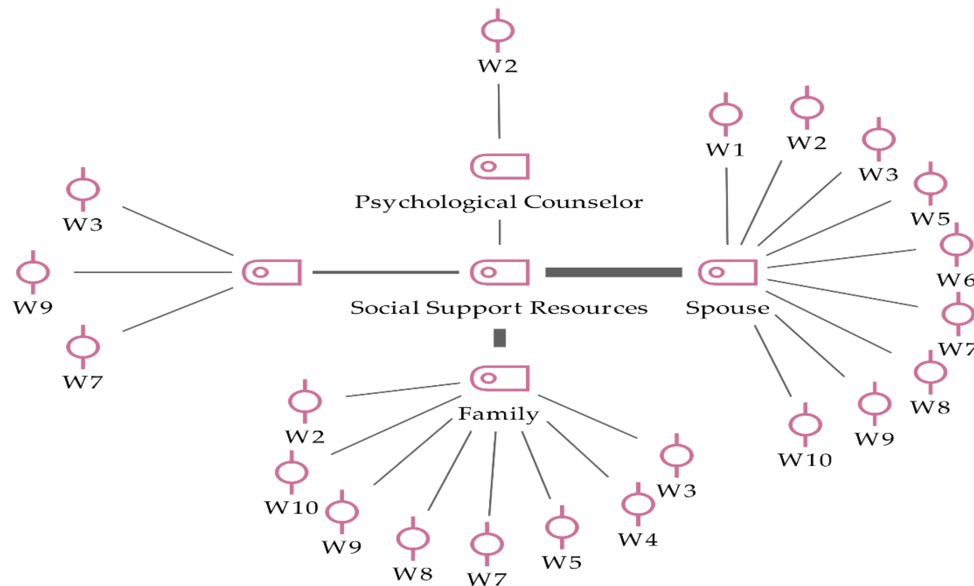

Figure 5. *Code Map for the Theme of Social Support Resources*

As shown in Figure 5, women diagnosed with infertility stated that they received the most social support from their spouses (f=9) and families (f=8) during the infertility process. However, some women also receive support from their friends (f=3) and psychological counselors (f=1). Examples of such statements by women are as follows:

W2: "My husband. As the person with whom I lived the process, he was always by my side and never took it to personal judgment. My parents and my mother. My mother is the one with whom I share my feelings and receive support in a material and spiritual sense. My consultant. In this process, psychological support meets my need and helps me cope with my deficiency".

W4: "I see the greatest support from my own family. They are constantly trying to be with me, both financially and spiritually. They keep me informed of new developments in this field and constantly suggest and give ideas".

W9: "First of all, of course, my husband. Then my mother and brother, and a few friends. My husband is very positive about this issue, he says that medicine has progressed a lot, and he definitely believes it will happen. He says that even if it doesn't, it doesn't matter to me. It's not a situation that will affect our marriage. I married you. I didn't marry for the child. He says God gives or not. It is something extra and always supports me when I feel bad. He never lowers his own morale, which affects me positively. My mother says that she will be my brother. It is a temporary process. They accept this situation as normal. My friends also say that everyone has these problems, and eventually they have children. During my treatment process, they asked what I did and were interested. They are constantly giving hope".

3.5.The Role of the Spouse in the Process of Infertility

As a result of the interviews conducted to examine women's experiences regarding the infertility process, the fifth theme that emerged was "The Role of the Spouse." All of the women participating in the study stated that their partners have a supportive role in the infertility process. Examples of such statements by women are as follows:

W3: "My husband has never asked me to get treatment anyway. Let it stand by itself. Not everyone has to have a baby, he said. He was very supportive of me".

W7: "My husband is actually setting an example for me by waiting with understanding and patience. Although it makes me feel good from time to time because there are no negative feelings as if it will never happen, sometimes I feel like he is taking it simple, and I get angry. Although I know that such a thought did not pass through him, I am offended because he expects more attention".

W10: "My husband is my optimistic side. He is my biggest supporter, with his positive attitude and his constantly optimistic opinion. No matter how long this process will take, I hope not, and I know that he will always be with me".

