THE PATH TO ADOPTION: EXPERIENCES OF COUPLES WHO HAVE TRANSITIONED FROM INFERTILITY

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THE PATH TO ADOPTION: EXPERIENCES OF COUPLES WHO HAVE TRANSITIONED FROM INFERTILITY

By

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In accordance with Rule G5.6.3, I hereby declare that the above-mentioned dissertation is my own work and that it has not previously been submitted for assessment to another University or for another qualification.

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TO WHOM IT MAY CONCERN

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This serves to confirm that I edited Mrs Brophy's Masters in Social Work (Research) treatise.

Yours faithfully

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ABSTRACT

Parenthood is a life goal for the majority of individuals and couples who have reached a certain life stage. For many couples parenthood is, however, not a reality through expected means. Statistics gathered, in an unpublished information document, by the Port Elizabeth Infertility and Wellness Clinic, it is estimated that 10 to 15% of all married couples in the region experience infertility. After failed infertility treatment, adoption is considered an option for many couples wishing to have children. The social worker plays an integral role in the assessment and preparation for adoption. However, there is no legislated preparation for the fertility treatment process as there is for adoption in South Africa, yet both processes are intended to result in parenthood shadowed by stressful circumstances for prospective parents.

The study explored the experiences of couples who have transitioned from being diagnosed as infertile and have successfully adopted. The study was conducted from a qualitative research perspective and employed the exploratory-descriptive strategy of inquiry. Purposive sampling was applied and eight married couples participated in the study. The participants were sourced from a support and information network for adoptive families as well as referrals from social workers working within the adoption field. Semi-structured interviews were conducted by an independent interviewer with thematic analysis being used for data analysis. Trustworthiness constructs were taken into account to ensure reliability and rigour. The major findings revealed the distinctive experiences regarding fertility treatment, the experiences regarding adoption and suggestions from couples for couples facing similar situations as well as for professionals in practice. The study is viewed as significant in guiding professional services to couples, who are intending to achieve parenthood via adoption, by adding to the body of existing knowledge in adoption and medical social work.

Keywords: adoption, couple, experience, infertility, parenthood

CHAPTER ONE

CONTEXTUAL INFORMATION AND BACKGROUND TO THE STUDY

1.1 Introduction

This chapter will present the background and rationale for the study. The theoretical framework consisting of the family systems theory and developmental life stage theory will be briefly identified as the theories underpinning the study. An overview of the research methodology which was employed will be described with the proposed structure of the report being identified.

Background to the study

Parenthood is a life goal for the majority of individuals and couples who have reached a certain life stage. It is a rite of passage similar to puberty, marriage, and retirement. Parenthood, family and the ability to conceive and bear children have different connotations and expectations for different cultures (Collins, 1994; Cooper-Hilbert, 1998; Gerrand & Nathane-Taulela, 2015). In South Africa this is specifically evident due to the diverse cultures within the country. It is therefore certain that the inability to conceive will have an influence on individuals, couples, family and society at large. For the individual and couple the consequences are the effect that it has financiallly, culturally, psychologically, socially and emotionally. As the couple are linked to their extended families and other social systems it will have an influence in terms of their relationship with these sytems.

A parent is defined as the lawful father or mother of someone in Black's Law Dictionary (Garner, 2011). Due to the changing family structure and progressive reproductive technology, it is suggested that the concept of parent includes "biological procreators, surrogates, foster and adoptive parents (Raphael-Leff, 2010). The inability to achieve parenthood and fulfill personal and societal goals can cause a life crisis (Menning, 1980; Berk & Shapiro, 1984; Forrest & Gilbert, 1992; Williams, Bischoff, & Ludes, 1992). Some scholars have gone as far as saying that humans are genetically predisposed to

desire parenthood (Miller, 2003; Baru & Dhingra, 2004). For many couples parenthood is, however, not a reality through expected means.

Infertility is growing to be a social challenge world-wide, with Assisted Reproductive Therapy (ART) being responsible for an estimated 219,000 to 246,000 babies born each year world-wide, according to the International Committee for Monitoring Assisted Reproductive Technology (De Mouson, Lancaster, Nygren, Sullivan & Zegers-Hochschild, 2009). The World Health Organisation determined in a study conducted in 2012 that one in four couples in developing countries have been affected by infertility (World Health Organization, 2012). In statistics gathered by the Port Elizabeth Infertility and Wellness Clinic in an unpublished information document, it is estimated that 10 to 15% of all married couples in the region experience infertility (P.E. Infertility and Wellness Clinic, 2014). Kruger and Van Der Merwe (2010), in a more recent study, suggest that the South African infertility rate is 15-20%.

Changes in lifestyle, female role changes, later age chosen to pursue the goal of parenthood and westernisation are all reasons for the onset of infertility being a current phenomenon. Couples are identified as being infertile when they have been unsuccessful in conceiving after one year. Infertility can be described as “the inability to conceive a child or a reduced state of fertility that is caused by various biological factors” (Wood & Westmore, 1984:14).

The main causes of infertility are generally divided into four main categories; namely female factor, male factor, combined male and female factors and unexplained, idiopathic or psychosomatic infertility (Cooper-Hilbert, 1998, Davajan & Israel, 1991). Wiswedel and Allen (1989) identify the leading causes of infertility in South Africa as tubal factor infertility (diagnosed in 57% of couples), male factor infertility (36%), and anovulation (29%). The statistics above have given rise to the fact that alternative methods of treatment are sought by individuals affected by infertility. The options for treatment include surgery, ovarian stimulation with fertility hormones, and /or the use of assisted reproductive technology treatments such as in vitro fertilisation which are available at various fertility clinics across South Africa.

Bereavement is a fundamental aspect of infertility, as couples are faced with the 'death' of the longed-for child who is "psychologically present but physically absent" (Burns & Covington, 2006:9). The diagnosis of being infertile is often associated with the loss of "what could have been." The news of the loss of the potential child is a factor which impacts the individual, couple, family and broader social circle of the couple, who is diagnosed. Menning (1980:34) points out, ''the most compelling feeling of conclusive infertility is grief. It is a strange and puzzling kind of grief involving the loss of a potential, not actual life.'' The loss experienced is that of potential parenthood. The expectation is that conception will be a natural process and not that there will be any challenges with this. It is therefore devastating to be informed that becoming a parent through expected means will not be a possibility.

Menning (1980) links Kübler-Ross's five stages of death and dying model (shock, denial, anger, bargaining, and acceptance) to the experience of infertility, contending that each stage must be negotiated in order to effectively work through the losses associated with infertility and in so doing, enabling couples to move on with their lives. Applegarth (2006) supports this by proposing five stages to the infertility grieving process. Furthermore Menning (1980) links Erikson's psychosocial developmental life stage model to infertility. According to Erikson's theory, those in early adulthood that proceed successfully from the intimacy versus isolation stage enter the generativity versus stagnation stage of life, wherein it is expected they will start a family. Infertile couples then are faced with a psychosocial life crisis, which they must negotiate and resolve before they can successfully proceed developmentally.

Studies investigating the psychological consequences of infertility have shown that infertility leads to emotional distress such as depression, anxiety, guilt, social isolation, and decreased self-esteem in both men and women (Myers, 1990; Abbey, Andrews, & Halman, 1991; Connolly, Edelmann, Cooke, & Robson, 1992; Grover, Gannon, Sherr, & Abel 1996; Greil, 1997; Sadler & Syrop, 1998). In a study conducted by Pedro and Andipatin (2014) six stages of psychological and emotional responses to infertility are identified. These are disappointment and shock, denial, anger and frustration, deep

state of sadness, acknowledgement and lastly hope and optimism. Pines (1990) identified shame and guilt as inevitable aspects of infertility.

As the woman conceives and bears children, infertility is often viewed by society as the woman's condition. Fertility treatment is mostly aimed at the female's biological functioning with the "invasion" of her body. As fertility is connected to the person's bodily functions the physical aspects of treatment are stressful on the couple. Domar, Zuttermeister and Friedman (1993) report that infertile women reveal psychological distress levels similar to patients with grave medical conditions such as cancer, heart disease and hypertension. Research confirms that the interruption of the normal stage of parenthood because of infertility creates additional psychosocial stressors (Greil, 1991; Monach, 1995), which may potentially have life-long effects on infertile individuals. It can, thus be argued that infertility will have an effect on both partners in the marital relationship and will have an influence on the systems that they are part of.

Infertile couples experience multiple losses, which include loss of sexual identity; loss of childbearing and child-rearing experience and the child they never were able to conceive; loss of the parental identity; loss of close relationships with a spouse, extended family members, and friends; loss of health; loss of status or prestige; loss of a sense of personal control; loss of genetic legacy; loss of a grand parenting relationship; loss of a sense of spirituality and hope for the future; and loss of feelings of self-worth (Carroll, Callister, Dyches, Marshall, Olsen & Robinson (2000:286); Gibson & Myers, 2000; Gonzales, 2008; Hart, 2002; Imeson & McMurray, 1996; Sherrod, 2004).

Since research has shown that education and counselling are key factors when working with couples experiencing infertility (Dyer, Abrahams, Hoffman & Van der Spuy, 2002), a holistic approach to the issue of infertility should be addressed through interventions from a multidisciplinary team. Such a team would include the medical professionals and counsellors, who can be psychologists and/or social workers. The social worker's role and be defined by specific guidelines. In a study, Blyth (2012) found that legislative guidelines for infertility counselling in some parts of the world ensure professional

security but that these are a work in progress. Applegarth (2006:130) states “the bereaved ultimately must withdraw their emotional investment in the loss in order to go forward with life.” In the final stage of grief counselling, the therapist can help the client to ‘move-on’. At this stage the clients are required to relinquish their dream insofar as to allow them to proceed with their lives. Firstly, the therapist should encourage the couple to accept the loss of the child, real or imagined; secondly as proposed by Leon (1996), the client should be helped to experience and express the pain of the loss and the feelings, and emotions attached to it; thirdly the child and the loss of that child should be commemorated. In the penultimate stage the therapist will help the client to let go of the child.

Due to the high costs involved and psychological impact of infertility treatment it is not always an option for all. After failed infertility treatment, adoption is considered an option for 30 to 40% of couples wishing to have children (Corson, 1999, Vandivere, Malm & Radel, 2009; Zhang & Lee, 2010).

Daniluk (2001) suggests that infertile couples experience difficulties in setting limits about how much time and money to invest in treatment, leading to some couples engaging in years of unsuccessful attempts. In Daniluk’s (2001) study, as time went on and each treatment option failed, couples found themselves considering, and sometimes pursuing, options they had initially deemed unacceptable (e.g., in vitro fertilization (IVF)). Adoption may have been one of the deemed unacceptable options but due to the unsuccessful treatment it becomes a very real option.

Once couples have exhausted medical options they realise the importance of making the decision to adopt. The reasons for the decision to adopt are often infertility and altruistic feelings. Adoption has been found to help improve the negative impact of infertility and can afford couples and their children the “potential for transformation and rebirth” (Fleckenstein, 1990; Bartholet, 1993; Daniluk & Hurtig-Mitchell, 2003; Malm & Welti, 2010).

The importance of processing the challenge of infertility for adoptive parents has been pointed out by many authors (Castle, 1982; Daly, 1990; Menning, 1977; Spears, 1999). These authors stress the importance of dealing with the loss associated with infertility before the decision to adopt. While infertility can affect the identity (Phipps, 1993; Daniels, 1999; Webb & Daniluk, 1999; Gonzalez, 2000), adoptive parenthood and involuntary childlessness require larger identity transformations than becoming a biological parent after experiencing infertility.

According to Omosun and Kofoworola (2011:1), "Adoption is the act of legally placing a child with a parent or parents other than those to whom they were born. An adoption order has the effect of severing parental responsibilities and the rights of the original parent(s), and transferring those responsibilities and rights to the adoptive parent(s)." In South Africa the rate of adoption, compared to the available children, is low (Mokomane & Rochat, 2012). This is due to the fact that many parents do not consider adoption across cultural and religious barriers.

Due to the South African demographic and socio-political landscape, there are still more Black African babies available for adoption and not many Black African prospective adoptive parents available. Many South African prospective adoptive parents are not keen to consider adoption across cross-cultural and religious barriers. Therefore there are prospective adoptive parents waiting for years for the right match. Legislation pertaining to adoption in South Africa is the Children's Act No 38 of 2005 (RSA, 2005) which states that a child can be adopted by:

- A married couple in a joint adoption.
- Life partners, same sex or otherwise, in a joint adoption.
- Other persons sharing a common household and forming a permanent family unit.
- Widower, widow, divorced or unmarried person.
- A person who has married the parent of a child can adopt the child, with the biological father's consent. This is called the adoption of a stepchild.
- The biological father of a child born out of wedlock.

- A foster parent.

There are thus various possible scenarios, which will enable a child to be adopted in the South African context. The Children's Act, No 38 of 2005, has created an integrated method of screening and matching adoptable children with prospective adoptive parents with the introduction of the Register on Adoptable Children and Prospective Adoptive Parents (RACAP) (RSA, 2006). An adoptable child's details must be placed on RACAP for at least 60 days, and if he or she is not matched with a fit and proper adoptive parent in South Africa, only then does the child become available for trans-racial adoption, including inter-country adoption (Davel & Skelton, 2009). Consideration is given to cultural differences in placements - including language and religion; however, cross-cultural placements are permissible.

Potential adoptive parents face two sources of stigma—the assumption that they are infertile and they do not share a blood tie with their child. For those who choose to adopt, the renegotiated identity appears to be grounded in letting go of fertility expectations and mourning lost fertility, coupled with imagining and embracing the adoptive parent role (Daly, 1988). This thus creates an opportunity for the social worker to support the couple that chooses to adopt after they have gone through infertility from the onset, and not only when they reach the stage of adoption. As a result of the stigma mentioned above there are many factors that need to be processed in terms of the decision to adopt.

The social worker plays an integral role in the assessment and preparation for adoption. However, there is no legislated preparation for the fertility treatment process, as there is for adoption in South Africa, yet both processes are intended to result in parenthood shadowed by stressful circumstances for prospective parents. This study therefore assumes that, if the preparation for the possibility of adoption occurs during the stage that the couple is undergoing fertility treatment, the transition to adoption would be easier.

From the background it is evident that literature and research with regard to the experience of couples who have undergone fertility treatment and have adopted is limited. Literature either focuses on adoption or infertility or only provides the male or female perspective. This is the reason for the use of dated literature. In this study the researcher focuses on the couple's experiences of infertility and adoption and thus provides a different perspective to research in this regard.

1.2 Theoretical framework

The theories which will guide this research are Family systems theory (Broderick, 1993) as well the Developmental life stage theory (Erikson, 1982). Family systems theory creates a framework from which to attempt to understand the complexity of families as an organised system. A perspective that focuses on the larger system or context surrounding an individual is ideally suited to a focus on infertility and adoption specifically because the experience is shared by both partners and their extended families. Developmental Life stage theory on the other hand focuses on the individual in the relationship and the life cycle stages that are necessary for optimum development to occur. It identifies the stages that the individual and couple should transition in order to resolve specific developmental tasks. Developmental life stage theory therefore provides the individual focus and Family systems links the experiences of couples to the systems in which they function.

Relevant aspects of both theories will be applied to the experience of unsuccessful fertility treatment and adoption. These theories are both related to the study in that they deal with the family as a unit as well as link to the individual as they transition the various life stages linked to being part of the marital and family systems and will be discussed below.

1.2.1 Family systems theory (McGoldrick, Preto & Carter, 2015)

A system is defined as a set of objects with relationships between the objects and between the attributes of the objects (Hall & Fagan, 1956). The family can thus be

considered a system because there are individuals who are in relationships and have a reciprocal influence on each other. The couple is also thus considered a system.

McGoldrick, Preto and Carter (2015) identify six stages of the family life cycle, a model that acknowledges the convergence of situational, developmental, and family-of-origin (historical) stressors. The stages and their tasks are (1) unattached young adult (2) married couple where the process of commitment to a new system needs to be made, (3) family with young children, (4) family with adolescents, (5.) parents launching children, and (6) family in later life. These stages are discussed in detail in chapter 2.

A comprehensive definition of the family systems theoretical framework proposes that the "individual behaviours of men and women are best understood in the context of their mutual interactions and systemic relationships" (Bertalanffy, 1969). The family system will thus have an impact on those diagnosed as infertile. The types of systems could include the actual family members, as well as external systems such as the workplace, society in general, etcetera. The family system would include the nuclear family system, which would be the couple that are seeking parenthood and the extended family, who would be the families to whom the couple belongs.

Another central premise of family systems theory is that families are dynamic in nature, with strategies and patterns that guide the manner in which they interact with each other (Broderick, 1993; Fleming, 2003). The dynamic nature of families provides them with the ability to adapt to the changing challenges of daily life and to assist in the developmental growth of the individual family members. This dynamic nature of families can also be described by referring to family systems as open, ongoing systems, where the term "open" can be described as an information and energy flow between the family system and its environment, while "ongoing" focuses on the fact that change may occur in relationship to time (Broderick, 1993). From a family systems perspective, one would focus on the family as a whole, and not merely on the separate parts or individual family members. These individuals are seen as being part of the family system.

As the experience of infertility and then subsequent adoption is a shared experience between the couple and members of their extended family, it is a phenomenon well suited to be studied using a family systems perspective. The diagnosis of infertility and the decision to adopt affects the couple as well as their extended families. It will also have an impact on external systems they come into contact with, such as the work environment, their spiritual interaction and family system. Support by the systems the couple find themselves in will influence their experiences of infertility and adoption wither positively or negatively.

1.2.2 Developmental life stage theory (Erikson, 1950)

Erikson (1982) maintained that within the span of a lifetime, individuals advance through a series of eight developmental stages, each characterised by a unique psychological issue. The degree of resolution (or irresolution) of each stage forms the characteristics of individual personality and impacts the degree of resolution (or irresolution) of later stages.

Erikson's (1982) eight stages are as follows:

Stage one is known as trust versus mistrust and the age is infancy which is between nought and one and a half. Stage two is characterised by autonomy versus shame and doubt and the age range is one and a half to three. Stage three occurs between three and six and is known as early childhood with initiative versus guilt as the psychosocial resolution. Stage four is known as industry versus inferiority which is middle childhood with ages between six and twelve years. Stage five is adolescence where ego-identity versus role confusion is addressed and the age group is twelve to eighteen. Stage six is called young adulthood which is between the ages of nineteen and forty and intimacy versus isolation is dealt with. Stage seven is known as middle adulthood with generativity versus stagnation with the age group being forty to sixty five. The last stage is characterised by integrity versus despair and consists of those in the age group sixty five and over.

According to Erikson's theory those in early adulthood, who are proceeding successfully from the "intimacy versus isolation stage", having formed an intimate relationship and having found their partner, enter the "generativity versus stagnation stage of life" which is the final stage. Erikson's crisis for this stage, generativity versus stagnation, is grounded on caring for the next generation by either rearing one's own children or educating and guiding younger individuals (Berger, 2010:456). The stage that will be relevant to this study is the early adulthood stage, as this is when it is expected that couples will start a family. Infertile couples then are faced with a psychosocial life crisis, which they must overcome. The crisis is linked to the fact that the expected life stage of starting with a family, which they expected would occur, does not.

The family life cycle, which is similar to Erikson's stages, is defined as the period beginning with the formation of the emerging adult to joining of families through marriage, the addition of children, families with adolescents, launching children and families in later life (Carter & McGoldrick, 1980). The authors identify six family life cycle stages as follows:

1. Launching the young adult
2. The couple
3. Families with children
4. Families with adolescents
5. Launching children and moving on
6. Families in later life.

These stages all have developmental tasks that are linked to Erikson's psychosocial stages of developmental for individuals. Gerrity (2001) further identifies life-crisis theory and bio-psychosocial theory as the most prevalent theories to understanding and treatment of infertility. These theories account for the effect of infertility over time and across family relationships. The life stage theory is also very relevant when considering adoption as an option. The individuals do not often foresee that adoption will form part of their life span. The acceptance of adoption as fulfilling the needs associated with

transitioning this period of the life stage is an important crisis for the prospective adoptive parents to overcome.

The Family systems and Developmental life stage theories both allow for the understanding of the couples experiences with unsuccessful fertility treatment and adoption. Family systems theory allows for an understanding of how the infertility and adoption influence the systems such as the marital relationship, relationship with extended family and other external systems. Developmental life stage development compliments family systems theory as it focuses on the individual stages that the couple will transition in order to accomplish the tasks associated with them.

1.3 Problem formulation and motivation for study

The diagnosis of infertility is often considered one of the most stressful experiences couples can encounter (Greil, McQuillan & Slauson-Blevins, 2010). A diagnosis of infertility has been described as a major life crisis affecting how men and women feel about themselves, their relationships and the world around them (Hart, 2002). Owing to the often prolonged and indeterminate time span of infertility and the uncertainty of treatment success, infertility is associated with substantial stress which can be chronic and thus can have major repercussions for women's health (Schneider & Forthofer, 2005).

The financial and emotional stress that accompanies the diagnosis of being infertile is overwhelming and requires the assistance of trained professionals. Domar, Zuttermeister and Friedman (1993) report that infertile women presented with psychological distress levels similar to patients with terminal illnesses such as cancer, heart disease and hyper-tension. The decision to adopt and the process that it follows, is coupled with additional stress for the couple concerned. The decision to adopt is mostly after many failed treatments for infertility. During the infertility process additional support is needed. In most cases, this is not a compulsory part of the treatment. When adoption is explored, the support of a social worker is part of the process. However, there is no legislated preparation for the fertility treatment process as there is for

adoption in South Africa, yet both processes are intended to result in parenthood shadowed by stressful circumstances for the prospective parents. Therefore, this study explored the experiences of couples who have transitioned from being diagnosed as infertile and have successfully adopted which is anticipated to provide depth of understanding of both processes.

1.4 Definition of key concepts

Adoption according to the Children's Act, No 38 of 2005 is defined as the process of placing a child in the permanent care of a person via a court order. It is further defined as a legal process that establishes a permanent relationship between a child and his or her adoptive parents which dissolves any legal rights and responsibilities between the child and his or her birth parents. (Australian Government, 2010)

Couple is defined by the Collins online Dictionary as two people who are married, living together, or having a sexual relationship.

Experience is defined by the Collins online Dictionary as something that happens to an individual and particularly has an effect on them.

Infertility is described as "the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse" (Zegers-Hochschild, Adamson, de Mouzon, Ishihara & Mansour, 2009).

Parenthood includes "biological procreators, surrogates, foster and adoptive parents (Raphael-Leff, 2010:9).

1.5 Methodology

1.5.1 Research Question

A research question is a comprehensive question that guides the questions during data collection and the purpose of the study, and is aimed at answering a research problem (Mouton, 2001). The research question which guides this study is as follows:

What are the experiences of couples who have transitioned infertility and adopted at least one child?

1.5.2 Research goal and objectives

The goal of the study is to enhance the understanding of the experiences of couples who have been diagnosed as infertile and have adopted a child. The objectives are as follows:

- To explore and describe the experiences of couples who have adopted after undergoing unsuccessful fertility treatment.
- To make recommendations to professionals in the field of treatment of infertility and adoption in order to inform professional services to couples, who are intending to achieve parenthood via adoption.

1.5.3 Research approach and design

A qualitative research approach was used as this allowed the researcher to engage with the experiences of the participants with the aim of exploring and promoting an understanding of the participants' experience. De Vos et al. (2011) indicates that the qualitative researcher is interested in understanding, observing and subjective exploration. Babbie and Mouton (2005) indicate that there are many qualitative research designs but all share the following features: "1) Detailed engagement with the object of study, 2) selecting only a small number of cases, 3) an openness to multiple sources of data, 4) flexible design features that allow the researcher to adapt and make changes where necessary" (Babbie & Mouton, 2005:278-279). In this study qualitative research was chosen in order to engage with the participants intimate experiences of infertility and adoption.

Marshall & Rossman in Ritchie and Lewis (2005) identify that qualitative research is mainly explorative and descriptive in nature. In this study the experiences of couples, who have experienced infertility and then adopted, were explored and then later described. Burns and Grove (2003:313) define exploratory research as research

conducted to gain new insights, discover new ideas and/or increase knowledge of a phenomenon. Descriptive research refers to research studies that have, as their main objective, the accurate portrayal of the characteristics of persons, situations or groups (Polit & Hungler 2004). In this study the researcher aimed to explore and describe the infertility and adoptive experiences of the couples interviewed.

1.5.4 Researcher's position

Hopkins (2007) stresses that the researcher must take the similarities or differences between the participants and the researcher into account. The researcher is a registered social worker and is employed as a lecturer at the Nelson Mandela University. In her personal capacity the researcher has been diagnosed as infertile, has undergone fertility treatment and has adopted. The researcher has thus had similar experiences to those the participants may describe. This similarity enabled the researcher to show empathy and understanding for the experiences that the participants discussed. The researcher was aware that the similarities in experiences could also have raised some emotional issues for the researcher. It is for this reason that the researcher used an independent interviewer but was present during the interviews. It is important to stress that debriefing after every interview was conducted with the independent interviewer as well as the research supervisor. The researcher was aware of and open to the possibility of engaging a helping professional for herself should the need have arised. Furthermore, although data was coded by the researcher, it was also objectively coded by an independent coder to reduce bias.

1.5.5 Population and sampling procedure

Polit and Hungler (2004) refer to the population as an aggregate or totality of all the objects, subjects or members that conform to a set of specifications. The process of selecting a portion of the population to represent the entire population is known as sampling. All individuals or objects within a certain population usually have a common, binding characteristic or trait. A sample is simply a subset of the population.

Leedy and Ormrod (2013) describe purposive sampling as sampling where the researcher choses a specific sample for a particular purpose. According to De Vos (2011:207), purposive sampling enables a sample that contains “the most characteristic, representative or typical attributes of the population”. Purposive sampling was thus employed in the study as the researcher had specific criteria for the population.

Due to the sensitive nature and the limited amount of participants being available the researcher used snowball sampling by asking the initial participants to recommend others they knew who could participate in the study. De Vos (2011) explains snowball sampling as a process where a single case involved in the phenomenon is interviewed to gain information on others who have similar experiences.

The researcher interviewed eight couples. The criteria which was used to select participants for this study were:

- Married couples of any age,
- who had undergone fertility treatment, and
- had adopted at least one child as a result of being infertile.

1.5.6 Method of data collection

Data collection was done by means of face-to-face semi-structured in-depth interviews, which were conducted with couples who have experienced infertility and have adopted. Qualitative interviews give a new insight into a social phenomenon as they allow the respondents to reflect and reason on a variety of subjects in a different way (Folkestad, 2008:1). Due to the nature of the researcher’s personal position, as mentioned earlier, an independent interviewer was used and the researcher observed the interview process. The interviews were conducted jointly with couples as per their availability.

1.5.7 Data analysis and verification

DiCicco-Bloom and Crabtree (2006) indicate that qualitative data analysis should occur parallel to data collection so that the researcher can produce an initial understanding

with regard to the research questions, which in turn will inform the sampling and the questions being asked. Thematic analysis of the qualitative data was completed in order to identify themes and subthemes which were common across the data collected. Due to the researcher being connected so closely to the experiences of the couples interviewed, an independent coder was used in conjunction with the researcher.

Data verification for the study was ensured based on the four criteria identified by Lincoln and Guba (1985) credibility, transferability, dependability, and confirmability. Credibility refers to the confidence in the 'truth' of the findings. Transferability refers to showing that the findings have applicability in other contexts. Dependability refers to showing that the findings are consistent and could be repeated. Confirmability is the degree of neutrality or the extent to which the findings of a study are shaped by the respondents and not researcher bias, motivation, or interest.

1.5.8 Pilot study

A pilot study, according to Creswell (2013), guides the researcher to refine interview questions and procedures for the research. It can thus be seen as a trial of all the aspects that are planned for the main study. In conducting a pilot study, the researcher assessed the suitability of the interview guide, which was used in the main study in order for relevant adjustments to be made.

1.5.9 Ethical considerations

Leedy and Ormrod (2013) identify protection from harm, voluntary and informed participation and right to privacy when considering ethical factors. Protection from harm to participants proposes that the physical and emotional risks involved should be no greater than risks of day-to-day living. The researcher is a registered social worker in accordance with the Social Service Professions Act (Act No. 110 of 1978) (South Africa, 1978), and implemented the code of conduct as prescribed by this act to ensure that no harm was done to participants. The researcher identified that recalling the experience of infertility by the participants may have been difficult and the researcher aimed to ensure non-maleficence by allowing the participant to share only that which they were

comfortable to share. The participants were informed in advance that should they experience any distress because of the interview the researcher would refer them to the Nelson Mandela Metropolitan University Psychology Clinic for therapeutic and psychological support.

Confidentiality was maintained by removing all identifying information from the transcripts, which were transcribed by the researcher. Pseudonyms were used instead of real names. Names of the participants were not disclosed at any stage of the study. The independent interviewer was a registered social worker bound by ethics in terms of sharing any personal information. Transcribed interviews did not contain the names or any identifying details when sent to the independent coder for coding.

Leedy and Ormrod (2013) further advise that informed consent should include that participants are informed of their right to self-determination regarding participation, the procedures that will be followed, the advantages and possible disadvantages of participation, and the credibility and role of the researcher. The concept of informed consent was explained to each participant and a consent form was implemented in this research study and will be elaborated on in chapter three.

Wassenaar (2006) identifies four ethical research principles of trustworthiness as being autonomy and respect for the dignity of persons, non-maleficence, beneficence and justice. Participation in the study was thus voluntary and informed consent was employed to ensure the dignity of the participants. In order to enhance trustworthiness of the study due to the researcher's personal experience data analysis was conducted by an independent coder as well as the researcher. Participants could at any time withdraw from the study. All participants were informed about their right to confidentiality. As the interviews were audio-recorded, prior consent for this was attained from the participants. Beneficence focuses on the "do good" principle. In this research the ultimate aim is that of understanding the experiences of the participants so as to make recommendations for practice in this area.

The study was presented to the NMMU ethics (Human) committee for approval and in thus doing ensure that ethical principles are adhered to. The ethical clearance number is H15-HEA-SDP-006 and the outcome of the ethics approval is attached as Appendix 5.

1.5.10 Dissemination of results

A copy of this Master's thesis will be made available in the library of the Nelson Mandela University. The results of this study will be written up as an article to be reviewed and published in an accredited journal. The researcher endeavours to consider presenting the findings at a recognized conference.

1.6 Proposed structure of the report

Chapter 1: Introduction and Background

This chapter deals with a short theoretical background and rationale for the study. It provides a description of the research problem and the aims and objectives of the study. A brief description of the chosen research methodology, ethical issues considered and the key concepts are provided.

Chapter 2: Literature Review

This chapter reviews literature relevant to the study as well as the conceptual framework that guides the study.

Chapter 3: Research Methodology

This chapter provides an overview of the research methodology followed, with a description of the procedures that were implemented to collect, analyse and verify the data obtained from the participants.

Chapter 4: Findings and Discussion

This chapter focuses on a description of the participants in the study as well as the themes that became evident in the analysis of the data gathered from the interviews.

Chapter 5: Conclusions, Limitations and Recommendations

This chapter presents the conclusions with regard to the findings of the study with recommendations to social workers and other professionals working in the infertility and adoption field. It will further present the limitations of the study.

1.7 Summary of chapter

This chapter provided an overview of the research study and provided the theoretical stance, which will guide the research. The research methodology was identified and will be discussed in detail in chapter 3. The next chapter focuses on describing the literature review, which will include the theoretical framework.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter focuses on the journey of infertility and transition to adoption as a means to becoming a parent by reviewing the literature pertaining to the topic. Furthermore, the theoretical frameworks underpinning this study are discussed.

2.2 Transition to parenthood

Parenthood is one of the natural life stages for individuals to experience. It is accepted as part of their planned destiny. When couples get married the next step is the decision to have children or not. In an article on female infertility, Parry (2005) mentions that a couple's desire to have a biological child is not only linked to wanting to replicate one's own genes; but it is also strongly related to the desire to create a child that is a mix of both spouses. It is a natural stage of life and individuals do not normally question their ability to naturally conceive.

According to a National Health Survey conducted in 2007 it was found that 20% of couples in the world are infertile with 50% of these couples eventually conceiving, 10 - 15% benefit by Artificial Reproductive Technologies (ART) and the remaining 35- 40% are considered as sterile or infertile after undergoing different types of treatment for a few years. For some, it is thus an easy process and the transition to parenthood is without challenges. For a large percentage, it requires facing time consuming treatment and emotional decision making when they are diagnosed as infertile. Societal norms place additional pressure on couples to have children after marriage and this adds to the emotional and psychological stress experienced by those involved.

Fertility treatment is a journey which entails physical and emotional stress on the couple. It is characterised by hope that this process will lead to parenthood. Many couples explore fertility treatment as a means to become parents. For some couples

treatment is successful. Others explore adoption as an option after failed treatment. This chapter will firstly address the theoretical framework that will guide the study and thereafter explore infertility and adoption.

2.3 Theoretical framework

Erikson's (1950) Life Stage Theory and McGoldrick, Preto and Carter (2015) Family Systems Theory were used as a foundation for the theoretical research as they speak to the stages that the couple may have encountered in their experiences of infertility and adoption. These theories are discussed below in relation to the research study.

2.3.1 Life stage theory

Erikson (1982) proposes that individuals advance through a series of eight developmental stages characterised by unique psychological crisis that need to be overcome. Complete mastery of the conflicts, which exist in each stage, is not necessary, but a positive resolution allows for the development of personal and social identity. The degree to which the individual resolves the crisis will have either a positive or negative impact on future stages.

The eight stages, according to Erikson (1950) are (i) trust vs. mistrust, which occurs in infancy (ii) autonomy vs shame and doubt, which occurs from ages one to three (iii) Initiative vs guilt, which occurs between ages three to six (iv) industry vs. inferiority, which occurs between ages six to twelve (v) identity vs. identity confusion, which occurs between ages twelve to nineteen (vi) intimacy vs. isolation, which occurs between the ages twenty to twenty five (vii) generativity vs. stagnation, which occurs between the ages twenty six to sixty four (viii) integrity vs. despair, which occurs between sixty five and death.

The stages that are relevant to this study are the intimacy vs. isolation or early adulthood and generativity versus stagnation or middle adulthood stages. These stages can be described as follows:

Intimacy versus isolation stage (20 – 25 years of age)

The intimacy vs isolation stage according to Erikson (1982) is characterized by the capacity to give and receive love, emotionally and physically, connectivity with others, being socially and inter-personally content, the ability to form honest sharing relationships and friendships and the capacity to bond and commit with others for mutual satisfaction. The ages linked to this stage are between eighteen and forty years old. For the infertile couple this is the stage where they will be newly married and connected through friendships family and collegial relationships.

Intimacy means the individual will strive to achieve relationships with family and their marital partner. Erikson explained this stage in terms of sexual mutuality with the giving and receiving of physical and emotional connection, support, love, comfort, trust, and all the other elements that would be associated with healthy adult relationships conducive to reproducing and child-rearing. This is the stage where couples will start thinking about having a family and often be pressurized by family and friends to start with a family.

Isolation contrary to intimacy means being and feeling excluded from the usual life experiences associated with this stage of life. The infertile couple may find that they do not “fit” in due to their inability to achieve parenthood. Couples struggling to achieve pregnancy and identified as infertile could experience the isolation that Erikson identifies as part of this stage. The couple will be isolated from achieving parenthood as well as society at large who have achieved this goal.

Generativity versus stagnation (26 – 65 years of age)

In Erikson’s theory those in early adulthood that are proceeding successfully from the “intimacy versus isolation stage,” having formed an intimate relationship and having found their partner, enter the “generativity versus stagnation stage of life,” wherein it is expected they would have started a family. The ages associated with this stage are between forty and sixty five years. During the stage of generativity, adults are faced with

the struggle to give back to society and become something greater than themselves through their careers and/or families. A positive resolution is one in which adults care for the future generations.

Generativity refers to "making your mark" on the world through caring for others as well as creating and accomplishing things that make the world a better place which is most often expressed through parenting or caring for others. Stagnation refers to the failure to find a way to contribute. These individuals may feel disconnected or uninvolved with their community and with society as a whole. Those who are successful during this phase will feel that they are contributing to the world by being active in their home and community.

There are also numerous factors that can influence feelings of generativity versus feelings of stagnation for the couple. Couples who have positive relationships with others, good quality health and a sense of control over their lives will feel more productive and satisfied. Those who suffer from poor health, poor relationships and feel that they have no control over their fate are more likely to experience feelings of stagnation. For the infertile couple they may reach the age associated with this stage but still be fulfilling the roles associated with the previous stage and thus may feel that they are stagnating. The feeling of loss of control over their life course can also have an influence on their crisis of stagnation. This stage also relates to the extended families of the infertile couple specifically their parents as they have the need to be grandparents and in thus doing the tasks associated with this stage of life.

According to Erikson (1982), each crisis does not have to be catastrophic but provides one with both increased vulnerability and enhanced potential. The more success one has of resolving each developmental crisis, the healthier the person will be in the next stage. Infertile couples, then, are faced with a psychosocial life crisis, which they must negotiate and resolve before they can successfully proceed developmentally as they are faced with the reality that they will not have children via normal means. It is thus essential that couples who are undergoing infertility treatment be offered the opportunity to deal with the psychosocial crisis that may arise before they explore other options to

parenthood. The experiences of the couple do not exist in isolation and therefore the family systems theory as discussed next is so important to understand the influence of on the larger system.

2.3.2 Family systems theory

Bertalanffy (1968) identified the concept of General Systems Theory and he believed that every organism is a system that is dynamic in nature. He further proposed that every system is part of a larger system. Newman and Newman (1991) indicate that systems theory invites one to look beyond the obvious or presenting problem and further analyses the multidimensional influences of a particular problem. The theory is thus not interested in cause and effect, but rather focuses on other factors that could have an influence on the issue at hand.

Within social work practice, systems theory can be implemented at three different practice levels: micro, meso, and macro. Micro systems are understood to refer to small-size social systems, such as individuals and couples. Meso systems focus on intermediate-size systems, including groups, support networks, and extended families. Macro systems focus on large systems, such as communities and organisations. This differentiation of systems depends on the social worker's perspective as well as the organisational context, and its purpose, in which he or she practices (Greene, 2000). At micro-level, the couple is influenced by the diagnosis of infertility as well as the decision to adopt. Meso level will refer to extended family, work, church, friends. Infertility will threaten the loss of the family's future, for example, couples who are infertile are often isolated from the meso level. The macro level refers to larger social systems such as adoption agencies and government organisations. For the couple who is infertile and then adopts, the interaction that they have with support groups will fall into this level.

Zastrow (1992) further explains that systems theory stresses that a change in the one part of a system impacts on the other parts of the same or other systems. Three key concepts of systems theory are wholeness, relationship and homeostasis. Wholeness means that the sum is more important than the individual parts. In this study the

individual parts could be considered the individuals who form part of the marital couple, the individual members of the extended family and the individual members of the friendship/collegial group. The sum could be the marital relationship, family relationships, friendship and collegial relationships.

According to family systems theory, the family life cycle framework defines a series of stages with expectable timelines that most people imagine as their predictable life course. Successful passage through family life cycle stages depends on the effectiveness of developmentally appropriate negotiations of tasks and stressors. Similar to Erikson's life stage theory (1982), McGoldrick, Preto and Carter (2015) identify six stages of the family life cycle, a model that acknowledges the convergence of situational, developmental, and family-of-origin (historical) stressors. The stages and their tasks are (1) Unattached young adult, where the emotional processes which need to be made are accepting emotional and financial responsibility for self, (2) Married couple where the process of commitment to a new system needs to be made, (3) Family with young children, where new members need to be accepted in to the system, (4) Family with adolescents, where increased flexibility of family member's boundaries are permitted, (5) Parents launching children, where exits from the family system need to be accepted and (6) Family in later life where the shifting of generational roles need to be accepted.

The stages that are relevant to this study are stage two, the married couple and stage three families with young children. According to McGoldrick, Preto and Carter (2015) the following changes in family status need to occur in order for the individual to proceed developmentally:

- Formation of marital system.
- Realignment of relationships with extended families and friends to include spouse.
- Adjusting marital system to make space for children.
- Joining in child rearing, financial and household tasks.
- Realignment of relationships with extended family to include parenting and grand parenting roles.

While parenthood enables couples moving forward through the predictable stages of the family life cycle, childlessness stops the whole family system dynamic. Infertile couples are thus stuck in the “couple stage” of the family life cycle and can feel responsible for preventing other family members and/or the family system from moving forward. For the couple who are trying to become parents, if the one is identified as infertile, it will affect the couple more than it will affect the individual. If both partners are diagnosed as infertile, there may be a negative effect on the marital relationship. The childless couple must redefine the meaning of family to include a marital dyad without children. Couples must alter their life, goals, and personal identities and all members of the family system must adapt and adjust as they rework family boundaries. These are challenging tasks for individuals, couples, and families.

According to Matthews and Matthews (1986), the transition to non-parenthood is as important and demanding a transition for families and individuals as the more traditional transition to parenthood. Adoption is also a process that requires adaptation and the adjustment of all parties involved, including the biological parents, adoptive parents, and the adopted child. However, the dynamics of adoptions not only affect these parties, but also extend to affect the extended family either positively or negatively. They need to re-imagine their family based on the couples decision to adopt.

Homeostasis refers to the fact that systems seek to maintain balance, in order to preserve themselves. For the infertile couple the diagnosis of infertility will upset the balance and the couple will try to maintain homeostasis. Fertility treatment and then the decision to adopt will aid the couple in achieving homeostasis as a couple as well as the family system.

Both theories described above have specific stages that need to be followed in order for individuals to lead a balanced life. Erikson’s (1982) theory describes human stages of development and Family Systems theory describes the interconnectedness of the different environmental systems and how they influence each other. These theories therefore complement each other in understanding the totality of the experiences of couples who have transitioned infertility and have adopted in this study.

2.4 Diagnosis of infertility

The diagnosis of infertility is made after the couple have been trying to conceive naturally for a period of twelve months. The clinical definition for infertility is thus “a disease of the reproductive system defined by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse” (Zegers-Hochschild et al., 2009). Infertility can further be defined as being either primary or secondary. Mascarenhas, Flaxman, Boerma, Vanderpoel & Stevens (2012) defines primary infertility as the inability of women who want to have a child, who have been in a union for at least five years, where they have not used any contraceptives and a live birth has not occurred. The World Health Organisation further adds that a woman whose pregnancy spontaneously miscarries, or whose pregnancy results in a still born child, without ever having had a live birth would be diagnosed as having primary infertility.

Secondary infertility is defined as the absence of a live birth for women who desire a child and have been in a union for at least five years since their last live birth, during which they did not use any contraceptives. (Maracarenhas et al, 2012). The distinguishing feature is whether the couple has ever had a pregnancy that led to a live birth.

Although the rates of infertility vary throughout the world (ranging from less than 5% to over 30%), it is estimated that approximately one in ten couples have either primary or secondary infertility (World Health Organization, 2002; World Health Organisation, 2003). Martin (1999) estimates the incidence of infertility in South Africa at 15% - 20% of couples of reproductive age. This creates a need for more focused attention on the experiences of these couples in South Africa.

2.4.1 Causes of infertility

According to Wiswedel and Allen (1989), the leading causes of infertility in South Africa are tubal factor infertility (diagnosed in 57% of couples), male factor infertility (36%), and anovulation (29%), the male factor, combined male and female factors and infertility of

undetermined cause. In the past infertility was exclusively a female concern as the focus was on why the female partner was not becoming pregnant. Fertility is now considered to be a condition affecting the couple as a system rather than placing the responsibility and blame on an individual in the system.

Davajan and Israel (1991) divided the causes of infertility into four major categories; namely, the female factor, male factor, male and female factor and unexplained infertility.

Approximately 32-35% of infertility problems are attributed to the male partner (Dooley, 2006). Male factor infertility is usually defined by abnormal results on semen analysis and includes problems such as poor semen quality, low sperm count, no sperm or abnormal sperm (Hirsh, 2003). Among the causes of male infertility are abnormal sperm motility, anti-sperm antibodies, hormonal abnormalities, retrograde ejaculation, suboptimal sperm and lack of sperm (Davajan & Israel, 1991; Dooley, 2006; Metzger, 1998; Monach, 1995). Semen analysis is the primary screening test for male infertility and the results often provide valuable clinical information for diagnosis and treatment. Diagnostic procedures for males include assessment of hormone levels, sperm analysis and in some cases, testicular biopsy and vasography to test for tubal obstructions (Pacey, 2009).

Causes of female infertility can be linked to not producing and releasing mature eggs, scarring of the fallopian tubes that may interfere with conception, or the fertilised egg that may not be able to implant properly due to structural or hormonal difficulties.

It has been found that infertility is rarely the result of the impact of one of these factors, but is more often the result of the interaction of these factors (Cooper-Hillbert, 1998; Davajan & Israel, 1991). Stoppard (2001) indicates that 20-30% of infertility problems are “shared” by both the female and male partner. The shared nature of infertility is thus imperative for this study as the researcher focused on the experiences of couples who have undergone fertility treatment and have adopted.

2.4.2 Fertility Treatment

When the couple has made the decision to undergo fertility treatment it is preceded by time spent on trying to conceive and not being successful. Fertility treatment itself is an emotional roller-coaster for couples as it instills hope in the fact that they may soon be parents, but the reality that treatment may not be successful also needs to be faced. It is an emotional process as there are many disappointments which couples need to deal with effectively along the way.

There are many treatment options which could range from less invasive procedures such as medication which can be taken; to Invitro Fertilization, which entails months of preparation and has physical as well as psychological consequences. Medical treatment could last from a few weeks to years dependent on the type of treatment chosen. The cost of fertility treatment makes it an option for only some of the couples who are diagnosed as infertile. Often other life goals are adversely impacted as fertility patients utilize their financial resources for treatment (Benyamini et al., 2008; Kraaij et al., 2010). Fertility treatment is considered a couples problem, because both partners are necessary for its treatment. This is the reason that the researcher chose to include both partners as participants in the research. When researching the impact of infertility on the couple it became evident there were specific factors relevant to the wife, the husband and the couple. The following section will explore these factors.

2.4.3 Impact of infertility on wives

Rosner (2012) found that infertility can have a profound impact on the identity of women. He indicated that women often begin to imagine themselves as mothers long before they actually have children. This is influenced by implicit cultural and societal messages with regard to motherhood. When this is not a reality it may result in feeling a loss of control, threaten her imagined future, and cause her to doubt her womanhood.

In a study conducted by Dyer, Abrahams, Mokoena, Lombard and Van der Spuy (2005), focusing on the psychological distress among women suffering from couple infertility, it was found that these women experience much higher levels of distress when compared

to women who were not infertile. They further stress the importance of interventions to assist the women who are in this position and indicate that it should not only focus on the physical factors but also the psychological, social and cultural factors associated with the diagnosis of infertility.

Rosner (2012) further found that women felt marginalised or stigmatised because of their infertility when they are surrounded by pregnant peers and/or those who have small children. This is due to the fact that parents often form friendships and stay connected to each other through their children. Significant shifts in friendships were identified by participants and infertile women experience a lack of empathy, support and sensitivity to what they are experiencing. This will lead to the woman feeling like she does not fit in and it may even lead to a feeling of guilt as she is not able to provide a child to her husband or grandchild to their parents.