3.6.Coping Skills with Infertility

As a result of the interviews conducted to examine women's experiences regarding the infertility process, the sixth theme that emerged was "Coping Skills." The theme consists of religious beliefs, social activities, the sense of common humanity, work, and psychological support codes. The following are the findings related to these themes and codes:

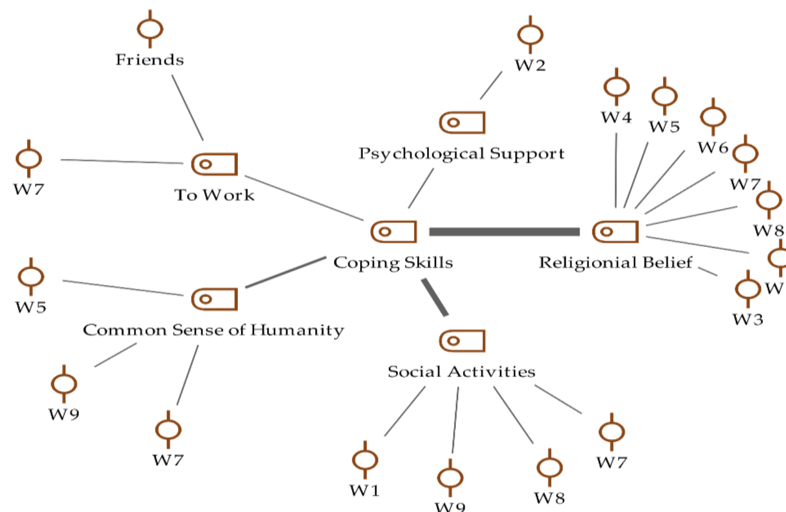

Figure 7. *The Code Map for the Theme of Coping Skills*

As can be seen from Figure 7, women benefited the most from their religious beliefs (f=7) to cope with the infertility process. However, women coped with the infertility process through social activities (f=4), the common sense of humanity (f=3), working (f=2), and psychological support (f=1). Examples of such statements by women are as follows:

W5: "The observation that many people have had such experiences has helped me cope. My existential faith, husband, and family are among the biggest factors in my ability to cope with this experience".

K7: "Firstly, I'm not the only one experiencing this problem, and this is a fact of life. There are too many who encounter this situation, have a successful treatment process, and take their baby into their arms. Positive thoughts such as "maybe it will be late, but somehow I will become a mother too," etc., do me good. I already have a busy life. I usually work. Spending most of the day working, producing, and being with my students strengthens me. My belief is also very effective".

W9: "I think I'm doing my best by going to the doctor, which relaxes me. After doing my best, I think it's a destiny because some people have children even if they don't want them, which means that child has to be born and live. Although some people want it very much, it doesn't happen. I think it's a matter of luck, regardless of the circumstances. That's why I try to rely on a little more spiritual resources and think according to my religious beliefs. Another source is the support of my relatives. As I explained above, although I do not have children, there are people who love and care about me, and being in a close relationship gives me the strength to cope".

3.7. Belief in Treatment

As a result of the interviews conducted to examine the experiences of women diagnosed with infertility regarding the infertility process, the seventh theme that emerged was "belief in treatment." The theme of belief in treatment consists of the codes of hope and despair. The following are the findings related to these themes and codes:

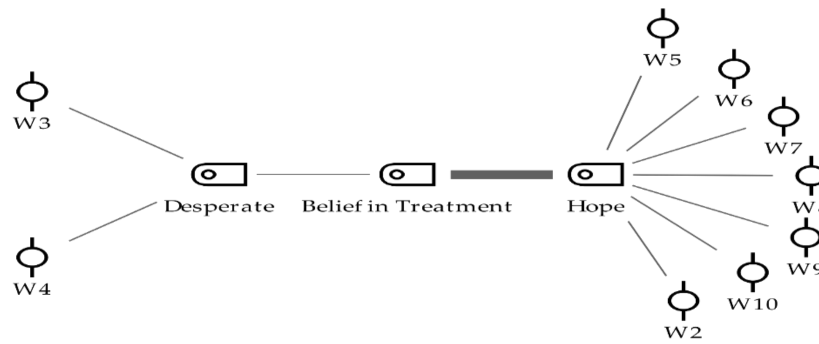

Figure 8. *The Code Map for the Theme of Faith in Treatment*

As can be seen from Figure 8, most of the women indicated that they were hopeful about their treatment during the infertility process (f=7). However, two women are hopeless opponents of the treatment process. Examples of such statements by women are as follows:

W4: "I paused the treatment because I was hopeless right now. We are worried about trying again because our efforts have not been fruitful, so we are not willing to try".