2.4.4 Impact of infertility on husbands

Socially and culturally masculinity is associated with the ability to produce children. Dooley, Nolan & Sarma (2011) investigated the psychological impact of male factor infertility on men and found that being infertile had a major impact on the participant's sense of masculinity and body image. Infertility was generally experienced as a stigma, which was difficult to talk about with any other men. Over half of the participants reported feeling isolated from their friends and families, due to perceived or real social unacceptability and a lack of empathy. Grover et al. (1996) reported that males were also likely to blame themselves for their fertility problems, often feeling "less of a man" because of them.

Men are often non-communicative in their response to the painful emotions associated with infertility. As a result, women may not realise their husbands are experiencing these emotions. Chachamovich, Fieck, Cordova Knauth and Passos (2010) and Hassani (2010), in their studies, have found that men seldom express themselves which is sometimes wrongly interpreted as being indifferent. In fact, men do not show stronger emotional responses and will not speak more about the problem, as women will.

Studies indicate that men are much less likely than women to confide in others regarding infertility (Daniluk & Hurtig-Mitchell, 2003). Peterson, Newton, Rosen and Schulman (2006) found that the expectation to be a father was not as important a part of the male identity, as the expectation to be a mother was of female identity. Many husbands were upset, not by the experience of infertility itself, but by its effect on their wives – and on their relationship with their wives. In addition, men commonly feel helpless and unable to cope with infertility because they view it as a problem they cannot solve. This inability to rapidly solve the problem may add to their difficulty in discussing their feelings related to infertility.

James, Thomas, Alan, Paul, Holly, Lauri and Patricia (2009), in their study, further discussed that infertility may place significant stress on a man's social and marital relationships. Couples often feel that they lose control of the fertility process and over their own bodies. Infertility stress and unsuccessful treatment can result in significant negative marital satisfaction. Male partners, among infertile couples, who feel that they are solely responsible for the couple's infertility, are at a higher risk for sexual, emotional, and psychological strain relative to men without this belief.

2.4.5 Impact on the couple

A variety of psychological responses characterise couples who are coping with involuntary childlessness due to infertility. These include anger, grief, depression, anxiety, feelings of isolation and powerlessness (Greil, 1997; Syme, 1997). A series of losses experienced by the infertile couples include loss of self-esteem, relationships, health, financial security and the emotional reaction to infertility can be very intense. The differences that exist between men and women concerning infertility can sometimes cause mutual problems between the couples. Women usually externalise the problem and show emotional reactions, while men seldom express themselves, which is sometimes wrongly interpreted as being indifferent. In fact, women show stronger emotional response and speak more about the problem than men do (Klock, 2008; Hassani, 2010).

In research conducted by Monach (1995), it was found that couples who experience infertility feel like “outsiders,” “odd,” “different,” when compared to their contemporaries. They seemed to “see themselves as different from and, therefore, inferior to their child-bearing friends and relatives and inferior to their own parents who conceived and bore them. Infertile couples are often isolated from the fertile world due to these feelings.

In a longitudinal study by Berg and Wilson (1991) it was found that most couples perceived their marital adjustment and sexual relationship as being adequate during their first year of infertility treatment but that partners had begun to experience the acute effects of stress associated with the early stage of treatment. In the second year, partners were managing stress adequately and maintained levels of healthy psychological functioning. The third year proved to be the most difficult year for couples, during which couples reported increased psychological strain, depression, marital strain, and increased levels of hostility, anxiety, obsessive-compulsive behaviours.

Infertility places a large amount of stress on the marital relationship and couples are forced to be vulnerable which could lead to a deeper level of empathy and appreciation for each other. Both partners are faced with stress and uncertainty that will challenge the life they envisioned as a couple. Not every marriage is able to withstand the effect of infertility on the relationship. Conflict often arises about, for example, which treatment to pursue, when to stop treatment, or when to adopt. When couples are not able to agree on these important decisions, it is often due to an existing issue in the marriage prior to the infertility arising.

Leilblum (1997) found that, for some couples, there was a serious deterioration in their relationships after infertility treatment, whereas for others they emerged closer and experienced relationships that are more satisfying. Burns and Covington (1999) and Meyers, Weinshel, Scharf, Kezur, Diamond and Rait (1995) mentioned shame, guilt, anger, and self-blame as emotions that affect the couple’s relationship and communication abilities. Often, one member of the couple copes by talking about their infertility and seeking social support while the other refers to maintaining secrecy and coping through denial. A partner might delay talking about infertility issues with his or

her partner in order to “protect them.” Furthermore, discussions about plans and needs may be put on hold due to this very reason.

Regardless of the resolution by couples to become parents, the grief and anxiety related to infertility has an influence on the marital relationship and needs to be addressed through counselling or other means. The role of the social worker in guiding and assisting the couple going through the process is essential and will be discussed next.

2.4.6 Social work and counselling support for infertility

Domar and Seimal (1997) identify one of the most difficult emotional consequences of infertility as the loss of control over one’s life. Infertility treatment does not only have physical consequences but also psychological, emotional, cultural and economic consequences. Due to these factors, researchers such as Van den Broeck, Emery, Wischmann and Thorn (2010), and Boivin (2003) recommend psychosocial counselling as part of the infertility treatment process.

Bergart (2000) further indicates that the social worker has an imperative role to play in educating, supporting and clinically intervening in the lives of those who are challenged with infertility. On a micro level, individual and couple counselling, with an educational focus, is advised. Issues that should be focused on are acknowledgement of the feelings, communication, mutual support and decision-making. On a meso level, group support is identified as an area of assistance the social worker can provide. Greenfeld (1997) supports this by indicating that the role of the social worker is to provide support and to educate.

Holbrook (1990) indicates that social workers should take a leadership role in terms of assistance to couples who are experiencing infertility at service and policy level. At service level, it is proposed that guidance needs to be provided with regard to appropriate medical treatment and counselling. The financial impact of treatment is also an area that the social worker can assist with. The different alternatives need to be explored with the client and assistance needs to be provided with regard to coping with the success or failure of the attempts to achieve parenthood. Those couples, who

consider adoption should be evaluated with regard to their readiness, willingness to learn more about the process, decide on the type of adoption, and deal with the legal and financial aspects. As can be seen from Holbrook's (1990) recommendations the social workers role is essential from the onset of the infertility diagnosis and should continue throughout the process of seeking parenthood.

Gerrity (2001) identified the following as areas that should be addressed by the counselor in assisting couples in dealing effectively with infertility:

- Should familiarise themselves with the different medical technologies and the physical, emotional, financial and social demands that these place on the couple.
- Be careful not to generalise literature on infertility to all clients.
- Be aware that coping styles may change depending on the client's gender and stage of treatment.
- Assessment of the combined coping strategies of the couple should be done in order to determine their flexibility and adaptability.
- Assist couples to understand the differences in coping styles by men and women at different stages of treatment to ensure that differences are normalised.
- Assist clients to understand that their partners cannot provide all the support that they need and that other resources are sometimes necessary to assist with stress in the relationship.
- Assess problems in sexual functioning.
- Consider group interventions for couples.
- Assist couples in making joint decisions about future treatment or alternatives.
- Assist couples to understand the effect of infertility on their families and assist them not to take responsibility for the pain and sorrow of others.
- Assist couples take control of the factors that they can control and letting go of those they cannot.

Read (1995) suggests an infertility counselling model, which involves five stages: (i) diagnosis (ii) managing feelings, (iii) planning action, (iv) understanding medical

treatment, and (v) awaiting treatment outcomes. The stages of this model may be repeated as the individual or couple adapts to the situation.

Although counselling is offered to couples who opt to go for fertility treatment the social worker is not often part of the process. The decision to go for counselling is voluntary and referral is usually made to a psychologist that is part of the team responsible for the couple. After couples have spent many years trying to achieve parenthood though unsuccessful fertility treatments adoption becomes an option for many.

2.5 Making the Decision to adopt

For many couples the option to adopt is preceded by years of trying to conceive naturally. Once a couple is diagnosed as infertile, and experiences a failed attempt at parenthood through fertility treatment, adoption is very often the next option. The process that precedes the decision, and then the actual adoption, is characterised by intense emotion, physical invasion and psychological distress. The couple needs to get to the stage where they accept, and grieve about, the fact that they will not be biological parents. In a study conducted by Daniluk (2003), couples participating identified grief with regard to the inability to conceive and unsuccessful fertility treatments. Many of the couples reflected on the need to find ways to acknowledge and grieve for the many losses associated with infertility so that they could move forward with the consideration of other options.

Chateuneuf and Ouellette (2015) identified three types of situations that give rise to couples making the decision to adopt. The first is the couple who has had many unsuccessful medical attempts to parenthood, the second is the couple who has initiated the adoption process and is still in the process of infertility treatment and the last are the couples who adopt quickly after they have initiated one infertility treatment, which has not been successful.

It is important for the couple to consider how they will involve their extended families once they have made the decision. Some may involve the family in the decision making process and others may choose not to involve them but merely tell them about the

important decision they have made. The couple's decision will have an impact on the whole family system as the child will become part of the family system and it is thus an essential consideration by the couple.

The Children's Act No 38 of 2005 (RSA, 2005) identifies that a child is considered adopted if they have been placed in the permanent care of a person in terms of a court order. Reitz and Watson (1992) define adoption as "a means of providing some children with security and meeting their developmental needs by legally transferring ongoing parental responsibilities from their birth parents to their adoptive parents; recognising that in so doing we have created a new kinship network that forever links those two families together through the child, who is shared by both. In adoption, as in marriage, the new legal family relationship does not signal the absolute end of one family and the beginning of another, nor does it sever the psychological tie to an earlier family. Rather, it expands the family boundaries of all those who are involved." This definition is based upon the reality of the adopted child's dual family status.

In a study conducted by Mokomane and Rochat (2012), the majority of adoptions in South Africa occur within foster families, meaning that families who have fostered unrelated children end up adopting them. According to the National Adoption Coalition of South Africa (2016), there are two main types of adoption possibilities in South Africa; namely disclosed/open adoptions and non-disclosed/ closed adoptions. A disclosed or open adoption occurs when the person who wishes to adopt knows the person giving the child up for adoption. The details and identity of the adoptive parents may be disclosed to the biological parent/s and vice versa. These are mostly family-related, or step-parent adoptions. Non-disclosed or closed adoptions occur when there is no disclosure of identity and the personal details of the biological parent/s or guardians/s of the child is not known to the prospective parents. In other words, there is no contact or communication between the parties.

2.5.1 Adoption Process

According to Meintjes and Hall (2012) and Mokomane and Rochat (2010), there are an estimated 3.8 million orphans in South Africa, with approximately 1.5 - 2 million children considered adoptable. The purpose of adoption, according to the Children's Act No 38 of 2005 (RSA,2005), is to "protect and nurture children by providing a safe, healthy environment with positive support and to promote permanency planning by connecting children to other safe and nurturing family relationships intended to last a lifetime." Adoption in South Africa is relatively low given the high number of children currently in foster care (Mokomane & Rochat: 2010). This creates possibilities for infertile couples who have made the decision to adopt.

The Children's Act No 38 of 2005 (RSA, 2005) prescribes that children may be adopted when they are orphaned, the whereabouts of the parent or guardian cannot be established, they are abandoned, the parent has deliberately neglected or abused the child or has allowed abuse or neglect, or a child is in need of a permanent alternative placement. Children in South Africa may be adopted jointly by a husband and wife, partners in permanent partnerships and other persons sharing a common household who form a family unit. They may also be adopted by a widower, widow, divorced or unmarried person, a married person whose spouse is the parent of the child, the biological father of the child born out of wedlock or by the foster parent of the child.

Holbrook (1990) argues that the social worker should be involved in supporting those who have been diagnosed as being infertile and assist in the decision to adopt. The role of the social worker in the infertility and adoption processes is thus very important. In research conducted by Mokomane and Rochat (2012), there is evidence to suggest that low adoption rates in South Africa may be linked to social work practice obstacles or restrictions to adoption and social worker attitudes and engagement with adoption as a heavily burdened bureaucratic practice.

Once the couple has decided to adopt they will apply to adopt a child via an accredited adoption organisation. The process will be driven by social workers usually in private

practice or employed by a non-governmental organisation. According to the Children's Act (RSA, 2005) the adoption service includes counselling for the parent and where applicable the child, an assessment of the child by the adoption social worker, an assessment of the prospective adoptive parent, the gathering of information for proposed information and completion of a report. The adoption social worker will normally conduct a screening process that involves an orientation meeting, interviews with the social worker, full medicals, marriage and psychological assessments, home visits, police clearance and checking of references. This process allows the social workers to get to know prospective adopters as a family, their motivation to adopt and their ability to offer a loving and stable home. If the social worker is satisfied with the results, the couple will be placed on the Register of Adoptable Children and Prospective Adoptive Parents (RACAP). An adoptable child's details must be placed on RACAP for at least 60 days, and if he or she is not matched with a fit and proper adoptive parent in South Africa, only then does the child become available for trans-racial adoption, including inter-country adoption.

Qualitative studies suggest that infertility can be the most difficult experience a couple encounters (Greil, Slauson-Blevins & McQuillan, 2010). After the couples have endured the failed fertility treatment process, the additional stress of being put onto a waiting list for a baby adds to the stress. The slow process of adoption has been attributed to low capacity to implement the system effectively. For example, many children in institutional care or places of safety have not been assessed to be placed on RACAP (National Adoption Coalition of South Africa, 2012). Additional factors include poor or slow implementation of the Children's Act by the Department of Social Development, some NGO's and private practitioners, faults with RACAP, a severe lack of social workers and resources, and long waiting periods prescribed by the Children's Act due to bureaucracy. For example, what used to be a three month period for adoptions now takes seven to nine months (NACSA, 2012).

In non-abandonment adoptions the birth mother has 60 days from the time of the birth in which she may change her mind about putting her child up for adoption. This can cause additional stress for the couple and the family concerned if the child is placed in their

care. Most of the adoptions in South Africa stem from abandoned babies. Anecdotal evidence suggest that in these cases it may take up to eight months before the child can be released from a place of safety whilst social workers attempt to trace the biological parents.

Once a child becomes available, adoption procedures are started at the Children's Court where an adoption order is given. The adoption order states that the child is as "as if born" to the adoptive parents. The couple has then eventually entered the world of parenthood.

2.5.2 Adaptation to parenthood after adoption

In a study by Daniluk (2003), couples initially framed adoptive parenting as a "backup plan" that they may consider if they were unable to produce "their own child." However, as did the couples in Daly's (1992) study, when faced with the prospect of permanent childlessness, they seemed to go through a process of re-socialisation during which they shifted their identity from seeing themselves as biological parents to seeing themselves as adoptive parents. Couples need to deal effectively with the loss of the prospect of having biological children and need to both accept that they will endeavour to become parents through adoption. The identity of the couple and extended family change through adoption.

When the adoptee is placed in the adoptive parents' arms for the first time, many emotions may become evident. The couple has achieved the long awaited title of that of parent. They suddenly "fit in" but are different. The couple may suddenly feel a deep responsibility for someone else's child. In accepting the child, the couple is accepting the "ghosts" of biological parents and of their families, too (Rosenberg, 1992: 192).

Just as in the transition to biological parenthood, couples adopting a child (or children) face new identity challenges as they take on new roles as a parent and expand their family system from a dyad to a triad or more to include consideration of their child or children (Goldberg, 2009).

Researchers (Paulsen & Merighi, 2009) have indicated that when parents are not given adequate information they are not prepared to deal with the problems that arise with their children post adoption. Because of the changes that an adopted child can bring upon a family, adoptive parents and families need to understand short and long term challenges associated with adoption. Many Individuals and groups could serve as sources of information for adoptive parents to learn more about the adoption process and life after adoption; these include other adoptive parents, adoption support groups, family members, and Internet searches.

A willingness to learn about the issues related to adoption and to be open in seeking support if necessary can help to ensure that parents and children experience happy and healthy family lives (McKay, Ross & Goldberg, 2010).

2.5.3 Counselling support for adoption

As with the infertility treatment process the social worker plays and essential role in the adoption process. The social worker is very often the only link between the biological parent and the adoptive parent. The social worker is the only official source for information that adoptive parents have when learning about the adoptive child and social workers are meant to be a guide for adoptive parents during the adoption process (Wind, Brooks & Barth, 2007). Communication is an essential part of the adoption process.

The interaction between social workers and adoptive parents may either enhance or diminish parents' adoption experiences. Social workers can serve an important role in assisting adoptive couples to maintain a sense of personal efficacy during the adoption. During this period, couples can be helped to cope with the unique stresses of making this transition as well as helping them to mobilise the considerable personal and relationship resources they bring to adoptive parenting.

2.6 Summary of chapter

This chapter focused on literature relevant to this study. Life stage theory and family systems theory were discussed as the theoretical frameworks for the study. The transition to adoptive parenthood of infertile couples was discussed, including the initial diagnosis of infertility, the treatment and adoption process. Adaptation to parenthood after adoption and possible counseling support for adoptive parents was identified as important. The next chapter will explain the research methodology utilised in the research study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

The previous chapter focused on the literature related to the study as well as the theoretical framework, which guided the study. This chapter will focus on the research methodology, which was employed in the research.

3.2 Research approach and design

Research is defined as a systematic process that is undertaken with the view of expanding knowledge and insight on a particular topic (Delport & De Vos 2005:45). Qualitative research in particular aims to obtain a first hand, holistic view of the specific research problem by adopting a flexible approach to the problem formulation and data collection process (Strauss & Corbin, 1998:10). Furthermore, the qualitative research approach seeks to understand people's lives and experiences (Fouché & Schurink, 2011) and report of these findings in a non-statistical way. Leedy and Ormrod (2005) outline the following characteristics of the qualitative approach:

- Qualitative research focuses on interpretation and meaning. The study aimed to interpret the experiences of couples who have been diagnosed as infertile and have adopted a child.

- Qualitative research focuses on descriptions. In this study the experiences of the couples were described.

- Qualitative research involves verification. The researcher aimed to verify the experiences of the couples interviewed by means of engaging with relevant theory and past studies.

In contrast, the quantitative research approach emphasizes measurement, testing of theories and quantities, as opposed to detailed, rich descriptions of peoples' experiences of certain phenomenon (Nicholls, 2009b:591). Since the researcher wanted to explore the experiences of couples who had undergone unsuccessful fertility treatment and then turned to adoption, the research approach that was best suited to the study was qualitative. Berrios and Luca (2006) refer to the qualitative research approach as an investigation into the experiences of the participants and the participants are seen as the main source to develop insight into issues that would lead to improved and relevant techniques, relationships, principles and procedures.

A research design forms the foundation of a research study and determines its quality (Terre Blanche, Durrheim & Painter, 2006:34). It is a strategic framework, stemming from a research problem and hypothesis or/and research question, and describes the implementation of the research design (Terre Blanche, et al., 2006:34). Research design is the plan that the researcher follows in conducting the research project (Leedy & Ormrod, 2005:85). It provides the structure for how data is collected and analysed, and which procedures the researcher will follow in the research process. Many research designs are suitable to use with the qualitative approach enabling the researcher to choose a design which best suites their studies. Fouché and Schurink (2011:312) cite Tesch (1990) as identifying 28 approaches and Crabtree and Miller (1992) as identifying 18 approaches to research design. Cresswell (2013), however, identifies only five qualitative research designs. According to Fouché and Schurink (2011) Narrative biography, Ethnography, Phenomenology, Grounded Theory and Case study are the most frequently used designs. In this study, the researcher found that the study gravitated between the phenomological and narrative biography research designs. Phenomenology refers to a study of lived experiences. According to Crabtee and Miller (1999:25) cited in Alpaslan (2010:17) one "seeks to understand the lived experience of individuals and their intentions within their 'life-world'".

In the study the researcher sought to understand the experiences of couples who have transitioned infertility and adopted a child. However, the intention was not to delve into the "lived experience" but rather to understand their current experiences as well.

According to Schwandt (2007) cited in Fouché and Schurink (2011:313) "a person's life world can best be understood from his or her own account and perspective and thus the focus is on individual subjective definition and experience of life." This is the essence of narrative biography. The challenge for this study adopting a narrative research design was "generating a question that will allow a narrative to develop that is not interrupted or obstructed by the interviewer" (Flick, 2006 cited in Fouché & Schurink, 2011:313).

Therefore taking into account the vast array of research designs in qualitative studies, in the study the researcher remained true to the qualitative research approach and developed the study around the exploratory descriptive contextual strategy of inquiry (Alpaslan, 2010) within the broad parameters of the phenomenological and narrative designs. After the literature study, it became evident that the present study proved a relatively unfamiliar research area in terms of researching the experiences of couples who had undergone unsuccessful fertility treatment and then adopted to achieve parenthood in the South African context, an exploratory descriptive method was deemed the appropriate research method to use. The researcher aimed to qualitatively explore, understand and describe the experiences of couples who had undergone fertility treatment and had adopted a child in their quest to become parents.

Descriptive and exploratory research strategies of enquiry were chosen to assist the researcher to answer the research question, as limited existing knowledge regarding couples who had experienced infertility treatment and the adoption process within the South African context was available (Babbie, 2009:92-93; De Vos et al., 2005:106; Hesse-Biber & Leavy, 2006:49; Ritchie & Lewis, 2003:27-28).

Descriptive research aims to portray accurate profiles of persons, events and objects. While this research did not portray people or objects, it did portray an account of the

experiences of the participants. Another purpose of a descriptive research approach is to describe single or multiple variables, which in this study entails the experience of unsuccessful infertility treatment and the experience of adoption. (Gravetter & Forzano, 2003). Babbie (1995:85) echoes that descriptive studies describe situations and events. The descriptive nature of the design was intended therefore to enable the researcher to obtain a complete picture of how couples experienced infertility treatment and adoption.

Marlow (2005:334) defines exploratory research as follows: “A form of research that generates initial insights into the nature of an issue and develops questions to be investigated by more extensive studies.” Exploratory research is often a prelude to a more detailed study, but it can also be an important form of research in its own right (Alston & Bowles, 2003:34). De Vos, Strydom and Delport (2011) explain the purpose of an exploratory research design as gaining insight into a particular topic of interest. In exploratory research, there is a deliberate avoidance of predetermined research hypotheses and theories, as exploratory research aims to seek out new insights and to assess phenomena from a different perspective (Neuman, 2003).

The strength of an exploratory research design is that it allows for the topic to be studied broadly and generally, usually yielding at least some insights into the observed behaviour and arriving at recommendations for areas of further study. The main weakness of the exploratory design is that it often does not yield definitive results and further explanatory research is needed to obtain satisfactory answers to research questions (Babbie 1995:85).

An exploratory descriptive research strategy of enquiry was used because descriptive studies “aim to obtain a detailed description of a phenomenon” (Durrheim & Painter, 2006:44). The researcher explored the experiences of couples who had undergone fertility treatment and then adopted at least one child, which is a relatively unfamiliar research area within the South African context.

3.3. Research question

According to De Vos, et al. (2011:79) before one can conduct or even design a research study, one must have a clear picture of the direction of the study; which can then be refined in the form of a research problem, problem statement and or research question. This study posed the following research question:

What are the experiences of couples who have transitioned infertility and adopted at least one child?

3.4 Research goal and objectives

The goal of a research study should be clear and specific, and it should describe the intentions of the researcher (Holloway & Wheeler, 2010:27). Focusing on the goal of qualitative research, Welman, Kruger and Mitchell (2005:192) assert that the goal should provide a description of the field of interest. The research goal of this study was to enhance the understanding of the experiences of couples who have been diagnosed as infertile and have adopted a child.

De Vos et al. (2011:108) state that the objectives should be clearly stated and specific in nature. The objectives of the study were as follows:

- To explore and describe the experiences of couples who have adopted after undergoing unsuccessful fertility treatment.
- To make recommendations to professionals in the field of treatment of infertility and adoption in order to inform professional services to couples who are intending to achieve parenthood via adoption.