W5: "If the treatment is not successful, I will consider alternative situations in my life where I will make up for this failure. But my belief in success is connected with my belief in existence. If success is a miracle, I could be pregnant at any moment".

W6: "No matter what the end of treatment is, it should be finished, not wandering. If there is no result after the end of one treatment, it is necessary to start another treatment. So everything becomes easier".

4. Conclusion, Discussion and Recommendations

This study is a phenomenological study based on qualitative research designs created to examine the experiences of women diagnosed with infertility regarding the infertility process, and the findings of the study were discussed in the light of the literature. In the study's first finding, they stated that women diagnosed with infertility experience a state of helplessness caused by waiting for a long time and will likely experience disappointment and struggle with their lives if the treatment process ends in negativity. In studies on the experiences of women struggling with infertility problems; It has been revealed that women experience intense negative emotions such as anger, disappointment, helplessness, sadness, loneliness, despair, pessimism, and anxiety in this process (Aarts et al., 2011; Fieldsend & Smith, 2020; Gözüyeşil et al., 2020; Karaca & Ünsal, 2015; Kaya & Oskay, 2019; Mete et al., 2019).

According to the second finding from the study, women experience the most stress due to pressure and expectations in the process of infertility. However, women also noted that factors such as uncertainty, the wearing of treatment, personal conflicts, responsibility to the spouse, failure, and the search for a solution also create stress. There are findings in the literature that coincide with the results of this research. Experiencing conflicts due to infertility problems, entering the divorce process, and marrying another spouse (Dimkpa, 2010; Obeisat et al., 2012; Sami & Ali, 2012; Taghipour et al., 2020; Wiersema et al., 2006), exclusion of women by the society, and being alone (Khodakarami et al., 2009; Kırca & Pasinlioğlu, 2013; Martins et al., 2013); verbal and physical assault by the social environment (Omoaregba et al., 2011), rejection by the spouse's family, and uncertainties about the infertility process (Yong et al., 2000;) cause stress.

According to the third finding, women acquired the most ability to cope with difficulties in the infertility process. In addition, women acquired medical knowledge, hope, shared sharing, body recognition, gender awareness, and healthy eating skills. This finding is in parallel with the studies conducted in the literature. Studies have shown that women return more to themselves, pay more attention to their bodies and nutrition, do not allow others to enter their personal boundaries, share more role responsibilities at home, and spend more time with the social environment (Afshani et al., 2019; Duymaz-Diler, 2020; Kroemeke & Kubicka, 2018; Yanık, 2021).

According to the fourth finding obtained from this study, women diagnosed with infertility stated that they received the most social support from their spouses and families during the infertility process. However, some women also receive support from friends and psychological counselors. Similarly, studies have shown that

women mostly receive support from their spouses, relatives, friends, and mental health professionals during the treatment process so that they can cope with negative situations such as depression, stress, and anxiety in a healthy way (Bayley et al., 2009; Gülseren et al., 2006; Lemmens et al., 2004; Noorbala et al., 2008).

According to the fifth finding of the study, all of the women who participated in it stated that their spouses played a supportive role in the infertility process. In the related literature, the majority of women feel the support of their spouses, and their spouses understand that thus the level of satisfaction from marriage is high (Altıntop & Kesgin, 2018; Benli, 2010; Gameiro et al., 2015; Lee et al., 2010; Massarotti et al., 2019; Seymenler & Siyez, 2018; Yanıkkerem, 2008); it is also known that the spouses approach the infertility treatment process with a very critical and humiliating attitude, therefore, and therefore the process is interrupted (Podolska & Bidzan, 2011; Sezgin & Hocaoğlu, 2014;).