3.5 Researcher's position

The researcher was diagnosed with infertility and underwent artificial insemination and IVF treatment. The treatment led to the researcher experiencing a miscarriage. The researcher thus has experienced the grief and trauma of infertility and failed treatment.

After the failed fertility treatment, the researcher and her husband decided to explore adoption as an option. Adoption allowed the researcher and her husband to experience becoming a parent. The most intense grief of infertility had been healed by the transition to parenthood. This left the researcher asking what the experiences were of other couples who had experienced similar grief, hope and then eventually love for an adopted child. Being engaged in this research process, led to the researcher reliving her own experience and being able to relate to the opinions expressed by the couples interviewed. The researcher debriefed during research supervision. The research process has been an emotional and fulfilling experience for the researcher as the participants validated her experience.

Kanuha (2000) defines insider research as a situation where researchers conduct research with populations of which they are also members. Asselin (2003) further clarifies it as meaning that the researcher shares an identity, language, and experiential base with the study participants. The researcher shares the experience of undergoing an unsuccessful fertility treatment and then adopting and therefore shares the experiential base of the participants interviewed. Furthermore, there were other similarities with some participants, as the researcher adopted cross-culturally and some of the participants also did.

Bonner and Tolhurst (2002) identified three key advantages of being an insider researcher: (a) having a greater understanding of the culture being studied, (b) not altering the flow of social interaction unnaturally, and (c) having an established intimacy which promotes both the telling and the judging of truth. Although there are various advantages of being an insider-researcher, there are also problems associated with being an insider. For example, greater familiarity with the phenomenon being studied can lead to a loss of objectivity. Unconsciously making wrong assumptions about the research process based on the researcher's prior knowledge can be considered a bias (De Lyser, 2001; Hewitt-Taylor, 2002).

The topic, which was researched, contained an emotional element for the couples being interviewed as well as for the researcher. It is for this reason that the researcher opted

to use an independent interviewer to conduct the interview. The independent interviewer is a professional social worker registered with the council for social work and upheld the ethics and values throughout the interview process. As an observer, the researcher was able to experience the interview process to which she could relate, therefore not becoming an “outsider” in the research process. Debriefing discussions after each interview between the independent interviewer and the researcher were very valuable as the content and process of the interviews were dealt with.

3.6 Population and sample

The participants of the study were selected by means of non-probability sampling method of purposive sampling. Strydom cited in De Vos (2005:202) describes this type of sampling as being entirely based on the judgment of the researcher, as the sample is composed of specific characteristics that are relevant to the study. Therefore, the research question was significant for a defined group of individuals, which was maintained through purposive sampling.

The purposive sampling technique is used when a sample is chosen for a specific reason to provide insight into a particular field of interest, and is determined by the research topic (Alston & Bowles, 2003:90; Bless, Higson-Smith & Kagee, 2007:121). Leedy and Ormrod (2005:206) propose this sampling technique as suitable for qualitative research. Welman, Kruger and Mitchell (2005:69), however, question the level of representation from the population of this sampling technique. In order to combat this limitation, Leedy & Ormrod (2005:206) advise that a researcher be clear about the reason why the sample is viewed as relevant to the research problem and research question. The sample is described by Bless et al. (2006) as the subset of the whole population which is actually investigated by a researcher and whose information will be generalised to the entire population.

Purposive sampling was employed in this qualitative research study to provide the researcher with a sample to access specialised insight obtained from couples with regard to their experiences related to unsuccessful infertility treatment and adoption.

Purposive sampling involves approaching a specific population who have shared a common experience, and then to select a sample from that group that is “willing and able to talk candidly about their experiences” (Nicholls, 2009). In this study, the population included couples who had experiences specific to the research topic. The population for the study consisted of married couples of any age, who had undergone fertility treatment and had adopted at least one child as a result of being infertile.

Snowball sampling was the planned method of finding potential participants. Snowball sampling according to Strydom in De Vos (2005:203) “involves approaching a single case that is involved in the phenomenon to be investigated in order to gain information on other similar persons who could make up the sample”. Snowball sampling is thus a method of asking study participants to make referrals to other potential participants, who in turn make referrals to other participants, and so on.

The researcher initially contacted an organisation, which provides support and promotes the placement of orphaned and vulnerable children into loving families and supportive communities, which is based in Port Elizabeth and East London in the Eastern Cape. Couples that met the criteria of the study were identified by the contact person, who asked for permission for their details to be given to the researcher. Once the details were received, the researcher contacted the couples via e-mail and sent the letter to participants (Appendix 1). Once the couples agreed an appointment was arranged to suit the couple’s schedule. This was not always easy, as it had to be arranged at a time that suited both husband and wife. Having the couple in the interview added to the richness of data collected. It enabled the researcher to identify both the male and female experience in the process, which adds to the unfamiliar research area as either the male or the female perspective, has been described in previous research.

The researcher asked the first two couples referred by the organisation if they could recommend couples who would be interested in participating in the research, thus introducing snow-ball sampling. They indicated that they could not assist in referring other couples. As snowball sampling proved to be unsuccessful, the researcher made contact with social workers in private practice and at non-governmental organisations

that work with adoption in order for them to refer possible participants. Six couples were identified by three social workers who also first got permission before couples were referred to the researcher to contact. This aligns with good ethical practice. Eight couples formed part of the sample and were interviewed.

3.7 Data collection

The following sections give a full explanation of the data collection process.

3.7.1 Pilot study

According to Creswell (2013), the researcher conducts a pilot in order to refine the interview questions and determine if the data collected is linked to the goals of the study. Leedy and Ormrod (2005) indicate that a pilot study should be done to ensure that the researcher is able to answer the research question. The pilot study would indicate whether participants respond to the research questions. Strydom (2005) considers a pilot study as a small scale trial run of all the aspects planned for use in the main inquiry. It assisted the researcher to determine whether the methodology, the sampling and methods of data collection and analysis were appropriate and efficient for the research.

A pilot interview was conducted with one couple. After the interview the independent interviewer and researcher met to discuss the effectiveness of the interview guide as well as the process that was followed in the interview. It was found that the interview guide sufficiently dealt with the data to be collected. The questions were pitched at an appropriate level for the participants to understand and no questions had to be explained. The additional prompts which were part of the interview guide (Appendix 2) assisted in clarifying if necessary.

3.7.2 Semi-structured face-to-face interviewing

In this qualitative study, the researcher made use of semi-structured interviews which were conducted with couples who voluntarily agreed to be a part of the study. An

interview guide (Appendix 2) was used to ensure consistency in approach with the couples who were interviewed. Face-to-face interviews allowed the participants to draw on their own frame of reference to answer open ended questions and encouraged spontaneous participation. The choice of face to face interviews was made due to the sensitivity of the experience being shared. The choice of an interview also allows the researcher and the independent interviewer the opportunity to observe non-verbal cues which may allow opportunity for probing.

DiCicco-Bloom and Crabtree (2006:314) contend that "The individual in-depth interview allows the interviewer to delve deeply into social and personal matters." This will ensure that the data collected is rich. The in-depth interview allows the researcher the opportunity to ask open ended questions as per an interview guide but also allows the opportunity to ask additional probing questions.

Preparation for data collection for this study was done in accordance with the following recommendations from Rogers and Bouey (in Tutty, Rothery & Griell, 1996: 65 – 66):

- The purpose of the study needs to be explained to potential interviewees.
- The possible value of the study is to be explained.
- An introduction of the researcher is essential.
- An explanation of how the researcher got the details of the participants.
- Motivation of why the participants were specifically chosen to be a part of the study.
- Explain the nature of the questions to be asked.
- Identify where the interview will take place and how much time would be used.
- Explanation of the process to be followed with audio-taping the interview with written permission being given for the interview to be recorded.
- Ethical issues of confidentiality and management of information and the research findings to be explained.
- Only once the participants have been fully prepared for the process of data collection may the data collection proceed.

After being invited to participate in the study, participants indicated their willingness to be interviewed by providing written consent. The consent form (Appendix 3) provided information regarding the study, to ensure the participants were properly informed. The consent form also outlined the rights they are entitled to, such as confidentiality, anonymity, privacy and protection from harm. It was explained to participants verbally and in the consent form that they may choose to disengage from the research process at any point. It did not appear that any of the participants experienced psychological distress as a result of the interview, therefore none of the participants needed to be referred to relevant psychological services. Once the research is complete most participants wanted copies of the research findings. The researcher plans to follow up with participants at that stage to determine if the interview initiated any psychological distress that needs referral to psychological services.

Additional consent was obtained from participants to audio record the interviews (Appendix 4), as this is how data was recorded. Details regarding the recording, storage of recordings, transcription, and destruction of recordings were provided to the participants. The audio recording of the full interviews allowed for the reliable capturing of all information.

Eight interviews were conducted. According to Denzin and Lincoln (1994), the interviewer must be flexible, objective, empathic, persuasive, and a good listener. The independent interviewer was a qualified social worker and thus possessed all the skills necessary for the interviews. Seven of the interviews were conducted in the participants' homes where they were comfortable to share confidential information. One couple opted to meet in a coffee shop on their request and the researcher confirmed their comfort in this regard.

3.8 Data Analysis

Qualitative data analysis can be described as the process of making sense from research participants" views and opinions of situations, corresponding patterns, themes, categories and regular similarities" (Cohen, Manion & Morrison, 2007:461). Marshall

and Rossman (1999:150) state that qualitative data analysis is a search for general statements about relationships among categories of data. Esterberg (2002) describes qualitative data analysis as a process of making meaning. In contrast with quantitative methods that examine cause and effect, Muijs (2011) suggests that qualitative methods are more suited to looking at the meaning of particular events or circumstances.

The goal of qualitative analysis is to focus on the potential meaning of data. Patton (2002) states that qualitative analysis transforms data into findings. This involves reducing the volume of raw information, sifting significance from trivia, identifying significant patterns and constructing a framework for communicating the essence of what the data reveals. The process of data analysis involves making sense out of text and image data. It involves preparing the data for analysis, moving deeper and deeper into understanding the data, representing the data, and making an interpretation of the large meaning of data (Creswell, 2013). Leedy and Ormrod (2010) further state that qualitative researchers construct interpretive narrative from their data and try to capture the complexity of the phenomenon under study. Qualitative researchers thus use a more personal, literary style, and they often include the participant's own language.

Fouché and Delport (2005) indicate that in qualitative research, the data obtained from an interview is not quantified, but rather described in terms of themes, sub-themes and categories; relating the experiences of the participants. This descriptive data then makes use of quotes from participants to illustrate and record the findings. (Bogdan & Biklen, 2006). Patton (2002) proposes that qualitative analysis transforms data into findings. This involves reducing the volume of raw information, sifting significance from trivia, identifying significant patterns and constructing a framework for communicating the essence of what the data reveals. The aim of qualitative research is to present the text in ways that capture the essence of the respondents experiences and the context inwhich these occur (Schutt, 2011), without stripping the experiences of their meaning (Maykut & Morehouse, 1994).

Ryan and Bernard (2003) indicate that qualitative content analysis and thematic analysis are classified under the qualitative descriptive design. They are sets of techniques used to analyse textual data and identify themes within them. Thematic analysis was used in this study. According to Braun and Clarke (2006:79) thematic analysis is a method used for 'identifying, analysing, and reporting patterns as themes within the data'. The reason that this method was chosen is because 'rigorous thematic approach can produce an insightful analysis that answers particular research questions' (Braun & Clarke, 2006:97). It minimally organises and describes your data set in (rich) detail. However, it also often goes further than this, and interprets various aspects of the research topic (Boyatzis, 1998). Advantages of Thematic Analysis are identified by Braun and Clarke (2006) as follows:

- Flexibility.
- Can usefully summarise key features of a large body of data, and/or offer a "thick description" of the data set.
- Can highlight similarities and differences across the data set.
- Can generate unanticipated insights.
- Allows for social interpretations of data.

Thematic analysis occurs when the researcher translates and transcribes the tape-recorded interviews, then read and rereads the interviews in their entirety, reflecting on the interviews as a whole. The interviews are then summarized; keeping in mind that more than one theme might exist in a set of interviews. Once identified, the themes that appear to be significant and concepts linking substantial portions of the interviews are written down (Morse & Field 1996:115).

Braun and Clarke (2006) identify that a theme captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set. As an implicit topic that organizes a group of repeating ideas, it enables researchers to answer the study question. Each theme may

have some subthemes as subdivisions to obtain a comprehensive view of data and uncovers a pattern in the participants' account (Aronson, 1994; Lopez & Willis 2004).

The following table identifies the phases of thematic analysis according to Braun and Clarke (2006:87) and the corresponding phases which were followed in this study.

Table 3.1 Processes of thematic data analysis (adapted from Braun & Clarke, 2006:87)

Thematic analysis (Braun & Clarke, 2006:87)	Thematic analysis in the study
<u>Familiarising with data</u> Transcribing data, reading and rereading the date, noting down initial ideas.	The researcher transcribed the data verbatim and identified initial ideas while doing this. The researcher read through each transcribed interview a number of times to gain insight into the data as a whole and wrote down any ideas that were identified.
<u>Generating initial codes</u> Coding interesting features of the data systematically across the entire data set, collating data relevant to each code.	Initial codes were identified after reading though the data. Examples of the codes identified are infertility experience, loss, feelings, adoption experience, etc.
<u>Searching for themes</u> Collating codes into potential themes, gathering all data relevant to each potential theme.	The researcher organised the codes into more abstract themes. The researcher selected the main themes and explored the underlying meanings from the interviews and the qualitative questionnaire.

Reviewing themes Checking if the themes work in relation to the coded extracts and the entire data set, generating a thematic map.	The researcher identified a list of similar themes, as well as of all the topics, which had surfaced during her readings; and these similar themes were clustered together. An independent coder also identified themes and these were then compared to the themes identified by the researcher.
Defining and naming themes Ongoing analysis for refining the specifics of each theme and the overall story that the analysis tells, generating clear definitions and names for each theme.	The most descriptive text was organised into new themes, which the researcher may have missed during the previous transcript examining. The feedback from the independent coder was compared to the researchers identified themes. The data that related to each theme was then grouped together; and a preliminary analysis was performed. Subthemes were identified.
Producing the report The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a report of the analysis	While writing up the research report the researcher reviewed identified themes and subthemes comparing it to those identified by the independent coder.

Due to the researcher's close association to the topic the use of an independent coder was employed to counter any potential researcher bias during the data-analysis phase of the study. The researcher utilised an experienced independent coder from the Health

Sciences faculty of Nelson Mandela University who used the same data analysis process, in order to ensure the consistency of the data obtained during this study.

3.9 Data verification

According to Durrheim and Wassenaar (1999), validity refers to the degree to which the research conclusions are sound. Lincoln and Guba (1985) propose constructs which can be used in the qualitative paradigm in order ensure the soundness. These constructs were used by the researcher to verify data collected. Lincoln and Guba (1985) cited in De Vos (2005:346) propose the following four constructs, namely: credibility, transferability, dependability and confirmability. A brief explanation of these constructs follows:

Credibility is the alternative to internal validity, in which the goal is to demonstrate that the study was conducted in a manner that ensures that the research participants were identified and described in an accurate way. This implies an in-depth description, showing the complexities of variables and interactions. This would increase the probability that the data gathered from the setting would be valid. The study was monitored by a research supervisor and an independent coder was used to ensure the credibility of the study.

Transferability, as a criterion of trustworthiness, refers to the degree to which the findings can be applied to other settings and contexts outside the study. Durrheim and Wassenaar (1999) refer to this phenomenon as reliability. The exploratory-descriptive strategy of inquiry was used to describe the experiences of the particular participants. The research methodology is recorded in this chapter in order to enhance transferability. It is not the intention of a qualitative study to be generalized or transferred, however, if necessary to transfer a study of this nature to other research areas of interest, a prospective researcher will be able to utilize the exploratory descriptive strategy of inquiry and obtain similar results (De Vos, 2005:346).

Dependability is viewed as the alternative to reliability. With reliability, the researcher attempts to account for the dynamics surrounding the research subject, such as changing conditions, as well as changes in the design, as the researcher gains a more refined understanding of the setting. Dependability attempts to determine whether the findings would be similar if the study were to be replicated (De Vos, 2005). In this study, the following strategies were implemented to maximise consistency, including: (a) a detailed description of the strategy of inquiry and the process followed, (b) data collection and analysis procedures, and (c) the use of an independent coder.

Confirmability represents the fourth and final concept in Guba and Lincoln's model of trustworthiness; and it has to do with neutrality or the traditional concept of objectivity. This refers to the extent to which outside influences, biases, perceptions and motivations impact the findings of the study. Guba and Lincoln (1989) stressed the fact that others should be able to confirm the findings of the study. The goal is to remove the subjective influence of some of the characteristics that are inherent to the researcher, and to rather focus on the data themselves (De Vos, 2005). In this study an independent interviewer was used to prevent bias in the way that questions were used in the interview. Furthermore, the use of an independent coder was employed to assist in countering any potential researcher bias during the data-analysis phase of this study

3.10 Ethical considerations

De Vos et al., (2005:56) offers a description of ethics as follows: "…Ethics is a set of moral principles that are suggested by an individual or group, are subsequently widely accepted, and offer rules and behavioral expectations about the most correct conduct towards experimental subjects and respondents, sponsors, employers, assistants, students and other researchers…" Strydom (2005) values ethics in research as a measurement of a scientific standard, and further explains that ethical practice ensures that society is not misled.

According to Wassenaar (2006:61) the purpose of research ethics is "to protect the

welfare of research participants." The fact that human beings are the objects of study in the social sciences brings unique ethical problems to the fore, which is normally not relevant in the pure, clinical laboratory settings of natural science (De Vos et al., 2011). Babbie and Mouton (2001:520) states therefore that the researcher needs to take caution and to be aware of the general agreements about what is proper and improper in the conduct of scientific inquiry.

The study was presented to the NMMU ethics (Human) committee for approval and ethical approval was granted. The ethical clearance number is H15-HEA-SDP-006 and the outcome of the ethics approval is attached as Appendix 5. The following ethical considerations were implemented throughout this research study:

3.10.1 Informed consent

Graziano and Raulin (2000) believe that participants have the right to know exactly what they are getting into and to refuse to participate if they so choose, this is the basis of informed consent. According to De Vos et al. (2011) informed consent ensures the full knowledge and cooperation of subjects, while also resolving, or at least relieving any possible tension, aggression, insecurity or resistance of the subjects. "Informed" according to Williams, Grinnell and Tutty (in De Vos et al., 2011:117) means "…that each participant fully understands what is going to happen in the course of the study, why it is going to happen, and what its effect will be on him or her." Consent forms (Appendix 3) were signed by each participant, indicating their willingness to participate without duress.

Leedy and Ormrod (2005) advise that informed consent should include that participants are informed of their right to self-determination regarding participation, the procedures that will be followed, the advantages and possible disadvantages of participation, and the credibility and role of the researcher. This was explained in the letter to participant (Appendix 1) and at the beginning of the interview. Appendix 3 and 4 were used to ensure that informed consent was implemented in this research study.

3.10.2 Confidentiality

Babbie and Mouton (2001) distinguish between confidentiality and anonymity and further believes that confidentiality implies that only the researcher should be aware of the identity of the participants, and that the researcher should make a commitment with regard to confidentiality throughout the study all possible means of protecting the privacy of the participants was applied by according to the ethical guidelines. Confidentiality and anonymity was upheld in this study in the following ways:

- In the letter to the proposed participants (Appendix 1) the matter of privacy and confidentiality of data was explained. It was also explained that the information obtained during the data collection process would not be exposed in its raw form, upholding confidentiality. Furthermore it was explained that the research findings may be published and that the identities and interest of those involved would be protected.
- Participants' privacy was respected by allocating a code to each participant eg. P1, P2, etc. thereby ensuring anonymity in the interview transcripts.
- The audio recordings were transcribed by the researcher herself, thereby not exposing raw data to others.
- The transcripts and notes from the research were stored in password protected files on the researcher's computer, whereto only the researcher had access (Strydom, in De Vos, et al., 2005:68).
- The transcripts were independently coded by which time the transcripts were de-identified and did not include any names or details which would identify the participants in any way.

3.10.3 Protection from harm

Leedy and Ormrod (2005:101) propose that the physical and emotional risks involved should be no greater than risks of day-to-day living. The independent interviewer and researcher are registered social workers in accordance with the Social Service Professions Act (Act No. 110 of 1978) (South Africa, 1978), and implemented the code

of conduct as prescribed by this act to ensure that no harm was done to participants. Preparation for data collection and data analysis were conducted in such a manner that the participants were not in physical or emotional danger. As recalling the experience of infertility by the participants could have been difficult, the interviewer allowed participants to share only that which they were comfortable with. The participants were informed in advance that should they experience any distress as a result of the interview the researcher will refer them to the Nelson Mandela Metropolitan University Psychology Clinic for therapeutic and psychological support.

3.11 Summary of chapter

This study subscribed to the qualitative research approach and used the exploratory descriptive strategy of inquiry based on this study's aims and purpose. The data was gathered by using semi-structured interviews with couples that met the research criteria. Purposive sampling procedure was utilised when choosing the participants. Throughout the process, the ethical guidelines discussed in this chapter were taken into consideration by the researcher. Thematic Analysis was used to analyse the qualitative data. Guba and Lincoln's model of trustworthiness was used to verify data. The research findings of the study will be discussed in the next chapter.

CHAPTER FOUR

RESEARCH FINDINGS AND DISCUSSION

4.1 Introduction

In the previous chapter the research methodology was covered. In order for the study to reach its goal of enhancing the understanding of the experiences of couples who have been diagnosed as infertile and have adopted a child, this chapter will analyze and interpret the semi-structured interviews that were held with couples meeting the criteria for inclusion in the study.

As the participants were interviewed as a couple it is necessary to note that participants will be referred to as couples in this chapter for ease of reference. Furthermore, quotes cited from husbands will be depicted with an H, and those cited from the wives will be depicted with a W and the number of the couple as it appears on the table below.

4.2 Biographical Data

Eight couples were interviewed with diversity in terms of age of participants and adopted children, years of marriage, type and number of fertility treatments, number of children and whether they opted for transracial or "same culture adoption". Table 4.1 below gives an indication of the diversity of the couples interviewed which will be discussed in more detail later.

Table 4.1: Biographical information about couples interviewed

Couple	Years Married	Age of Husband	Age of Wife	Number of Fertility treatments	Number of children	Age of first adopted child	Age of other children	Transracial (T)/same Culture (S) Adoption
1 (H1,W1)	11	41	39	AI x2 IVF x4	2	8	5	T
2 (H2,W2)	3	39	32	Surrogacy	1	1	N/A	T
3 (H3,W3)	8	45	48	IVF x2	1	2	N/A	T

4 (H4,W4)	13	37	35	AI x3 IVFx1	1	2	N/A	S
5 (H5,W5)	10	41	36	AI IVF x1	1	5	N/A	S
6 (H6,W6)	25	51	46	AI IVF x7	3	16	6 5	S
7 (H7,W7)	5	38	38	AI x2	1	3	N/A	T
8 (H8,W8)	27	53	53	AI x1 GIFT	2	24	21	S

Legend:

H – Husband
W – Wife

Transfer

GIFT - Gamete Intra Fallopian

AI - Artificial Insemination
IVF - In Vitro Fertilization

All eight couples who formed part of the sample were heterosexual couples and ranged in age between 30 and 55 years. The number of years the couples have been married ranges between 3 and 27 years. The first adopted children's ages range between 1 and 25. Two of the couples have adopted a second child and one couple had a biological child shortly after adopting. One couple adopted three children in total. As can be seen from the information above, most of the couples were married for at least two years before they adopted their first child. This links to the medical definition of infertility as the inability to achieve a pregnancy after a period of at least twelve months of regular sexual intercourse without contraception provided by the World Health Organisation (2003). The average age of the couples when adopting in the study was 30, this is much later than the "expected" age for a couple to have their first child. Ceballo, Lansford, Abbey and Stewart (2004) confirm this by explaining that first time adoptive parents are older in age on average than couples who have first time biological children.

Artificial insemination was an option explored by most couples in the initial stages of being diagnosed as infertile. When artificial insemination proved to be unsuccessful

couples are given the option to undergo In Vitro Fertilisation (IVF). In this study IVF was the treatment option of five of the couples. One couple had as many as seven IVF treatments. The financial implications of the treatment options the couples opted for are very evident in the findings of the study, and will be discussed later in this chapter, and are the basis of the decision that couples opted not to continue with the treatment. One couple experienced Gamete Intrafollopian Transfer (GIFT).

Couples with children of diverse ages were part of the study. The children's ages range from the youngest being one year old and the oldest being 24. The placement of all the adopted children in the study was done within the child's first six months of birth. Only one couple interviewed had a biological child after adopting.

Half of the adoptions were from the same cultural group as their parents and half of the adoptions were transracial. This adds to the diversity of the study. Szabo and Ritchken (2002) explain that in South Africa there are not as many White children in need of adoption as there are White families applying to adopt. There are also not as many Black families applying to adopt as there are Black children available for adoption, which has led to the increase of transracial adoption placements.

The following section will discuss the research findings.

4.3 Research Findings

The research findings will be described in terms of themes and subthemes as per thematic analysis, which was the data analysis tool used by the researcher. The research findings are summarized in Table 4.2 below for ease of reference and to provide a guide to the in depth discussion which follows.

Table 4.2 Themes and Sub-themes

THEME 1	**SUBTHEMES**
Distinctive experiences regarding the infertility journey	Longing for parenthood.

	Life Stage transitioning Physical and emotional consequences of fertility treatment Lonely journey with limited support Losses Experienced Psycho-social and spiritual journey. Financial Challenges
THEME 2	**SUBTHEMES**
Experiences concerning adoption	Adoption being positive experience. Distinctive adoptive experiences. Adoption experiences with social workers in private practice versus those at NGO's and government organisations.
THEME 3	**SUBTHEMES**
Suggestions to assist the infertility treatment and adoption process for others	Exploring fertility options early in the relationship. Importance of support from marital partner. Support related to infertility and adoption. Need for structured information sessions and group support throughout both processes. Need to restructure policy and process in order to speed up the adoption process.

Theme 1: Distinctive experiences regarding the infertility journey

Distinctive experiences regarding the infertility journey was a key theme that emerged in this study. According to Jordan and Revenson (1999) the infertility experience can have an impact on almost every aspect of a couple's psychosocial functioning. Some aspects that may be affected are the couple's identity, decisions concerning treatment, shared beliefs about the importance of being a parent, as well as the experience of continuous and day-to-day stress associated with treatment. It was found in this study that the

couples identified such experiences which will be discussed under the subthemes that follow.

Subtheme 1: Longing for parenthood

Langdridge, Connolly and Sheeran (2000) examined the reasons for couples wanting a child and found that the reasons 'to give love', 'to receive love' and to 'experience enjoyment' were all rated highly amongst their research participants. All the couples interviewed in the current study expressed the fact that they desperately wanted to be parents and experienced the diagnosis of infertility as a loss. It is described aptly by the following participants:

"We wanted to be parents so desperately so badly to be parents to the point of giving up" W4.

"The saddest time in my life was realizing there probably won't be children in our life because it did come as a shock when we were at the doctor and he said there would be no chance of having children and at that time we just didn't believe it" W3.

Couples also expressed the desperation experienced when trying to have a child especially when it does not happen naturally and neither by assisted means. The words of one of the wives echo this, as follows:

"I didn't care what I was getting myself involved with I just wanted a baby……." W6.

The desperation to have a child becomes all that is thought about and sometimes may even lead to thoughts about surrogacy and illegal options such as offering bribes to women who may want to abort their unborn babies. This is evident from the thoughts that this wife had with regard to options to becoming a parent:

"In the process I had looked for a surrogate as well which we then decided against. I even thought maybe I should go to these abortion clinics and find someone there and pamper and pay and then adopt their child. This was how easy it was in my mind. My mind never stopped thinking about babies" W6.

"You are so young and you are so desperate because that is what is in your mind, what you want and what is in your heart. I think you are totally silly. You are totally stressed and it is all you think about and all that you do" W6

The longing to be a parent is for most couples the next stage after marriage. The couples in the study identified this and their experiences will be linked to Erikson's (1982) and Carter and McGoldrick (1980) stages in subtheme 2.

Subtheme 2: Life stage transitioning

Couples expressed that they are not transitioning the "normal" life stages as identified by Carter and McGoldrick (1980), who describe six stages of the family life cycle, a model that acknowledges the convergence of situational, developmental, and family-of-origin stressors. The stages and their tasks are: 1. Unattached young adult, 2. Married couple, 3. Family with young children, 4. Family with adolescents, 5. Parents launching children, and 6. Family in later life. The stages that are relevant to this study are married couple and family with young children. While parenthood enables couples to move forward through the predictable stages of the family life cycle, involuntary childlessness prevents this progression and impacts the whole family system dynamics. Couples identified the fact that their life was somehow on hold or stuck, which is identified by this participant:

"Like we were stuck not feeling like you are moving forward so we were just ready to give up" H4.

If couples experienced the feeling of being “stuck” they would not be experiencing Erikson’s stages within the expected time frame. The stages Erikson (1982) identifies as the most relevant to involuntarily childlessness in men and women are: young adulthood: Intimacy versus isolation; adulthood: generativity versus self-absorption. As Erikson (1982) points out, failure to move through these developmental stages leads to a sense of stagnation and interpersonal failure which may potentially impact healthy adjustment later in life, and successful achievement of developmental tasks contributes to happiness and success in later life. Not only are couples expected to have children, but also they are expected to have children “on time,” usually about 2 to 3 years after marriage (Daly, 1999:3). For these couples the need to be a parent was considered a natural stage that they would experience and this did not happen which leads to various psycho-social consequences as indicated by the wife below:

“You are so focused on IVF’s and children that you lost a part of your life. We always said that you either get divorced or you stay together because it is stressful in all aspects” W6

Furthermore, society also has an expectation that these stages will occur within a certain period of time. The wife below explains the process that they experienced as a couple and the societal pressure:

“I had a miscarriage and then remember it was a strange experience at 22 years of age and only married for a year. I remember the doctor and everyone said don’t worry you will fall pregnant quickly afterward. So this is in your subconscious and I think the stress builds up from there because the expectation is there that you are going to fall pregnant. You have just got married so everyone’s eyes are on you and they want to know when the baby is coming. This is how it went month by month and the issue to fall pregnant just compounded” W6.

When couples get married the expectation is that they will follow the next stage of life which is to have children. The following participant explains how she felt suffocated and how it was hurtful when people stopped asking when they would have a baby:

"I remember…… it was mother's day in church and I think it is the only time in my life it was almost like suffocating. That you walk into church and it was mother's day and people will say aaah one of these days for you……..then they stop asking. And that was very loud for us especially for me" W3.

One participant explained that as a couple they felt that they did not fit in which is linked to the "normal" stages that couples encounter as part of the family life cycle:

"We were married for 8 years and almost all of our friends already had children. You feel that you do not fit in. The mommy's talk children and the children are growing up around you. You feel as if you don't fit in. You don't belong to this group of people. They have different interests" W6.

The fact that couples do not "fit in", leads to couples withdrawing socially. A wife explained that she withdrew from social functions such as baby showers as this reminded her of what she did not have. This decision was based on the fact that she wanted to protect herself from being faced with the fact that she did not fit in to the reality that others were experiencing:

"I didn't eventually want to go to people's baby showers also. Like not that you are not happy for people who were going to have babies but it was like you know carry on. We are not going to be bothered by that and it does funny things to you. It just makes you a hard person I think that hole not having a kid and you want a kid" W6.

The following wife identified the fact that socially they would not speak about their infertility but people showed pity because the fact that they were childless was obvious.

“In the process you withdraw even more and I think the fact that everyone knows everything about you it is not nice. The pity irritated me and I thought just leave me alone. I don’t want to say it to anyone but it is impossible because everyone knows.”W6

The involuntary childless couples life is on hold as they redefine the meaning of family to include a marital dyad without children. Couples must alter their life, goals, and personal identities and all members of the family system must adapt and adjust as they rework family boundaries: these are challenging tasks for individuals, couples, and families. In a qualitative study conducted by Pedro and Andipatin (2014) it was found that couples go through distinctive stages after being diagnosed as infertile. These stages include disappointment and shock, denial, anger and frustration, deep state of sadness, self-blame and blaming others, acknowledgement, hope and optimism which were also identified in the study.

More than one participant also alluded to the fact that they are older parents. The biographical data provided earlier indicates that the couples are all older parents. This creates some anxiety and is linked to their lives being on hold for a period of time and that it did not go as planned as indicated below:

“You start panicking that you are getting older. You want a child” W6.

“We are older parents than I would have preferred to have been” H1.

For these couples the experience of wanting to be parents so desperately and then being diagnosed as infertile changed their imagined future and they had to redefine how they would achieve parenthood. Once couples had come to terms with the infertility diagnosis Infertility treatment was the next option for the majority of couples who were found to be in this position. Subtheme 3 will focus on the physical and emotional consequences of fertility treatment experienced by the couples interviewed.

Subtheme 3: Physical and emotional consequences of fertility treatment

According to Diamond and Kezur (1999), there are five distinct phases couples go through when going for infertility treatment. They are (1) dawning, (2) mobilisation, (3) immersion, (4) resolution, and (5) legacy. At first the couple becomes aware that they have a problem in conceiving and seek medical assistance. Mobilisation is the first step when couples begin with diagnostic testing. Immersion is the most complex and demanding phase. It begins as couples undergo more testing and treatment. The resolution phase consists of three overlapping sub-phases. These are ending medical treatments, acknowledging and mourning the loss, and refocusing on adoption or childlessness. The legacy phase encompasses the aftermath of the infertility experience. The wives below give an indication of the experience of initiating treatment:

"It was about a year into it where then they said ok now we can move along to the fertility clinic and at the clinic is where we first did artificial insemination twice I think and then after that they said ok that didn't work now we will put you on the medication to do IVF and it started from there… it took about a year." W1

"He started with hormone treatment and fertility medication. I then had artificial insemination done that was not successful. We then had GIFT done which was very expensive." W8

The physical side effects of fertility treatment were identified as being experienced mainly by the wives as the majority of the invasive medical procedures are performed on them. Most couples spoke about being considered "pin cushions" as can be seen in the responses below.

"Then the doctors come and they scratch and say this is wrong and this is not wrong" H6.

"the medical practitioners don't make you feel any better especially when they just want to use you as a pin cushion" W2.

"I felt like a pincushion and then the injections and then all the tests you had to have. They didn't tell you about the side effects. They are not telling you that you need to restrain yourself and that this going to literally make you crazy" W7.

Couples expressed that they wanted help coping with the emotional and physical stress that accompanies fertility treatment. They often felt as though they had not been adequately warned about the difficulty and length of the treatment process or the challenges to come, such as side effects of hormone therapy or their chances of success based on age or medical history. The participant below went for fertility treatment while married to her previous husband and opted not to pursue that option in her current marriage due to the effect that had on her physically and emotionally which ultimately influenced that marital relationship negatively. The emotions that are experienced during treatment can either strengthen or weaken a couple's relationship as is indicated here:

"I was married previously and so I went on fertility treatment at that stage. It did not work. It just made me feel bigger and horrible and I had no control over my hormones. It was just crazy and I was not prepared to do that to my second marriage as well" W7.

"Fertility treatment is from the devil. You hear words coming out of your mouth but you have no control over it. I almost stabbed by ex-husband with a knife. I had no control over myself and I was not prepared to do that to my second marriage" W7.

Other wives concurred with the participant above in respect of the effect that the fertility treatment had on their physical weight, but also made reference to emotional weight, implying an emotional heaviness that fertility treatment brought:

"Getting fat and picking up 20kg with IVF so that's how I eventually started this and it was like you know we are getting nowhere. I needed to get rid of that emotional weight" W4.

"I have PCOS (polycystic ovarian syndrome) so I am already a big girl and all of a sudden I gained like 30 kg. You feel horrible and now you look horrible" W7.

Infertility is often experienced as a crisis and has the potential to negatively influence different aspects of the marital relationship (Burns & Covington, 2006). It was found that the infertility diagnosis had a large influence on one relationship in that the wives mentioned that they thought the infertility was their fault and that they were responsible for not giving her husband a child. The negative factors experienced on an emotional level are identified in the experiences described below:

"I always had very high expectations and the disappointment was very emotional for me. It was difficult to accept and it was traumatic for me. I do think it placed strain on our marriage because I believed it was my fault. There was nothing wrong with E it was my fault. I couldn't give him a child and therefore I was a failure. I felt like I had disappointed him" W8.

"You are so focused on IVFs and children that you lost a part of your life. We always said that you either get divorced or you stay together because it is stressful in all aspects" W6.

"We argued about it a lot because I am going through the worst and I have a low threshold for pain, it is terrible. It is really very embarrassing. He only has to go to give a sperm sample. It felt to me as if he was angry for days after that. I think many times he was angry because he had to go through that no matter what I had to go through" W6.

Most couples identified the effect that it had on them physically and that they were overwhelmed by the medical procedures. The following quotes identify the areas that were overwhelming:

“It takes an emotional toll on you getting these injections and feeding you these pills” H4.

“Women’s bodies get dumped with all the pills” H5.

“I was so sick from all the hormones from the IVF. Every time you are done with the IVF some time needs to go by. Then I am overweight, then I am underweight, then I must lose (weight). We ride to Bloemfontein and for example you (need to) weigh 65 (kg) and I was 63 (kg) they would say sorry come back next month. It is very emotional “W6.

“It really felt like you were this machine it was like you were in autopilot” W7.

As with a study conducted by Daniluk (2001), the couples interviewed indicated that due to the invasiveness of the treatment, if they were given the option to consider treatment as an option again, they would not have considered it. Some indicated that the process was not worth it:

“Every month when the pregnancy test is negative you are just like we are only going to do one more month. All those tests it was really not worth it. To me it was not worth it” W7.

“That is a long process. I actually said to someone last night if I had to do it now I would not do it. I would definitely not do it” W6.

“The big frustration I think as I said earlier if I knew then what I know now I would not have gone for the treatment” W6.

Infertility treatment has a large range of physical side effects which have an influence on the functioning of the individual as well as the marital relationship which need to be processed effectively by professionals who are part of the infertility team. The psycho-social stress that couples endure during the process of infertility treatment also requires

support from various professional role players. What was found in this study was that the couples describe the infertility journey as a lonely one with limited support. Subtheme 4 outlines that the much needed support is voluntary and couples often do not make use of it making it a lonely journey.

Subtheme 4: Lonely journey with limited support.

All couples identify the infertility journey as one filled with very little support from family or friends. This is due to the fact that most chose not to share the fact that they are going to explore this option with many people. Couples identified the reasons for not sharing the experience with others as them not feeling like it was anyone else's business and also identified possible consequences for a child that is born through fertility treatment. They also expressed the fact that couples, who did go through the process, were also so silent about it that they could not get support from them:

"No one supported me during the fertility treatment. It was just us. I don't even remember if I told friends maybe one or two colleagues" W8.

"It is only them that we have let know also and like close friends of ours because it is also like we have a small circle of friends so those people are the only people that knew ok fine S is going in for a procedure this weekend and I mean you have got to tell somebody because it is a painful procedure" W4.

"The reason for our secrecy wasn't because we were ashamed or shy. We just felt it wasn't anybody else's business at work you know. It was not that we hid it away" W3

"I just thought if the IVF was successful I wouldn't want there to be a stigma attached to the child of well you have given birth to a child" W3.

They also shared the loneliness in terms of not being able to tell anyone if the treatment was not successful due to the fact that they had kept it to themselves or a very small group of people:

"We couldn't have children then the IVF was unsuccessful and we couldn't even talk to people about it because we didn't tell anyone except my sister" W3.

If they did tell someone it would only be one or two close family members or friends who then became part of the process. It also affected them when the couple experienced loss:

"They also get wrapped up in it and they become part of the procedure and they don't want to see their child or children go through the pain and all that's involved with it so they just also want to make it better" W1.

In a South African study conducted by Pedro and Mwaba (2013) participants explain that although psychological trauma is evident when undergoing treatment there was no psychosocial support available as part of the fertility clinics management of their treatment. Some of the clinics had the services of a psychologist available but the patient had to cover the consultation themselves.

The couples in the study identified that there was minimal emotional support from the medical professionals involved in infertility process. The offer of voluntary professional support was made but only a few of the couples explored that option which could be due to the fact that this would have additional financial implications. Professional support was very often only offered once a loss, such as a miscarriage, was experienced:

"*We didn't really have professional support" H2.*

"They don't walk you through the process. They never asked are you prepared, are you strong enough to go through this and come out whole on the other side" W7.

"No one medical gave me any advice or said anything. They were just like this is it bye bye, pay your money at the front. That's what I experienced" W2.

Couples who did have some type of support experienced it as positive and described it as follows:

"They (the infertility specialist and other staff at the clinic) really treated us well and we felt like almost they were in our corner which they were obviously they were supporting us and trying to get us pregnant and all this and they felt our joy when we did when S fell pregnant and they felt our pain when we lost the baby. The second time they were also disappointed so you know very empathetic towards us" H4.

"We knew we had someone who could relate to us in the process not just someone who is running a business you know they talk us through it. Then afterwards when the IVF was unsuccessful the doctors and the lady in the infertility clinic (were) compassionate and they did say the services of a psychologist or someone in that profession would be prepared to meet with us" W3.

Fertility treatment and the pre-ceded diagnosis of infertility bring with it many losses that the couple will experience. Subtheme 5 will address the losses experienced.

Subtheme 5: Losses experienced

Multiple losses experienced by infertile couples include loss of sexual identity; loss of the childbearing and child-rearing experience and the child they never were able to conceive; loss of the parental identity; loss of close relationships with a spouse, extended family members, and friends; loss of health; loss of status or prestige; loss of a sense of personal control; loss of genetic legacy; loss of a grand parenting

relationship; loss of a sense of spirituality and hope for the future; and loss of feelings of self-worth (Carroll et al., 2000: Gibson & Myers, 2000; Gonzales, 2008; Hart, 2002; Sherrod, 2004) The following wife indicates that she feels that as a couple they have lost a part of their lives in the process of pursuing parenthood.

"You are so focused on IVF's and children that you lost a part of your life. We always said that you either get divorced or you stay together because it is stressful in all aspects." W6

The focus of the losses experienced was overwhelmingly linked to the loss of potential children. All couples spoke of experiencing numerous miscarriages before or after treatment. One couple experienced the loss of a baby due to an ectopic pregnancy. In the study it was determined that one couple experienced the loss of twins that were born after an IVF treatment. One twin died at birth and the other died a few days later. Three couples identified adoption losses. Two of the couples "lost" the babies that they were due to adopt after the birth parents changed their minds and for one couple a legal battle ensured that their adoptive child remained with them.

"We had 7 miscarriages and 3 of them were with me (Wife had 7 miscarriages in total - 3 with current husband and 4 with previous husband). One of them was one of a twin with A. We had already gone through miscarriages and were now going through treatment and everything" H7.

"The GIFT worked but it was an ectopic pregnancy and the fallopian tube had to be removed. It was very traumatic. I just wanted to say every time I am just disappointed by these processes I can't do it again" W8.

One of the participants explains the process of going for fertility treatment and identifies the hope that is linked to it and then the loss at the end if the treatment was not successful:

"You have so much hope. They do the IVF. You are present when they do it and you see the sparkling little things and you see them going in. After two or three weeks then it is like bang! Then there is totally nothing" H6.

This was also experienced by another couple below who had a successful treatment and then had a pregnancy loss:

"I just wanted a baby and I think because we had gone through the fact that we had done the fertility treatment and I had, I was pregnant and we had that experience and then we had the sadness of having it but not having it" W1.

The earlier bonding possibilities of couples to the child have compounded the losses experienced since the arrival of pelvic ultrasounds and the visualisation of ova as well as fetuses. (Malkah, Mirium & James, 1997). Infertility is further an experience of multiple losses and, unlike bereavement, the losses are very often invisible as they could normally not be grieved as with death.

Grief and loss therefore, formed part of the experiences described by the participants. The losses of infertility identified below involved the loss of individual and/or couple's health, physical and psychological well-being, life goals, status, self-confidence, and assumption of fertility, loss of privacy and control of one's body, and anticipatory grief at the possibility of being childless. Couples spoke openly and in depth about the painful losses they had experienced.

Erikson's (1982) life stage theory prescribes that there are certain life stages that will affect the infertile couple; these will also influence the extended family as they would not have achieved the relevant life stage within the time frames indicated by Erikson (1982). The participant below explained how the pregnancy loss extended to affect her family and specifically her father. What is also identified in the father's response is that he did not know how to respond to the loss experienced by his daughter.

"My parents were just as disappointed for us when that first one was successful and then it wasn't and then obviously it was a miscarriage you have got to go to hospital. I cried that entire day. It was horrible and then my Dad came here and I mean my Father is not emotional type does not hug and kiss a lot very old school also. Hug and kiss you when you need to but he was here and I remember that night specifically because God knows best which we do understand. We just sat here we didn't have to say anything to one another we were just like ok cool carry on and he was also like carry on" W4.

The physical loss of a baby due to miscarriage is not the only loss experienced by the couple. It is also a loss of what could have been. Cudmore (2005) explains this as a loss of person to be, rather than that of a consciously known person that was. She further describes the loss as being the loss of the future as opposed to the loss of past, an imagined, fantasised baby and a fantasised image of becoming a parent. The husband below identifies this loss of the imagined which remains a question for the infertile couple:

"When we were trying to fall pregnant I can remember us imagining what our children would look like. We would then laugh about it. I think you still think what would they have looked like and how would they have been. I think this will remain a question forever" H6

The losses experienced by the couples lead to all aspects of their lives being affected. The psycho-social and spiritual journey identified by the participants will be discussed in subtheme 6.

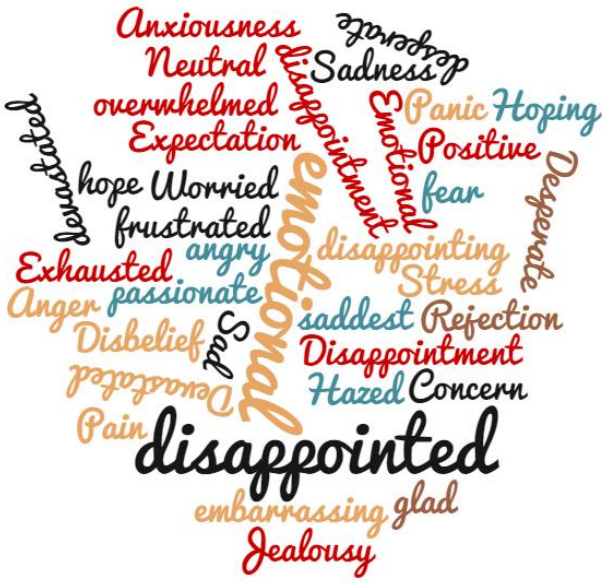
Subtheme 6: Psychosocial and spiritual journey

Wright, Bissonnette and Duchesne (1991) indicate that most infertility patients, especially women, consider infertility treatment to be the most upsetting experience of their lives. The couple experience a chronic monthly hope-loss cycle. The devastation worsens each month; and their ability to deal with the pain weakens. They are on a

monthly emotional roller-coaster, alternating between calm acceptance and highly intense emotional outbursts (Cooper-Hilbert, 1999; Daniluk, 2001; Boivin, 2003).