According to the sixth finding obtained from the study, women mostly benefited from their religious beliefs to cope with the infertility process. However, women have coped with the infertility process with social activities, a common sense of humanity, and psychological support. This finding supports the results of similar studies. It has been revealed that women who are faced with infertility problems mostly resort to social support resources, participate in community service practices voluntarily, feel stronger with the support of their spouse and family, and benefit from relaxation exercises such as yoga and meditation as well as religious rituals (Altıntop & Kesgin?????). , 2018; Benli, 2010; Gameiro et al., 2015; Kuş, 2008; Lee et al., 2010; Massarotti et al., 2019; Seymenler & Siyez, 2018; Yanıkkerem, 2008;).

According to the seventh finding from this study, most of the women indicated that they were hopeful about their treatment during the infertility process. However, two women are desperate for the treatment process. When the relevant literature is examined, it is seen that there are individuals who have both hope and despair in the infertility process. The reason for this is that women who have been dealing with infertility treatment for many years and have failed many times have a hopeless attitude, but people who have just started the process and have not yet applied medical reproductive techniques are more hopeful (Ataman, 2007; Keskin & Gümüş, 2014; Shindel et al., 2008).

This study aimed to examine the experiences of women diagnosed with infertility regarding the infertility process. For this purpose, the national and international literature discussed infertility experience, stress factors, acquired skills, sources of social support, the role of the spouse, coping skills, and belief in treatment. Infertility is a biological, psychosocial, and economic crisis that affects couples and other family members (Seymenler & Siyez, 2018). In the process of infertility diagnosis and treatment, couples need psychological support and social support resources (Aşcı & Beji-Kızılkaya, 2012). Today, a new field that requires expertise has emerged: infertility psychological counseling. However, it is known that the content of psychological counseling sessions is still insufficient to be concrete and clear (Speroff & Fritz, 2020; Yanık, 2021; Zeren, 2016). When the approaches, models, and intervention systems related to infertility are examined, first of all, a model, which includes the topics of informing couples about sexuality, infertility diagnosis, and treatment, creating realistic and concrete expectations and goals, gaining the ability to cope with crisis and stress in a healthy way, applying to social support resources, instilling hope, creating alternative solutions (adoption, living a life without children), and strengthening psychological resilience, can be suggested (Clapp & Adamson, 2006; Mokhtari-Sorkhani et al., 2022; Sorkhani et al., 2022; Yılmaz & Oskay, 2015; Kaya & Oskay,2019). However, individual and group counseling sessions, including the themes generated in this study shown in Figure 9 (including infertility experience, stress factors, acquired skills, social support resources, the role of a spouse, coping skills, and belief in treatment), can be configured.

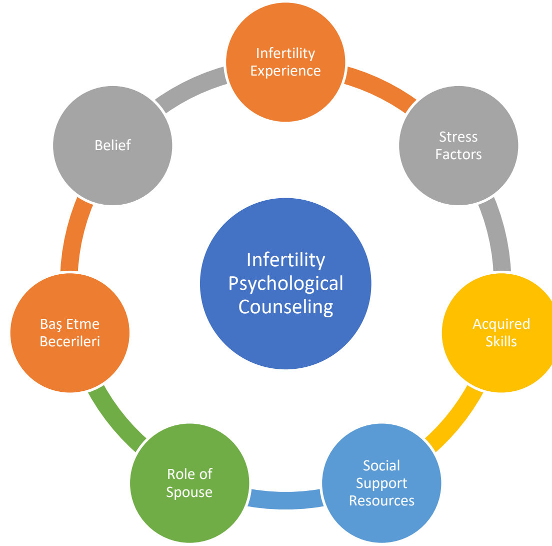

Figure 9 *Themes That Can be Used in the Process of Infertility Psychological Counseling*

When the national and international literature on infertility is examined, it is seen that cultural values create differences between countries. While infertility in Turkey is seen as a problem that is most burdened by women and that they have difficulty coping with, we can see in international publications that women and men face the problem of infertility together and that men actively participate in the treatment process (Abdollahpour et al., 2022; Aygün et al., 2022; Fırat & Şahin, 2022). From this point of view, it is thought that it may be useful for mental health professionals to organize culture-sensitive guidance activities for couples.

This study is limited to 10 women who have been diagnosed with infertility. A qualitative study can be organized about the treatment process and afterward by reuniting with the individuals participating in this study. In addition, a psychological counseling process can be started with the same people in groups and later, if needed, with the individual. By including the spouses of the women participating in the study, their feelings, thoughts, and reactions to this process can be learned

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