The couples in this study identified emotions ranging from hope to disappointment to describe the infertility process. The diagram below shows a word cloud of all the emotions identified by participants which was created by entering all the emotions identified on an online word cloud generator (wordcloud.com). Disappointment and emotional seems to be the emotion which was mostly identified. The disappointment and emotions identified were linked to the infertility diagnosis and the losses experienced by all couples.

Diagram 4.1: Word cloud of emotions identified by participants (created in wordcloud.com)



Throsby and Gill (2004) investigated couples' experiences of unsuccessful IVF treatment. They found that in general, women wanted their partner to talk about his feelings and to share his emotions rather than 'to be strong' which was experienced

as distancing and invalidating their own grief and distress. Other men in the same study felt they must protect their partner from their feelings and 'put on a brave face' in order to be supportive. This marital dynamic sets the scene for fertility treatment and may have influenced how the couples, as a unit, were experiencing the process.

In this study it was found that when asked about the experience of infertility the focus with all couples was on the experience of the wife in the process. The general feeling by the husbands was that the fertility treatment was driven by the wife. The husbands focused on the support that they needed to provide to their partners. A direct question was asked with regard to the experience of the husband and it was found that it links to the findings described by Throsby and Gill (2004) and they replied as follows:

"We need to be supportive of them generally and provide the sperm where it is necessary. Once you do that that's your job done. You must be a support for them mainly. Look we also (as) the men at the end of the day want the same results that the women want they want the kid you know at the end of the day so we must both be supportive of that end goal" H4.

"I could see it was a heavy thing that women go through in terms of the IVF procedures and the toll it takes on them. It is not an easy thing for them" H4.

"I think at the end of the day the woman puts much more pressure on (herself) going for treatment and she is the one that pursues the adoption. As men we carry on" H6.

Males are often reluctant to discuss infertility with their partner, which has been found to further enhance her feelings of distress (Peterson et al., 2006; Webb & Daniluk, 1999). This dynamic can result in frustration and communication difficulties within the couple (Greil, 1997). According to Cousineau and Domar (2007), research indicates that the male partner feels, due to the greater involvement of women in treatment, that they are less entitled to their own stress reactions and feel pressure to play a constantly supportive role as is indicated by the husband below:

"When we were going through the infertility side as much as I wanted a child I could see the pain that K was going through and it was extremely important not to show my pain or my frustration or my sadness but be the strong one even when we had the twins pass away…. I showed the emotion but I tried to be as strong as I possibly could for the both of us" H1.

Wright et al. (1991) suggest that men appear to deal with the transition to a childless lifestyle more easily than their wives, who find it more difficult to accept infertility. What became evident in what the partners shared in this study is that it allowed them to identify factors which they maybe had not discussed as openly with each other before as is seen in the quote from the husband below:

"It was interesting to hear what she says because for me having a child was much less of an issue than it was for her. I think for her it was I don't think I can say an obsession but it was much more urgent. As a young man I never dreamt of having children. That was not really so important to me. When we made peace, she struggled to make peace, with the fact that we would not have biological children. If she had said ok that is it I think I would have accepted it. I think it was something that was driven by her. To have children and also then eventually the adoption was driven by her" H8.

According to Cooper-Hilbert (1999), the ten stages in the developmental cycle of couples undergoing infertility treatment are: (a) expansion and promise, (b) contracting and betrayal, (c) resolution, (d) defining territoriality, (e) issues of attachment, (f) ranking order, (g) mating and marriage, (h) expansion, (i) contracting, and (j) the post-parental stage. According to Cooper-Hilbert (1999), each stage of the developmental cycle has to be mastered if the relationship is to be successful, and not end in divorce or separation. Schmidt, Holstein, Christensen and Boivin (2005) have proposed the concept of "marital benefit" where the experience of infertility has strengthened the marriage and brought partners closer together. For the couples who formed part of this

study, factors that brought them closer together were their religion, and being supportive to each other throughout the process which is described by the following wives:

"I can clearly remember that day sitting there and he had done tests and um we thought we will pray, we will faith this through and there are miracles and after a couple of years of going through it wears you down a bit but we were supportive to each other we always had that glimmer of hope but it was a sadness" W3

"I told my husband so many times if we stay together it is due to God's grace because it is terribly stressful. Then you must, then you can't, then you want to and then you don't want to" W6.

Enduring a stressful time can lead to questions about faith, the meaning of life and the existence of God. Couples start asking questions with regard to the reasons why they are not able to fall pregnant and religion plays an integral part of the questioning as is seen by a husband below:

"You start asking questions like why and you ask the Lord why what is wrong with my wife what is wrong with me?" H6.

It is possible that the couple could experience a loss of faith as a result of having gone through stressful times, but they may also emerge with a stronger faith and a conviction that it was God that brought them through (Van Wyk, Owen & Duff-Riddell, 2011). A comment from a couple referred to a time when they questioned their marriage and whether they should be together as they were not having children. They also identify the fact that infertility affects you deeply in the sense that it humbles you that you will have to struggle to have children while others can very easily experience the joy of parenthood:

"We joked for a long time about how the Lord sees us. Did he think no, you won't be good parents and that's why we could not have children? Or did he think this match does not work" W6.

"I think if you go for treatment it takes something else out of you. You must how can I explain it, not humiliating, you get cut to size. You become humble and you realize that others get married and fall pregnant easily. You start asking questions like why and you ask the Lord why? What is wrong with my wife? What is wrong with me?" H6.

Acceptance of the infertility label was also identified as a difficult emotional battle for couples and the following wife explained how seeing the diagnosis on the application completed by the doctor for the adoption application was difficult for her. She felt the need to substantiate the fact that she had fallen pregnant and even though it ended in miscarriages:

"H gave the form to the doctor and I had to collect it and I remember the day that I fetched it and he wrote infertility I thought that is terrible. I told him 'that is not true I can have children. I think I had 3 or 4 miscarriages I can have children and we had perfect embryos. They were always so excited because they divided so beautiful and they looked beautiful. I think every time something like that happened it set you back a bit and you thought I don't want to I do not have the energy" W6.

One of the most difficult aspects that infertile women describe is the difficulty in social settings, such as dealing with feelings of jealousy and envy when learning of other women's pregnancies or being in the presence of others who have infants. (Freeman, Boxer & Rickels, 1985). These feelings are described below:

"You think ag ok and then you see people with their kids. I didn't eventually want to go to people's baby showers also. Like not happy for people who were going to have babies but it was like you know carry on. We are not going to be bothered by that and it

does funny things to you. It just makes you a hard person I think that whole not having a kid and you want a kid" W4.

"The pity irritated me and I thought just leave me alone. I don't want to say it to anyone but it is impossible because everyone knows" W6.

Subtheme 7 will address the financial pressures, which were identified as being part of the infertility treatment process.

Subtheme 7: Financial Challenges

As the high cost of fertility treatment is not covered by medical aid it carries a large financial burden for couples that pursue that option. All the couples interviewed identified the financial implication of fertility treatment and for many this was the reason that prevented them from pursuing this option further. Couples expressed the fact that their medical aid did not cover the costs of the treatment and that this placed strain on them financially. Couples identified the fact that the fertility clinics were interested in the financial aspect mostly. The financial aspect is captured in the experiences below:

"Firstly it was not going to be covered by the medical aid so it was going to be a huge financial burden and there was no guarantee that it was going to work. So if we adopted we knew that there would be a certain amount that we would pay for the legal fees and the process you were going to go through and then you have definitely got the child" H7.

"So what I would like to see happen is for medical aids to cover it. It is a medical procedure it is not a choice, it is a medical procedure" H5.

"After the second treatment was unsuccessful, after the second IVF was unsuccessful financially it was a lot and emotionally it took its toll on us as well so we decided no we

are not going to do that again. We were going to look at other avenues and one of the things that we looked at more strongly than others was adoption" H4.

"I think especially the doctors when we did the fertility stuff. They just went through it like it is just another case. You really felt like a number like this is not working there is nothing we can do about it. We can do this and this and this and this is how much it will cost. There was always money involved. So it really felt like they wanted to get money out of us and they didn't want to help us" W7.

For some couples the financial burden added additional strain to the marital relationship. The following statement indicates that the financial strain created some pressure in the marital relationship:

"I think it put pressure on as a result of the financial situation. We could not really afford it. I can't remember how we paid it" W8.

"The pressure of the money is terrible. All the money goes into that. All your money, time and energy go into it" W6.

The need to be a parent left couples with the need to keep trying all possible options many times which had huge financial implications for them:

"Just another one ja just another one let's just get more money just another one and then you sit with no house or a half built house" W1.

A husband mentions the fact that it is money wasted as they had many other things they could have done with the money:

"You think 'what could I have done with that money?' You save and you save and you get everything together. It is like money blown into the wind" H6.

In a study conducted by Van den Broeck, Holvoet, Enzlin, Bakelants, Demyttenauere and D'Hooghe (2009), couples drop out of fertility treatment for a variety of reasons. They mention that with the longer duration of infertility the reasons are physical burden, financial burden and perceived lack of staff expertise. The financial burden as a reason to end treatment is reverberated in the comment by the husband below:

"We would have gone through it many more times I suppose. Well there were two things. The one thing was mainly money. It is an expensive process and the second one was S was just tired of the injections and the emotions" H4.

After many years trying to achieve parenthood naturally, being diagnosed as infertile and then going for treatment and spending large amounts of money couples make the decision to explore adoption as an option. Theme 1 encompassed the findings and discussion pertaining to the distinctive experiences of couples regarding the infertility journey. Theme 2 theme will discuss the findings with regard to the couple's experiences concerning adoption.

Theme 2: Experiences concerning adoption

Subtheme 1: Adoption being a positive experience

According to Vandivere et al. (2009), most adoptive parents report to having an overall positive experience with the adoption process. All couples in the study shared how adoption was an incredible experience and that it had fulfilled the hope that they would be parents. It enables couples to move from the intimacy versus isolation stage and provides entry to the next stage of Erikson's (1982) life stage theory, which is called generativity versus stagnation. It had fulfilled the need that they had yearned for. They also talk about how their lives have changed for the better and how a void or space had been filled:

"He has filled that little space in our hearts" H4.

"It is just phenomenal. So it has added another dimension to our lives" H4.

"It is such a beautiful privilege to be a parent" W3.

"We didn't think it was possible but it was wonderful to become a parent" W8.
"To us it was the best thing that has happened to us. It was amazing. It has changed our lives and S is just sunshine. If we weren't approaching 40 in a couple of months' time we would consider it again. It was a beautiful experience" W7.

"It is life changing. You have your own mind set of what it would be like to raise a child but when he came into our life it was completely not what we expected" H3.

"He was placed there it was part of his life's destiny us and him" W3.

Couples spoke about their children being placed in their care either by being part of the birth process or from places of safety. The wife below mentions the fact that she felt important when she became a mom, which is an indication of the scars that infertility had on her identity:

"It was also amazing because you were important eventually. You also feel as if all eyes are on you to see if you can do it" W6.

Another wife who was part of the pregnancy and birth process share the following:

"That was awesome for me because you saw this woman and you see her tummy and I can remember that I saw her kick. All I could think about was my baby, my baby. All that I physically did not do with M was give birth to her. I experienced all the other nice things. The other two were a week old and we got them from foster parents from XXX (NGO)." W6.

Subtheme 2: Distinctive adoptive experiences

All couples in the study made the decision to adopt after experiencing unsuccessful fertility treatment. Malm and Welti (2010) identify infertility, humanitarian reasons, and prior experience as the motivation for couples to decide on adoption as a means to becoming a parent. The decision to adopt was also made by both partners as described below:

"We then decided that we would not force adoption unless both of us said yes" W6.

"We were very at peace about adopting. It was never an issue. I said let's just adopt as I was not prepared to go through fertility treatment again " W7.

"We just knew and I think it might have something to do with our belief system you know Christianity and God directs and gives peace to make the right decisions that are prayed about" W3.

Couples experienced very different adoption experiences with specific positive experiences and challenges. For some the waiting period between application and placement was quick and for others it was a long waiting process. The mention of being put onto a list was made by all couples, which entailed a waiting period. For couples who had been waiting for such a long time the additional wait was often frustrating:

"We then put our names down for adoption and it was not very long after that that we were told that we would be parents" W7.

"It is two years after we filled in the forms and went through the whole thing and then you get the news" H3.

"Our total waiting period was five years" W5.

"We waited from 2012 three years" H4.

"The two year wait was… we didn't (lose hope) there was always the hope. I mean you trust and pray and there is always that element" W3.

The possible reason for the long wait for some couples stemmed from the fact that they adopted within their own cultural group. The majority of children being adopted in South Africa are white children being adopted by step-parents, but the overwhelming number of children in the child care and protection system who are eligible for adoption are black (Louw, 2009). Due to the greater number of black children being available for adoption in South Africa the wait for a child from that racial group may be shorter. According to Gerrand and Nathane-Taulela (2015) same race is the preferred adoption placement choice.

Anecdotal evidence suggests that there are fewer of the other racial groupings available and thus a longer waiting period if couples specifically request a child from the same cultural group as they are. There were couples who indicated that they would not consider a child from another cultural group due to them feeling that they would not be able to deal with the challenges associated with a transracial adoption. Their decision not to adopt transracially could be linked to them considering the effect that transracial adoption would have for them as a couple as well as their extended family. Family systems theory, according to Bertalanffy (1968), identifies that the action of one system has a ripple effect on the other parts of a system. The decision to adopt transracially will thus have an influence on the other systems linked to the couple.

Another factor that may influence the waiting period is if a couple is specific about the gender of the child. The husbands below identify this as the reason that they waited for the period of time they did:

"I don't know it is possibly why it took so long. We had a bit of a criterion as to what we wanted. No offense to anybody. We specifically chose not to adopt cross culturally.

We decided we don't want a black baby. We wanted it as close to us as possible. We specified we wanted a boy obviously" H4.

"You leave and your name is on the list and still nothing happens. They would assure you that one or two babies a year became available. That would be white babies. Black and mixed raced babies we could get immediately and we were not there. I think you must be there to be able to do it" H6.

Couples spoke about the fact that they felt that the placement of the child happened very quickly with very little time to prepare. They compared it to the nine months other couples had to prepare for the birth of a biological baby and expressed the need for time to prepare for the adopted child's arrival:

"I think initially other women had nine months to prepare for baby coming. We had two weeks, actually one week and then the court documents went missing and then we got an extra week" W5.

"We had 4 days to prepare or actually I almost got like "post natal depression" because when you are pregnant you get nine months to adjust to the fact that you are having a child. That was all we wanted at that stage. We wanted a child, we wanted a child. In your mind is it ever going to happen and all of sudden she is there like boom. Suddenly you have a baby" W7.

"At the time it was a bit strange because it was sudden. You did not have the same time to prepare" H8.

After the child is placed with the family there is a further waiting period of 60 days according to the Children's Act No 38 of 2005 (RSA, 2005), in which the birth parents can change their minds with regard to the adoption of their child. If the birth father is known but not involved in the child's life, a newspaper advertisement has to be placed, according to the Act, in order to give the father an opportunity to be part of the decision

making process. Couples expressed anxiety with regard to the waiting period as can be seen below:

"You are also so worried that somebody is going to take him away. We are aware of the 90 day period that the dad gets and the 60 day period that the mom gets and I think also because it was our first experience we wanted to have all the legal stuff so that nobody can take him away from us. We were worried about that" W4.

"Because then you panic you know because the minute you hear there was no consent from the father and it wasn't advertised in the newspaper if that father turns around tomorrow although you had her for three years it is the end of the story" H1.

"I would definitely walk the same path. I would definitely recommend it. I would prepare them (prospective adoptive parents) for the negatives as well as positives. The positives outweigh the negatives. The only real negative is the fear that the mother can change her mind" W8.

"S was in a safe home for two and a half months. They knew that she was going to be ours. I was worried about the two month waiting period. I was so worried" W7.

"We were so glad when she could be officially ours. It was definitely a difficult time that wait because by that time you had bonded and you didn't want to (lose the baby)" H7.

As can be seen from the above the waiting period adds additional anxiety for the coupled to endure after they have waited for such a long time to become parents.

The following husband identifies that the feeling that the feeling that they were not in control of the process was frustrating:

"I think the difference between an adoption and a normal situation is the fact that you feel you do not have control. Not that you have control but I don't think they feel so

vulnerable. If the doctor says everything is ok you have nothing to be fearful about. You have made the decision but you are in the hands of someone else. You are powerless. The other person can actually pull the plug on you" H8.

The following couple experienced their child being placed with them from birth and the birth mother withdrawing her permission for her child to be adopted. They described the experience as incredibly traumatic. The couple pursued legal action against the birth mother and was able to have their adopted child returned to their care.

"We cried terribly. It was like death. This child was going back. This fairytale had come to an end. As a shock it hit you the child is going back" H6.

"They arranged that we have her in foster care. We sued the mom and we had to prove that she was incompetent to take the child back" H6.

According to Robinson (2006) for mothers, fathers and other family members who have lost a child to adoption, it is often impossible for them to accept the reality of their loss, because they have no way of knowing exactly what they have lost when the child is relocated away from the family. There is also often a sense of unreality about the events surrounding the birth and adoption, especially for those who do not directly participate. Mothers who have lost children to adoption do not have a concrete focus for their grief, because what they have lost is intangible.

As part of the placement process couples spoke about the fact that in some cases they were treated differently compared to those parents who had given birth to biological children. The amount of maternity leave was less with one mother lobbying for maternity leave benefits to be reviewed at her company:

"We did have a little bit of a tough time I mean I only had ten days (maternity) leave" W2.

“Adoptive parents actually get treated differently to normal parents who actually give birth” W4.

“It shouldn’t be any different because you are raising a kid. It is the same thing like any other Mom would do who is able to have their own kids also” W4.

According to the Basic Conditions of Employment Act (1997), pregnant workers are entitled to at least four consecutive months of maternity leave. Adoption benefits as a right in South African Labour Law, do not exist. Maternity leave is thus a negotiated benefit between an employer and the adoptive parent which often places additional pressures on the new family’s adjustment.

Hajal and Rosenberg (1991) identify that the extended families are also affected by the couple’s decision to adopt. Grandparents need to, for example, grieve the loss of their biological bloodline. This is linked to Bertalanffy’s (1968) family systems theory in that the grandparents have also been affected by the decision to adopt. Most of the couples mentioned the involvement of extended family in the adoption decision. The support from family played a very important role in the couple transitioning to adoptive parenting. Some couples identify that they had the necessary support from their family members when making the decision to adopt:

“We didn’t hide the fact that we are going to adopt and luckily for us we have had support. We have had amazing support. He looks like one of the family. He is not treated differently” W5.

“Our parents were very supportive as if they were their own. They never spoke about them as adopted children. Our friends were as excited as we were. Because the infertility process was so difficult for me they were happy for us. I can’t remember anyone being negative” W8.

"Everybody was very happy, we will support you we will love the child as if it is our own. There wasn't any funny business from any of our family" H2.

The administrative process linked to adoption was identified by all couples as a frustrating and lengthy process. They identified that they were not able to function as a "normal family" due to the challenges experienced with getting their child's name changed. This had implications in terms of travel with the child as well as having the child reflected as a dependent on the medical aid. For some couples this even extended to when the children started attending school:

"The social worker said that at the end of January when she returned from holiday she would do our report. It is terrible because they check all your ins and outs and check if you are good enough to be a parent. You really go through so many emotions. You feel you are really scrutinized while other people just decide ok we are going to have another one (baby). Or they don't want (a baby) and they have (one) anyway" W6.

"It was basically there and then that they needed a court order that we would be a place of safety because they are all going on holiday they are all closing down and then when they open up we must say yes fine. They had never done something like that before but it just happened to be in that time frame and everybody was going on holiday" W3.

"Unless he has a green book (referring to the unabridged birth certificate) we can't do anything. I had to actually go and register him at gym and the woman looks at me and then I am like oh my gosh I must explain this. And it took gosh we got J on the 13 December filled in the stuff for Discovery (medical aid) and all those type of things. This is the other thing that I didn't like about the whole adoption process you have got to explain your story. You get a different person all the time. It just irritates me" W4.

"And also it was December nobody works in December in government" H4.

These challenges will be further discussed in subtheme 3.4. which will cover the need to restructure policy and process in order to speed up the adoption process.

As indicated earlier the majority of children being adopted in South Africa are white children being adopted by step-parents, but the overwhelming number of children in the child care and protection system who are eligible for adoption are black (Louw, 2009). Same race is the preferred adoption placement choice. According to Gerrand and Nathane-Taulela (2015), in the South African context, very few White, Coloured or Indian children become available for unrelated adoption. When they do, they are almost immediately placed with already screened South African adoptive parents who have been placed on a waiting list to be matched with a child of the same racial group. Transracial adoption has become a choice for some couples wanting to be parents.

Bilodeau (2015) defines transracial adoption (also referred to as interracial adoption) as the act of placing a child of one racial or ethnic group with adoptive parents of another racial or ethnic group. In this study half of the participants adopted transracially. This brought distinctive challenges that the family had to deal with which are identified in the quotes below.

"My family was really against the idea of adopting anything but a white child and to the extent that I had so many words with them that we ended up not talking to each other for about three months" H1.

"If she (her mother) is with me it is like she can't be seen in public with my child. I just say no anyway because if she can't be seen with my child I am not going (accompanying her mother to public places). It is just one of those things" W7.

"My step mom was taken aback by this and she never knew we wanted to adopt and she said as long as it is not a coloured or a black child. When J said coloured she jumped up and stormed out of the lounge" H3.

"So that was already rejection aimed at us because we had made the decision and now taken on a family member that the step-mother didn't approve of…. that was a struggle but more so for C because it was his father that he couldn't see. The father was in between pleasing the son and the stepmom" W3.

The rejection that couples experience from their extended family can cause a tremendous amount of stress. It is thus essential that the extended family be part of the process to ensure that the child is fully integrated into the family. The couples expressed shock and disappointment at the reactions from their family members as indicated below:

"We just saw another side that we never knew existed it was actually unpleasant. I can understand now why the social worker said speak to the family" W3.

The wife below indicates that her step-mother was not able to handle the fact that they had chosen to adopt transracially. The step-mother was happy that her step-son had married a "lovely girl" and then the incredibly negative reaction when they adopted a child of another racial group:

"C has met this lovely girl that she approves of and liked and things went well and we were all so happy and suddenly in comes a coloured child. She couldn't handle it. I have never had that feeling in my whole life that someone's viewing me with disdain" W3.

"Racism. My Mom and stepdad do not accept the fact that I have adopted at all. It is just we are not welcome in their house. We have accepted that. My step dad will not acknowledge the fact that she even exists" W7.

The following wife questioned the bond between their adopted children and their parents and expressed concern that the grandparents had a stronger bond with biological grandchildren:

"I think the love for their "own" grandchildren that they do have is stronger because they are biologically theirs than the ones that we have" W1

Couples who adopted transracially expressed the need to protect their children and families and indicated that they would choose not to have contact with certain people based on their responses to their family being "different".

"Those people who would stand by us and our decision they were fine those who don't sorry for you, you are not going to be part of her life and you know you are missing out" H2.

"I have lost a lot of friends because they didn't understand but to us there is never that negativity toward her" W7.

"I do have family members who do have issues with them but we don't see those people on a daily basis and they are not really a part of our lives so the people that are here that are important" W1.

Religious beliefs and practices also became evident in a discussion with a couple who had adopted a child and their religion prescribed that the child would not be able to inherit from them due to the fact that he was adopted. They, as seen below, expressed frustration and anger about this and indicated that they would not be told what to do based on their religion:

"There are a lot of limitations on our religion. Even with adoption as well he can't inherit from us but we are not so super religious. If anybody doesn't want him to inherit from us that is their story. We are raising him it has got nothing to do with them" W4 and H4

One of the greatest compliments that a new mother can receive is, "Your little girl looks just like you. She has your eyes." This "resemblance talk" of comparison of who the

child looks like in the family is a very common discussion among families (Becker, Butler, & Nachtigall, 2005). According to Lindsey (2012) comments about likeness are not something that the transracially adoptive family will hear often, but the desire to look like a family, even if they do not look alike, must be acknowledged and cannot be ignored. This lack of physical similarity can create confusion for the child and the parent as well as onlookers, and it can have a negative impact on the family. The wife below speaks about the challenge she experienced when comments were made about her daughter looking different:

"I think she was also hurt by people asking who she looks like and it is my fault because I used to say she looks like a family member. I think that hurt her because she was very self-conscious because she was different. People would ask in front of her why she looks different and make comments like that. Maybe I should have told people she is adopted in front of her" W8.

Ledderboge (1996) states that the public's interest in transracial adoption was often experienced as intrusive and as a stress factor for families who had adopted transracially.

Even for couples who adopted children from the same racial group the concerns with regard to how their children would be accepted was a reality. It is evident from the response from the wife below:

"Sometimes I wonder how family will feel about our children compared to the other grandchildren. You are so aware that people can be nasty" W6.

Subtheme 3 will focus on a comparison of the experiences of couples who have adopted using social workers in private practice versus those who have used social workers at NGO's or government institutions.

Subtheme 3: Adoption experiences with social workers in private practice versus those at NGO's and government organizations.

The choice of adoption agency also added diverse experiences as half of the couples in this study chose to make use of social workers in private practice while the other half made use of social workers at NGO's or government institutions. In a study conducted by Mokomane and Rochat (2012) it was found that social workers in South Africa felt there was a lack of consistency and uniformity in the interpretation and implementation of the adoption legislation, which was influenced by the lack of adequate resources to enable social workers to stay abreast of new developments. They further explain that as a consequence of prolonged understaffing, the adoption process in South Africa is viewed, by both service providers and adoptive parents, as 'long', 'painful' and 'complicated'. Half of the participants pursued the adoption process through social workers in private practice and the other half through NGOs that deal with adoption.

The wife below expressed the fear of dealing with social workers in government due to witnessing her friend's negative experience with them.

"I didn't want to go through government because I was afraid that something would go wrong. That was my biggest fear" W7.

Couples identified the challenges they faced when dealing with government social workers and social workers employed at NGO's. The unprofessional approach and inexperience of the social workers dealing with adoption are evident in the experiences identified below:

"We are still waiting for our interview through the department of social development…… and that is seven years later" W5&H5.

"Because we didn't get any feedback and whenever you phoned to find out they would say no the lady that deals with adoption is on maternity leave and there is no one else

doing her work and then we eased up a bit and then we found out about private social workers" W5.

"Unfortunately the XXX (NGO) lost their accreditation to do adoptions. Somebody had not filed their paperwork on time so we have just been waiting for that" W2.

"He (the magistrate) says ok "where is your character reference". She (the social worker) says oh no she hasn't done it yet and he (had) a look a disbelief and we went home" H3.

Couples had very diverse experiences when dealing with social workers in private practice. They describe the overwhelmingly positive experiences as follows:

"The social worker was amazing. Even with the things with my parent and things we would have an hour (or a) two hour long discussions just talking. Whenever we need her and even know with S birthday she gets a photo. So really she was amazing we couldn't have asked for better"W7.

"She was very warm and supportive. Before the adoption we were part of a group that met over a weekend where couples who were on the list to adopt met" W8.

"Her interests in earning some sort of an income was by far secondary or tertiary for that matter you know even to the extent that we said look we've just gone through IVF and all that well don't worry you will get an invoice from me and even if you pay me in five years' time from now it is ok I just want you to be happy and I want the child to be happy" H1.

"This is what she does for a living and she is so well suited to it. I am sure almost to a certain degree she has found 10 children in the space before she contacted us that she thought to herself wasn't right for us. She made the decision before even contacting us that now this kid won't fit with them. When she did contact us (she knew it was a good

fit for us) and then it turned out to be a good fit. Everything she does you know she has a little office in her home very cozy and comfortable. She makes you feel at home. She treats you well regardless of your race. She doesn't care what (or) where you come from or what you are. She treated us well and we are happy with the result. The entire process dealing with her has been nothing but a pleasure. I have not one bad thing to say about her at all" H4.

According to Attwell (2004) the social worker plays a significant role in the parents' consideration as they are gradually eased into the decision to want to adopt. There is a lot to consider when the initial thoughts of wanting to adopt comes to mind for the prospective parents. In the study conducted by Attwell (2004) a participant confirmed that without the help of the social worker they would not have had the baby and participants agreed that the social worker played an important role in the process of adoption and assisted in the actual adoption, in the processing of all the paper work.

Very few couples expressed negative and some unethical practices when dealing with social workers in private practice. The following couple describes a social worker in private practice who focused on enriching herself and did not have the best interests of the child or family at heart.

"It was how much can I enrich myself and earn more for my own back pocket so there was no honesty from that side" H1.

"She wouldn't allow us to go to court because we hadn't paid her in full" W1.

"The social worker from PE she heard when L was almost 3 and she still wasn't legally ours and then she said tell me what is going on and then the social worker from Pietermaritzburg sent our file to the one from PE and she said but there are things that are missing. She didn't even get consent from the father he hadn't signed" W1.

The social worker's role in the adoption process is so important and it thus needs to be professional, meeting the needs of the couple. Theme 3 will focus on the suggestions that the couples made with regard to the fertility treatment and adoption processes which will be of importance for the relevant practitioners.

Theme 3: Suggestions to assist the fertility treatment and adoption process for others.

Subtheme 1: Exploring fertility options early in the relationship.

Couples expressed the fact that if they had known what they know now they would have explored their fertility situation much earlier in their relationship. Due to the fact that a couple is only considered infertile one year into trying to conceive naturally, medical professionals only consider treatment after this time has lapsed. This then adds time to the process. The husbands below indicate that they would not have waited to try to conceive naturally and advise couples to start exploring this earlier in the marital relationship and not wait for a period of time. They advise couples to have their fertility status explored earlier in order to prevent them from experiencing some of the challenges they did:

"In hindsight maybe we would have practiced (tried to conceive naturally) earlier" H1.

"Um, I even go a step earlier you know when your friends go to get married and stuff go tomorrow after your wedding day you go to the doctor and you get yourself tested don't go through the rubbish we went through and waited for a long time" H1.

Subtheme 2: Importance of support from marital partner.

According to Ferreira (2005), infertile couples long for support and perhaps advice too; but they are afraid of being pitied. It is a painful secret that further isolates the couple from one another, as well as from friends, family and other means of support (Daniluk &

Tench, 2007). Abbey (2000) found that spousal support is essential in dealing with a shared hardship like infertility. This was also found in this study and identified in the following advice for couples in terms of the marital relationship:

"You shouldn't have (a situation) that when it gets too much, (you) fight. You (the couple) must stand together. Your communication…. You must be able to be there for each other and sometimes not always listen to (others) because everybody's got their own little opinion what they want to give (saying for example) and if I was you I would do this. Stay with each other, communicate with each other (and) be there for each other." H3.

"You have got to have a very strong relationship with your partner and B that your own strength has got to be bigger than any negatives that will come to you from your friends and family. You have to be there for each other" H7.

"There was 100% support from each other even when we didn't have answers for each other. We only had wishful thinking " W3.

Apart from support from the marital partner couples also identified other areas of support that are advised which will be discussed in theme 3.

Subtheme 3: Support related to infertility and adoption

Burns and Covington (2006) identify that couples want help coping with the emotional and physical stress that accompanies fertility treatment. They further indicate that couples often feel as though they had not been adequately warned about the difficulty and length of the treatment process or the challenges to come, such as side effects of hormone therapy or their chances of success based on age or medical history.

The advice to share your experience with your close family and friends was made by this wife as she expressed the fact that couples going through this process will need psychological, emotional and spiritual support from others:

"I believe you need to be able to share it with your immediate circle of family and friends. You have extreme emotional ups and downs and you need someone to walk the path with you. A church will also support you and it is different from the support you get from others" W6.

Another area that was identified as a need was to have support from other couples who have gone through the processes. The couples advise them to be prepared for the emotional response to the situation and that it would be understood if shared with other couples who have gone through the process:

"I think a person processes this thing that there will not be a biological child and you ask questions about why? I think it is something you should process. I think if someone is ready to go for treatment they should be able to speak to someone like L and I. It would be nice to counsel people in that process and tell them to try IVF and then put your name on a waiting list for adoption. Don't waste time. We actually wasted 8 years" H6.

"I would say be prepared there are a lot of emotions and you must chat to people who have gone through the process as well. You must be prepared that you will be broken, it is a long process unless you find an abandoned baby" W4.

"The emotions that you feel are normal. The anxiousness, anger and the jealousy when you see the other women being pregnant" W5.

"Don't think less of yourself because a lot of people do they think you know um I am not worth it you know and it is just part of life" W1.

What the wives above are advising is that couples engage in self-preservation. Schneider and Forthofer (2005) found that damage to self-esteem was a major consequence of infertility. Unworthiness is a searing, painful feeling associated with faltering self-esteem, and a sense of inadequacy, defectiveness and helplessness (American Society for Reproductive Medicine, 1995). According to the American Society for Reproductive Medicine (1995), anguish, self-doubt, and chronic sadness is evident as couples come to think of themselves as failing, not only in realising their own dream to reproduce and nurture, but failing their spouse, their parents, and their siblings as well.

The following participant expressed the need for couples who are considering trans-racial adoption to be ready to deal with societal stigma associated with adopting across racial lines:

"If you have adopted especially if you adopt a child of colour you have to be prepared to be in these fights. I have walked in a shop before and she was in the pram. They looked into the pram to see the baby and she turns around and her husband is behind me and she says, "It's a black one." I mean I am right here. We went to Beaufort West the one day and we were walking in the shop and someone walked past and said "O dit is 'n pittekop"(Oh that is a pip head). Those kind of things you will experience. You need to be ready for that" W7.

The social worker's role in the transracial adoption process as described by Attwell (2004) is to assist the couple to understand the specific challenges that they may face if they adopt a child from another racial group. It is essential that the social worker assist the couple to decide on how they will deal with these challenges.

Another mother who had adopted transracially expressed the need to have her son exposed to children who were also adopted in order to "normalise" it for him. The advice that she gave was that couples should expose their children to other families that look similar in order to assist their children with their identity development:

"I went there to start with I wanted T to meet other children who were also adopted because we are automatically different as a family, um I wanted him to see other families who are also the same" W1.

The need expressed by this mom was to allow her son to understand that their family system, although different from other families, was normal. The need for support from others that are in a similar situation is also expressed in the comment made.

The family who has opted to adopt transracially will have specific challenges with regard to integrating their child into their family system and will require the system to adjust to the decision they have made. The family could also form part of the decision making process and in so doing, ensure an easier transition.

Subtheme 4: Need for structured information sessions and group support throughout both processes.

Paulsen and Merighi (2009) argue that if proper communication and education are provided to parents, they are more likely to be satisfied with the adoption process and, more importantly, know to expect challenges with the adopted child and have the necessary resources to overcome those challenges. What was very evident in all interviews was the need that couples had to have information from the start of the process. They voiced the need to have all possible options discussed with them at the start so that they could make an informed decision with regard to the best option for them. It would have been important then that adoption be discussed as a possible option when infertility was diagnosed in order for them to decide if it would be the adoption option or fertility treatment. The couples below explain this need:

"I think maybe if gynaecologists are trained in a certain way to suggest that adoption is an option for you instead of saying there is nothing we can do for you but not once like

she (my wife) says did any one of those professional say there is another route called adoption" H2.

"They (medical professionals) must make information available. Tell people what options there are who they can speak to" W5.

"If we had that in the beginning or somebody that prior to starting this whole thing I think there was beginning of it you know just kind of like chat to somebody that doesn't know you from the outside (and have them ask) why do you want to do this? Are you sure you want to do this? and explain to us the ins and outs completely. Then maybe we would have obviously still gone through it but we would have been a little bit more prepared" W4.

In a study by Ferreira (2005), couples identified four major needs they felt that they lacked during their experiences of treatment – in order to help them cope better. These included the need for: (1) support from professionals in the field, as well as from friends and family, (2) information and knowledge on the treatment and the medical procedures, (3) a strong spiritual base, and (4) stress-management techniques. These couples therefore needed a strong support base providing information with regard to the medical procedures and assistance with the stresses associated with the treatment, which is similar to the needs identified by the couples interviewed.

Pedro and Mwaba (2013) identified in their study that the participants expressed the need to connect with other infertile people attending the fertility clinic so that through interaction they could compare and validate experiences, discuss various coping strategies and mechanisms and pose as a source of information and general support. The wife below also expressed this need:

"To speak to someone that is going through the same process as you. To encourage each other. It definitely would have helped" W8.

Couples also felt that during the adoption process more structured information and regular feedback would have been beneficial. The need for preparation for the psychological aspects related to adoption was also identified as a need.

"I think having somebody that helps you and not just say fill out this form and we will contact you in six months' time to renew your place of safety. Just sit down and explain everything. That would really have helped a lot" W2.

"I wish it would be more open as I said before it is only because of us reading one reads about the post-traumatic stress and all of that. It would be nice if adoptive parents could be introduced to that and be told about things like that you know" H5.

"And maybe a little bit more communication while the process is going on listen this is where we are now your paperwork must be sent up to Pretoria um we haven't heard anything from them yet but I will keep on trying you know just every now and then." H2.

A couple who had the experience of being in an adoption workshop before they adopted found this beneficial and recommended it for prospective adoptive parents:

"That weekend we were a group of if I remember correctly 6 or 8 couples. There were one or two couples who had a baby identified. We didn't at that stage. It was a workshop. It was useful because you were all in the same position. I can really recommend it" H8.

The couples expressed the need for couples who are diagnosed as infertile to have structured support throughout both the infertility and adoption processes. They identified that they would like professionals to provide assistance with advice with regard to both processes in order for them to decide on the option that suits them best. They expressed the need for psychological preparation for whichever process the couples had selected. A need was also identified for group support from others that had experience of what they would be going through.

Subtheme 5: Need to restructure policy and process in order to speed up the adoption process.

Couples expressed frustration with regard to the length of time adoption takes as well as administrative issues which could be managed more efficiently. These administrative matters have a very big influence on the family functioning after adoption. A specific concern which was evident for all couples was the change of name and birth certificates. The frustration can be seen in the comments below:

"The time frames should be less in terms of home affairs and birth certificates. There should be a uniform system between the organization as well as the court process" H2.

"The turnaround time from when you submit something and get feedback must be a lot quicker" H4.

"It is just the time frame and the costing. It's not that we don't want to pay for the service. All I am thinking about if we had a choice we would rather invest that money in a child's future than spending that money before you even get the baby" W5.
"That procedure, that process must be streamlined. You are waiting a long time as it is already for a baby you don't want to wait for the documentation so if that can be better. The documentation is so important for travelling and just to say that he is ours" H4.

"It just takes you forever. We are keeping her original name as her middle name. She knows her middle name so it is not such a big thing. On the medical aid she is still on her previous surname" W7.

"So from 2014 (when the child was placed in their foster care) till 2016 (when the child was legally adopted) we have officially legally (according to SA law) only then became parents" W3.

The consequences of the process taking so long are described by the father below who indicates that due to his son not having his birth certificate they could not put him on their medical aid and could also not travel:

"We couldn't put him on a medical aid. He couldn't go to the hospitals as we know. He got very ill the one time and he was in the Provincial Hospital and there are no blankets. There is just no care. If they speeded things up he would have got the right care that sort of stuff. We couldn't take him to family overseas because we can't get a passport there is all of that" H3.

A wife indicated that she found that the fact that the administrative processes were so slow have implications for South Africa and the preservation of family life as there are many children available for adoption and the process takes so long:

"*Ja a painfully slow process and that in itself is a tragedy for this country because there are so many little Xhosa children that are homeless. Because of the powers that be, the government, is too slow that (the children available for adoption) is your next generation. They (the children available for adoption) are not growing up with mommies and daddies being a family unit (and don't grow) into happy children. They maybe grow up without the basics in life and then you pick up problems" W3.*

Some participants indicated that they would have considered adopting another child, but if they considered the length of the process that they had to go through to make this happen, it affected the decision negatively. They also indicated that the cost of adoption and the length of the process may have an influence on others deciding not to adopt:

"We would love the thought of another little child a sibling for J but then that horrible feeling of going through that process" W3.

“If there wasn’t as much paperwork if it didn’t take so long and if it wasn’t so much heartache, uncertainty we would have had number two right now” H2.

“There would be more people that would adopt if it were more affordable” W1.

“I think a lot of people will probably never adopt would also adopt if the process was quicker but they hear so many bad stories of having to deal with the department (government adoptions)” H2.

The fact that the couples are not able to consider another child due to the processes involved is contradictory to their experience of infertility. When they went through the fertility process they experienced resilience to go for many treatments and endure extreme emotional and financial strain before deciding that they had explored all options. It could be linked to the fact that they now have achieved the goal of parenthood and thus the drive for a second child is not as urgent.

4.4 Summary of chapter

The couples’ experiences from the process of longing to be a parent, the infertility diagnosis, treatment and adoption process were explored in this chapter. Couples identified the losses experienced when undergoing fertility treatment as well as the joy experienced when they adopted and could finally become parents. They also provided advice for couples who would go through a similar process and identified some frustrations experienced with both processes. In the next chapter the summary, conclusions and recommendations of this study will be discussed.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

In Chapter 4, the findings of the research study concerning the experiences of couples who had undergone fertility treatment and had adopted, were discussed. These findings were linked to past research in this regard as well as literature which was relevant.

This final chapter presents a summary, conclusions and recommendations based on the findings from the research process. This chapter evaluates if the aim, goal and objectives of the study have been achieved and conclude with recommendations for future research with couples who have adopted after going through the infertility treatment process.

5.2 Summary of research process

The following sections will summarise the research under various headings.

5.2.1 Achievement of aim, goal and objectives

Firstly, the study need to evaluate whether has been successful in reaching the aims, goals and objectives outlined in chapter 1.

5.2.1.1 Aim of study

The aim of this study was achieved by exploring and describing the experiences of couples, who have undergone infertility treatment and adopted at least one child. This study will provide recommendations to social workers and other professionals who provide services to couples, who are diagnosed as infertile, undergo fertility treatment and choose to adopt.

5.2.1.2 Goal and objectives of study

The goal of this study was to enhance the understanding of the experiences of couples who have been diagnosed as infertile and have adopted a child. The objectives of the study were as follows:

- To explore and describe the experiences of couples who have adopted after undergoing unsuccessful fertility treatment.
- To make recommendations to professionals in the field of treatment of infertility and adoption in order to inform professional services to couples who are intending to achieve parenthood via adoption.

Both objectives identified above were covered in an in-depth discussion in Chapter 4, where the experiences of couples who have undergone fertility treatment and adopted, were discussed. The second objective will, however, be extended on in this chapter as this chapter pertains to summaries, conclusions and recommendations.

The study involved a qualitative, exploratory-descriptive research design in order to achieve the goals and objectives of the study. The objectives were achieved by:

- Designing a semi-structured interview schedule which ensured that the data collected was relevant to the objectives of the study.
- Recruiting eight couples through an organisation that supports couples who have adopted as well as via social workers in private practice and NGOs that deal with adoption.
- Conducting a pilot study in order to establish if the data collection questions would be relevant and appropriate for the participants in the study. The interview schedule was adequate and no adjustments had to be made.
- An independent interviewer conducted the interviews using the semi-structured interview schedule. The researcher was present to observe that the tool would allow for the collection of data relevant to achieving the objectives.

- Data collection and interpretation of results was done by the researcher as well as with an independent coder. Thematic analysis was employed to analyse data. Themes and subthemes emerged in consultation with the independent coder. The results were compared to previous research related to infertility treatment and adoption.

5.2.3 Summary of chapters

Chapter one introduced the research study and provided an overview of the study. The theoretical stance which would guide the research was discussed. The research methodology which would be implemented was also identified.

Chapter two focused on the literature review. The theoretical framework guiding this study consisting of life stage theory and family systems theory was discussed in depth. All aspects of the fertility process were explored, concentrating on the effect that it has on the couple. The adoption process was discussed from the decision to adopt, the application process, placement until the post adoption stage.

Chapter three focused on the research methodology which was implemented for this study. Qualitative research was described with an exploratory-descriptive design being used to explore and describe the experiences of couples who had experienced fertility treatment and adopted one child. Research goals and objectives were identified. The researcher's position was described in depth with ethical practices to overcome possible researcher bias.

Chapter four identified the biographical data relevant to the study. This was followed by a discussion of the themes, subthemes and categories. The findings of the study were compared to research findings with regard to infertility treatment and adoption.

This final chapter will focus on a summary, conclusion and recommendations for further research.

5.2.4 Summary of findings

The path to adoption: experience of couples who have transitioned infertility.

The study discovered that the infertility journey was filled with hope and disappointment with couples identifying physical side effects of the treatment. The couples experienced the treatment as emotional and highlighted the fact that it had an influence on their relationship. The financial burden of treatment was identified as the reason that some couples decided to discontinue treatment. They describe it as a lonely journey without the much needed support, due to the lack of disclosure to others and only voluntary referral for psychosocial support being offered by the fertility clinic.

The experience of adoption was an incredibly positive experience with couples identifying the intense emotions about becoming parents. However, the challenges experienced with the adoption administrative process were frustrating. Some couples identified having family support when adopting with their families accepting their adopted children. The trials of transracial adoption were discussed, with family responses and those of society in general, being identified. Couples identified the experience of choosing to use social workers in private practice and NGOs as mostly positive. The challenges that were experienced with governmental social workers were identified as social workers being inexperienced in dealing with the adoption process as well as an unprofessional service being provided.

Couples provided suggestions to assist the fertility treatment and adoption process for others. They identified exploring fertility options early in the relationship, accounting for the emotional and financial challenges, need for structured information sessions and need to restructure the adoption process in order to speed up the process as factors to be taken into account.

Couples related distinctive experiences regarding their infertility journey

All couples expressed the desire to become parents and explained that the diagnosis of infertility was not an easy one. The infertility journey was characterised by hope and

then incredible disappointment when couples realised that the treatment was not going to enable them to reach the ultimate goal which was to have a child. Couples expressed that they felt “stuck” in some way due to the fact that they were not parents at the expected life stage. Erikson’s (1982) developmental life stage theory and Family systems theory provided an understanding of the experiences described by couples with regard to their concerns with life stage transitioning. The couples identified the fact that they had not reached the required developmental life stage in at the associated age due their infertility diagnosis, treatment as subsequent adoption of a child. The influence of the couples experience on their extended families was identified and is linked to family systems theory.

They identified the physical side effects of the treatment and medication to have a negative effect on specifically the wife. Other physical side effects that were mentioned were the fact that the medication had an influence on the wives temperament and weight thus causing emotional stress to the couple.

The emotional consequences of undergoing fertility treatment were identified in depth. Husbands expressed the need to support their wives in the process and were very aware of the physical and emotional consequences of the treatment for their wives. They identified the fact that the treatment also had a negative effect on them emotionally and psychologically but they needed to stay strong for their wives. The silence associated with the fertility treatment within the marriage and with others added to the emotional and psychological burden.

The fertility treatment process was described as being a lonely journey without the much-needed support. Although couples identify the need for support they choose not to disclose the diagnosis and the fact that they are going for treatment to many people. This could be linked to the stigma attached to infertility and ignorance with regard to the psychosocial and physical effects on those concerned. Although psychological assistance was offered to couples at an additional cost they chose not to accept this type of support. Only when loss was experienced psychological support was made compulsory by the respective fertility clinic.

The many losses experienced were identified. These ranged from losses of babies through miscarriage, or the loss of hope due to a treatment not being successful. The marital relationship was affected by the emotions that the couple experienced throughout the treatment process. For most couples it was a strain on the relationship but they felt that the experience allowed the relationship to grow. Family systems theory supports the idea that if one part of the system is affected it will affect the whole system (Bertalanffy, 1969). The marital relationship as a system is then affected as the couple re-imagine their lives without children as well as the stress associated with the losses experienced.

Couples identified the psycho-social journey that they endured as a couple with social stigma with regard to their infertility leading to them withdrawing from social activities. Although they chose not to disclose their infertility diagnosis with many they felt that their involuntary childlessness made it obvious. Spirituality enabled couples to deal with the diagnosis, treatment and losses experienced because it gave them hope that they would be parents. Couples identified their path to parenthood as being influenced by their spiritual beliefs and hope that they would be Blessed with a child regardless of how this would be achieved. The relationship between partners, although strained ended up closer due to the experience of infertility and treatment.

The financial pressure of fertility treatment was identified by all couples as a concern. Couples questioned why medical aid schemes did not cover the expenses incurred for fertility treatment as they felt that it is a medical condition that they have no control over. When treatment failed they expressed the concern that it is money wasted, which could be invested in their future children.

After many failed fertility treatments couples started to explore the possibility of adoption as an option to become parents. The next theme focuses on the experiences concerning adoption.

Experiences concerning adoption

Erikson (1982) identifies generativity vs stagnation stage, as a necessary life stage which needs to be reached by couples, in order to navigate the other stages of life. What became evident in participants responses was that becoming a parent through adoption was identified as an incredible experience that was life changing. It changed their identity as a couple. Couples shared the fact that it was a privilege to be a parent eventually after fearing that it would not be a reality. These experiences allowed couples to transition to Erickson's next stage of generativity versus stagnation.

Couples experienced distinctive adoptive experiences dependent on the type of organisation chosen to manage the adoption process. Most couples experienced very long waiting periods for the adoption to be finalised in terms of placement and the paperwork concerned. These created challenges for the newly formed family to function effectively as the children could not be registered by their new names, on the medical aid and in some cases, could not be placed on the medical aid. Couples also mentioned the challenge of not being able to apply for a passport for international travel. The long wait for an available child and administrative process being so long, negatively influenced the couple's choice to adopt another child.

The fact that there was very little time between hearing that they had been matched to a baby and placement, was a difficult adjustment. This, as opposed to couples who could have a biological child, and would have nine months to prepare, yet adoptive parents only had a few days to prepare for the arrival of their long awaited baby.

Family support for the new family is essential and some couples expressed that their close family supported their choice to adopt and accepted the children as their own. Trials with regard to transracial adoption, such as family not accepting the adopted children as part of the family, were identified. Couples shared the disappointment in family members, who found it difficult to accept a child from another cultural group in their families. Most of these couples agreed that they understood the position of these family members and chose then to exclude them from contact with their children.

The perception of the role of the private social worker and social worker's from a public service provider was explored. Couples expressed the fear of using public service providers due to negative experiences that they had heard about. Those couples, who used the services of social workers at NGO's or government, were mostly unhappy with the services that were rendered. The delay in service delivery was mentioned, which could be due to the lack of resources that these organisations have. Unprofessional practice and inexperience of the social workers to deal with the adoption process were also identified. The experiences with social workers in private practice were generally positive with the social worker providing support at all levels of the adoption process. The financial strain of using private social workers was mentioned as a barrier in some cases.

Suggestions to assist the fertility treatment and adoption process for others

Couples were very eager to provide advice for couples who would be experiencing a similar journey to the one that they had. Exploring infertility options early in the relationship was identified as a necessity and it was advised that awareness and education should be offered by fertility clinics and medical professionals with regard to this so that couples could become aware of the need for it.

Couples identified that prospective parents need to prepare themselves for the emotional and financial challenges that are related to infertility and adoption. They advised prospective parents to communicate openly about the issues pertaining to both. The close marital relationship was identified as essential to a couple transitioning from infertility to adoption.

A need for more structured information sessions throughout both processes was identified. A need for the discussion of adoption as an option when being diagnosed as infertile was identified. Some couples experienced counselling during the process and found it very helpful. Couples identified the need for prospective parents to communicate with couples who had the experience of fertility treatment and had adopted in order to have some type of support and knowledge from them with regard to

what to expect. They identified a lack of communication from the medical practitioners at the infertility clinics with regard to the medical procedures experienced and expressed a need for this.

Although the adoption experience was described as being fulfilling as they had achieved long awaited parenthood, the couples expressed frustration with regard to the process it took to finalise the adoption. They identified the need for the adoption process to be restructured in order for it to be sped up. The delays in the administrative processes were identified as not being in the best interest of preservation of the new family unit.

5.2.5 Conclusions based on the research process

Qualitative research enabled the researcher to achieve the goal of the study as couples were able to reflect on their experience of fertility treatment and the experience of adoption. The semi-structured interview allowed for elaboration to be sought if clarity was required. Probing questions were asked in situations where the interviewer required more input. Observation of the couple's relationship dynamics also allowed for probing to be used as a resource to explore the meaning of interactions. The exploratory descriptive design allowed the researcher to explore, understand and describe in the research report which was aligned to the objectives.

5.3 Conclusions based on research findings

The conclusions are presented as three subsections consisting of conclusions pertaining to the infertility process, conclusions pertaining to the adoption process and then overarching conclusions pertaining to both processes.

5.3.1 Conclusions pertaining to the Infertility process

Achieving parenthood

It is concluded that parenthood is the ultimate goal of most newly married couples with the infertility diagnosis being a shock and painful for couples to accept. The infertility diagnosis and treatment do not only affect the couple but also the extended family.

The medical team

There is insufficient information and support from the medical team. The focus of the medical team is clinical and surgical. Couples are not kept abreast of how the treatment will unfold or how many times they will have to go through the process. Couples accept the uncomfortable surgical processes without bringing their discomfort to the attention of the doctors because they so desperately want to achieve parenthood. The perceptions of the participants was that the psychosocial consequences for the couple are secondary from the medical team's perspective. No counselling services are offered at the time of engaging fertility treatment. Adoption as a possibility is not explored by the medical team as part of the initial stages of deciding on a treatment option.

Psychosocial and physical impact

The infertility process is an emotional journey influencing the marital relationship, which either drives couples apart or brings them closer together. There are extreme physical side effects that accompany the infertility treatment such as excessive weight gain leading to low self-esteem. Husbands are aware of what their wives endure physically and emotionally and hide their own emotions for the benefit of their wives wellbeing.

Financial impact

Infertility treatment is expensive and therefore financially stressful due to the fact that medical aids do not pay for treatment. No guarantees of achieving parenthood are provided during the process. Many attempts are necessary in most instances, with the accompanying high costs, placing financial pressure on an already stressed couple.

Losses

The losses experienced range from losing a baby through failed treatment and miscarriages, losing hope (the possibility of what could have been), as well as losing the quality of the marital relationship. Couples lose support from friends because they do not share their experience of fertility treatment due to the stigma attached to being

infertile. This results in fertility treatment being a lonely journey. The emotions couples experience start with hope and end in despair when the treatment fails.

5.3.2 Conclusions pertaining to the adoption process

Hope

Adoption is experienced as a positive, life changing experience. The hope of becoming a parent through adoption is greater than that experienced in the infertility process.

Frustrations

The frustrating administrative processes linked to the adoption process such as consent from biological parents, court appearances, delays in obtaining birth registration and change of name documents all create physical and emotional delays for the new family who are keen to proceed to their next life stage but are unnecessarily held back from doing so.

The contrasting immediacy and delays of getting a baby

When adopting the couple needs to be ready to be a parent almost immediately as a baby may be available at any time. Couples need to be psychologically, socially and physically prepared for this so that the process is eased. In contrast though there is a long wait for an available child if couples wish to adopt a child from their own race group.

The impact of transracial adoption

In the South African context transracial adoption is prevalent due to the availability of black children and the need of “other” race groups to achieve parenthood. The decision to adopt affects all members of the extended family as the children adopted will become part of their family. Transracial adoption may lead to extended family relationships being strained due to the family not accepting the decisions that the couple have made. Transracial families face particular challenges with integration into a society where they

appear to be “different” to the societal norm. For the adoptive parents the need to achieve parenthood superseded race and culture. New parents become incredibly protective over their new families by keeping their distance from non-supportive extended family.

Private, NGO and public adoption services

Public adoption services are not recommended due to time delays and other resource challenges which are experienced. Private practitioners and NGOs are more geared to dealing with adoptive couples on a professional level. Adoptive parents appreciated consistency in services received as opposed to changing requirements by adoption agencies.

5.3.3 Conclusions pertaining to both infertility and adoption

It is concluded that due to the loss couples experience with regard to their inability to have biological children, both processes are filled with contrasting emotions that need to be dealt with by a professional such as a social worker who is skilled, trained and understands the challenges faced. Couples require support and guidance from the onset of the fertility struggle to the decision to become parents via alternative means, whether this is via infertility treatment to adoption or directly to the adoption process. The social worker has a vital role to play in the multi-disciplinary team that guides and supports the couple through these processes.

5.4 Limitations

The following limitations were experienced in this study:

- Participants for the study were all from Port Elizabeth. A wider geographical sample would possibly have increased the trustworthiness of the study.
- The population consisted of coloured and white participants only. This was due to the researcher struggling to find participants from any other cultural group.

The findings may thus not be able to be generalised to all couples experiencing similar circumstances.

- Researcher bias was identified due to the researcher experiencing fertility treatment and adopting, which was the same experience being researched. This was addressed by having an independent interviewer and independent coder.
- Literature consulted was mainly medical and psychological research and not social work research due to the limited amount of social work research in this field.

5.5 Recommendations

The following recommendations based on the findings and conclusions are made in terms of social work practice, policy review, future research, training and theory.

5.5.1 Social work practice

According to Sewpaul (1995), historically, social work with infertile couples began with adoption process. The findings of this study indicate that the social worker's function should start much earlier in the process.

5.5.1.1 Micro practice

On a micro level social workers should be involved from the pre-diagnosis level in that they could be offering **individual counselling** to couples who are newly married and are worried about their fertility. This can be instituted as a service at NGOs and government organisations that offer family counselling. Pedro and Andapatin (2014) state that couples who are experiencing difficulty in conceiving should be given effective coping strategies in dealing with infertility as well as information with regard to the infertility journey. What was evident in the study was that couples needed assistance with dealing with the initial diagnosis which entailed a loss for them, guided decision making with regard to the possible options, assistance with financial decision making and information with regard to all possible options.

Once the couple has been diagnosed as infertile it is imperative that they are guided to making a decision with regard to the future. What became very evident in the study was that the couples expressed the need for **some type of intervention** at this stage in the process. Social workers have an important role to play in assisting couples with deciding if they should explore the fertility treatment option or rather adoption. Social workers should form part of the **multi-disciplinary team** offering the fertility assessment and treatment. Factors such as financial situation and resilience in dealing with treatment or adoption could be dealt with in this interaction. The social worker should also be available to assist the couple with the many potential losses they may experience as part of the infertility process by the provision of **in-depth individual and couple counselling** to assist the couple to process the loss.

In assisting couples make the decision the social worker will then be able to provide the necessary **preparation for fertility treatment and/or pre-adoption counselling**. The social worker as per legal requirement does adoption screening. Couples expressed the need for social workers to **communicate** with them **throughout the process** and not just at the beginning and when going to court. This should be taken into account when considering micro intervention for adoption.

Transracial adoption has become a prevalent choice in the South African context and it is thus necessary for the social worker to **prepare couples for the possible trials** they may face making this decision. It will thus become an integral part of the micro contact. It may also be necessary for extended family members to undergo micro interventions such as individual sessions to identify the impact that the transracial adoption and their perceptions in this regard will have on supporting the couple with the decision. Some family members may also need some counseling with regard to their negative perceptions and the effect that it could have on the family as a whole.

Voluntary post adoption support may also be needed on a micro level to ensure that the newly formed family functions effectively should they need it.

5.5.1.2 Meso practice

On a meso level the social worker could be involved with therapeutic support groups with couples who are diagnosed as infertile. It would provide them with the necessary time to consult with other couples in similar situations in which they can be assisted with making the correct decision for them.

If fertility treatment is opted for, **support groups** can be arranged by the social worker where couples, who have gone through treatment before, can share their experiences with those that are entering the process. This is what was identified as a need as part of the findings from this study. This will provide a space for those couples that have been through the process to assist with the emotional, physical and marital challenges that were highlighted by the couples in the study.

As part of the adoption process, adoption support groups can be arranged for the families that need this type of intervention especially in transracial circumstances. Some of the concerns that were raised with regard to transracial adoption can also be dealt with in this type of intervention.

5.5.1.3 Macro practice

Public education and advocacy should be a strategy to change the medical model that views infertility solely as a medical problem to be solved, a dysfunction that needs to be fixed, and society's view that supports this medical view. Society needs to be aware of the immense impact of the crisis of infertility. The social worker on the macro level may arrange community development awareness projects, which will assist the couple, as well as the families that will be part of the process with them. General societal stigma can also be addressed by this intervention.

Infertility treatment and what it entails as well as adoption can also be **destigmatised** using educational awareness programmes. A greater awareness and tolerance of **transracial adoption could also be arranged by social workers.**

5.5.2 Policy recommendations

General guidelines with regard to infertility treatment and counselling need to be developed in order for couples to receive the needed guidance before and during the process. The role of the social worker in provision services at treatment level need to be addressed.

The Children's Act (2005) acts in the best interests of the child and family unit. Current legislation needs to be reviewed in order to hasten the adoption process to ensure that the adoptive family is preserved and can function as such. The following recommendations will assist the process:

- A checklist should be developed as a minimum standard for social workers working within the adoption environment in order to create consistency in the management of adoption cases. This would prevent oversight on the part of the social worker and ease the process for the adoptive family.
- Specialised accreditation should be initiated for social workers working in the adoption environment.
- Social workers should communicate the process which will be followed and attach timeframes to these processes in order for the adoptive parents to be informed throughout the process.
- Policies should be formulated to ensure that the documentation such as birth certificates and adoption orders are processed within a specified time period immediately after the adoption is finalised.
- The Basic Conditions of Employment Act (1997) should be reviewed to include adoptive parents as there are no consistent practices with regard to maternity leave and paternity leave. Some employers offer leave to adoptive parents whereas others do not. Negotiation for adoption leave is between the individual employee and the human resources departments of their employers.
- Medical aids should consider infertility as a medical condition requiring medical cover. for it. Fertility treatment is considered exclusive due to the cost involved making it difficult for poor and middle class couples to access. This is an area

which needs to be explored in order for couples to have some type of cover for their treatment.

5.5.3 Recommendations for future research

Future research in this area is necessary due to the limited amount of research which is South African based. Prior research points mainly to the medical or psychological spheres. The researcher recommends the following possible research foci:

- Social workers and other medical practitioner's perceptions of their role in the infertility and adoption processes to enhance the services provided.
- A narrative study with couples who have not opted for fertility treatment and have decided to adopt where the focus of the study is on the decision not to adopt and would lend itself to narrative enquiry in order to establish their journey of infertility to promote adoption as a first line option as opposed to the fertility treatment route.
- A study of couples who have had biological children and have made the decision to adopt to provide for the belonging needs where biological parents cannot assume responsibility for South Africa's large number of orphaned and abandoned children.
- A study with regard to the experiences of extended families in transracial adoption to develop effective strategies for effective extended family relationships.
- A narrative study of the experiences of transracial adoptive parents in order to document strategies for parents in similar situations.

5.5.4 Recommendations for training

With the increase of the incidence of infertility and subsequent transracial adoption in South Africa, the need exists for specialised training for professionals in the field. Training institutions could provide training with regard to infertility and its link to adoption. As couples experiencing infertility need assistance from professionals across

disciplines, it would be essential for a multidisciplinary approach to prepare medical professionals, psychologists and social workers to provide the much needed guidance and support that couples need. The training should focus on viewing the patient/client as part of many systems that will influence their response to the situation.

The results of this study could be used to develop continuous professional development (CPD) workshops where the results can be shared with other professionals in order to inform practice.

5.5.5 Recommendations for theory

Developmental life stage theory was used in this study in order to understand the experiences of couples who have, through their diagnosis of infertility, not reached the developmental stages that they should have as per Erikson's (1982) theory. As the study focused on the couple, family systems theory became evident as the behavior of one affected the behavior of the other. The extended family as part of the infertility and adoption journey also is part of the family system and created certain stressors for the new family.

Social workers can use the theories identified above to assist couples in understanding the experiences that they are going through and how it is linked to theory. The behavior of each partner as well as the extended family in both the infertility and adoption processes can be understood taking the theories into account.

5.6 Concluding remarks

This study aimed to explore and describe the experiences of couples who had undergone fertility treatment and adopted at least one child. This was accomplished by conducting semi-structured interviews with the couples. For these couples their path to adoption would not have been possible had it not been that they had transitioned infertility effectively. The experiences that they shared were those of hope and loss and then ultimately joy. The children that they had been gifted through adoption enabled

them to achieve the ultimate dream of being a parent. The quote below captures the essence of the experiences shared by all the participants:

"Not flesh of my flesh, nor bone of my bone, but still miraculously my own. Never forget for a single minute, you didn't grow under my heart but in it."

-Fleur Conkling Heyliger

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APPENDIX 1: LETTER TO PROPOSED RESEARCH PARTICIPANTS

10 March 2016

• PO Box 77000 • Nelson Mandela Metropolitan University

• Port Elizabeth • 6031 · South Africa • www.nmmu.ac.za

Dear ……

I am a qualified, registered social worker who is currently studying toward a Master in Social Work at the Nelson Mandela Metropolitan University. In fulfillment of the qualification, I am required by the University to conduct a research study. The topic of my research study is:

The path to adoption: Experiences of couples who have transitioned from infertility

The focus of my research study is to determine the experiences of couples who have been unable to achieve parenthood via normal means. The aim of this study is to explore your experiences of attaining parenthood via adoption after moving through fertility treatment. The purpose of exploring your experiences in this regard would be to identify areas which professionals in this field should give more emphasis to when engaging with couples who have had similar experiences.

I hereby request your participation in this study, as a couple:

- if you have experienced fertility treatment and;
- have become a parent through adoption.

Your anonymity will be ensured by keeping your details confidential. One face to face interview will be conducted with you (as a couple) by an independent interviewer for the duration of an hour at a time and venue convenient to you. The researcher will observe the interview in order to remove bias due to her also undergoing fertility treatment and adopting. If you are in agreement and should the researcher require clarification or further details from you, she will contact you and negotiate this. The researcher will

ensure that the study will be conducted according to the ethical standards as required by the board that governs the researcher's studies namely Nelson Mandela Metropolitan University and the South African Council for Social Service Professions.

Your participation in this study is voluntary, no payment will be made for your involvement and you can withdraw from the study at any time. The data collected and the transcripts will be kept in secure password protected files. No identifying details will appear on any document or recording. Should you experience any emotional stress caused by the study you will be referred by the researcher to a relevant helping professional who will assist you in processing the distress. You are welcome to contact the research ethics committee at the NMMU should you feel that ethics were violated in any way on the following number: 041 5042358

Should you have any further questions or queries related to the study please feel free to contact my research supervisor, Mrs Nevashnee Perumal on 041-5042349.

Yours faithfully

Mandy-Lee Brophy
MA Social Work Student

APPENDIX 2: INTERVIEW SCHEDULE

PO Box 77000 • Nelson Mandela Metropolitan University

• Port Elizabeth • 6031 · South Africa • www.nmmu.ac.za

- Tell me about becoming a parent?
    - Probes:
        - experience of adoption.
        - experience of infertility.
- How has the experience of infertility and adoption shaped you as a person?
- Tell me more about the adoption
    - Probes:
        - point at which adoption was considered as an option to becoming a parent.
        - Point at which you decided to stop fertility treatment
- Explain the type of psychosocial support you were you provided:
    - while experiencing infertility
    - whilst going through the adoption process.
- What were your support needs in both processes?
    - Probe:
        - type of support received from your extended family?
        - Support from other sources
- Advice for couples wanting to adopt?
- Suggestions for the following professionals:
    - Fertility team
    - Social worker
    - Courts

APPENDIX 3: CONSENT FORM

PO Box 77000 • Nelson Mandela Metropolitan University

• Port Elizabeth • 6031 · South Africa • www.nmmu.ac.za

Consent form

I, _____, agree to participate in this research.

The following points have been explained to me;

1. Participation is entirely voluntary and I can withdraw my consent at any time.
2. The focus of this research is on the parenting experiences of couples who have been diagnosed as infertile and have adopted a child.
3. Participation is limited to one, semi-structured interview, with the possibility of a further personal interview if the researcher requires clarification on any point.
4. Although no discomfort or stress is foreseen, should I experience any discomfort or stress I reserve the right not to answer any question at any time during the interview.
5. Should I experience discomfort or distress the researcher will provide details of counselling services of psychologists in private practice.
6. Participation in this research is entirely confidential and information will not be released in any individually identifiable form.
7. The researcher will answer any questions I wish to ask about this research now or during the course of the research process.
8. The results of the research will be made available to me if I so wish. Should I require a copy of the research I will communicate this to the researcher and provide the researcher with my postal details.

_____ _____
Signature of participant date

_____ _____
Signature of researcher (Mandy Brophy) date

_____ _____
Signature of research supervisor (Nevashnee Perumal) date

APPENDIX 4: AUDIO RECORDING CONSENT

PO Box 77000 • Nelson Mandela Metropolitan University

• Port Elizabeth • 6031 · South Africa • www.nmmu.ac.za

USE OF AUDIO RECORDINGS AND WRITTEN MATERIAL FOR RESEARCH PURPOSES – PERMISSION AND RELEASE FORM

Participant's Name: _____

Contact details:

Address: _____

_____

_____

Telephone No: _____

Name of researcher: Mandy-Lee Brophy

Level of research: MASW (Research)

Brief title of research project: The path to adoption: Experiences of couples who have transitioned from infertility

Supervisor: Ms. N. Perumal

Declaration

(please sign in the blocks next to the statements that apply)

1. The nature of the research and the nature	Signature:

of my participation have been explained to me verbally and in writing.	
2. I agree to participate in an interview and to allow audio-recordings of these to be made.	Signature:
3. The audio-recordings will be transcribed only by the researcher.	Signature:
4. Once the data has been transcribed the recordings will be destroyed.	Signature:
Date: Witnessed by researcher:	

APPENDIX 5: ETHICS APPROVAL

Copies to:

Supervisor: Mrs N Perumal

Summerstrand South
Faculty of Health Sciences
Tel. +27 (0)41 504 2956
Fax. +27 (0)41 504 9324
Marilyn.Afrikaner@nmmu.ac.za

Student number: 190239630
Contact person: Ms M Afrikaner

30 November 2015

MRS M-L BROPHY
80 GARDENIA DRIVE
STRELITZIA PARK
UITENHAGE 6230

RE: OUTCOME OF PROPOSAL SUBMISSION

QUALIFICATION: Master in Social Work (Research)

FINAL RESEARCH/PROJECT PROPOSAL:

THE PATH TO ADOPTION: EXPERIENCES OF COUPLES WHO HAVE TRANSITIONED FROM INFERTILITY

Please be advised that your final research project was approved by the Faculty Postgraduate Studies Committee (FPGSC) subject to the following amendments/recommendations being made to the satisfaction of your Supervisor:

COMMENTS/RECOMMENDATIONS

1. Page 5: "RSA, 2005" is not in the reference list (Children's Act) under "R" (listed under "South Africa").
2. Appendix 1: Add date.

3. REC-H form
   Corrections needed to the following questions 1 d), 1 i) and b).
   Item 9 – Select an item.

The ethics clearance reference number is **H15-HEA-SDP-006** and is valid for three years.
Please be informed that this is a summary of deliberations that you must discuss with your Supervisor.
Please forward a final electronic copy of your appendices, proposal and REC-H form to the FPGSC secretariat.

We wish you well with the project.

Kind regards,

Marilyn Afrikaner

FPGSC Secretariat

Faculty of Health Sciences