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Privacy Management as Unfinished Business: Shifting Boundaries in the Context of

Infertility

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Abstract

Privacy dilemmas are prevalent for women who experience a fertility problem. In this study, we use communication privacy management (CPM) theory to explore how privacy boundaries shift over time as women cope with infertility. Based on interviews with 23 women, we found that women described distinctive patterns of shifting privacy boundaries, including situations in which the experience of infertility served as a change agent, patterns in which women became more or less open over time, and patterns that indicated a continuous oscillation of boundaries. These ever-changing patterns of talk indicate that managing private information about infertility is unfinished business.

Privacy Management as Unfinished Business: Shifting Boundaries in the Context of Infertility

The management of private information has been a topic of perennial interest to scholars in communication and related disciplines, and work by Altman and Taylor (1973), Petronio (1991, 2002), and others has sparked a wealth of scholarship in this area. Yet, despite calls for scholars to expand their theoretical and methodological approaches for understanding privacy management (e.g., Baxter and Sahlstein, 2000), much of the research examining disclosure, secrecy, and topic avoidance, treats privacy management processes as singular events rather than complicated, ever-emerging endeavors. Afifi, Caughlin, and Afifi (2007) noted that scholars too frequently define and discuss these communicative acts in dualistic terms by treating phenomena like disclosure and topic avoidance as two discrete categories in a bivariate construct. Such oversimplification does not, however, capture the full range of options when it comes to privacy management. Indeed, the complex process of managing private information, of deciding whether and how to disclose or avoid disclosing, of engaging in ongoing conversations, is too often reduced to a singular event.

However, communication scholars are beginning to give greater attention to the ways that privacy management processes like disclosure, topic avoidance, secret keeping, and secret revelation unfold (e.g., Afifi & Steuber, 2009; Caughlin et al., 2008; 2009; Petronio & Ostrom-Blonigen, 2008). We wish to contribute to the ongoing scholarly conversations about the emergent nature of privacy management and advance popular theory by bringing the temporal nature of privacy management to the forefront of scholarly inquiry. More specifically, our investigation conceptualizes privacy management as an ongoing, ever-changing process rather than any one singular event marked by precise end points.

Conceptualizing privacy management as a process not only advances current theoretical understandings, it also has implications for individuals who are coping with life stressors that change and develop over time (e.g., chronic health conditions, divorce, financial crises). The experience of infertility is an example of one such stressor and provides a useful context for the present study. Women and couples who confront the challenges of a fertility problem have reported that infertility is a "transformational process" (Gonzalez, 2000, p. 619) that often progresses over a period of years (Daniluk, 2001). Thus, it is likely that whether and how people disclose or avoid talking about a fertility problem can fluctuate as they progress through a sometimes prolonged journey. Understanding fluctuations in talk is critical to the development of theoretically-informed support resources and interventions that offer assistance in coping with and talking about a long-term stressor.

The purpose of the present study is to examine how women with a fertility problem describe shifts in patterns and perspectives regarding their talk about infertility. Using a communication privacy management (CPM) framework (Petronio, 2002), we explore the nature of shifting privacy boundaries for women dealing with infertility and conceptualize privacy management as ongoing, unfinished business (Duck, 1990). In the following sections, we provide background information on infertility and discuss the potential trajectories that accompany a fertility problem. We then outline the key tenets of CPM that informed our study and detail the methods we used to explore privacy management in the infertility context. Finally, we describe prominent patterns of boundary shifting expressed by women in our study and discuss the implications of our findings.

Infertility, Chronic Illness, and Illness Trajectories

Infertility is typically defined as "a disease or condition of the reproductive system often diagnosed after a couple has one year of unprotected, well-timed intercourse" (RESOLVE, 2009). The most recent National Survey of Family Growth indicated that over seven million women of childbearing age reported trouble conceiving a child or carrying a baby to term (Chandra, Martinez, Mosher, Abma, & Jones, 2005). For the millions of American women who cope with the struggles of infertility, disclosing their experience is a major concern, and women have reported struggling with the communicative process of discussing their fertility problem with others (Bute, 2007; Miall, 1986; Sandelowski & Jones, 1986). Deciding whether and how to disclose infertility can be fraught with tension as women decide how to manage the potential for social stigma (Miall, 1985, 1986; Whiteford & Gonzalez, 1995), respond to intrusive questions about their childless state (Bute, in press), and manage strained interactions that can arise from talking about infertility (Becker, 1997; Exley & Letherby, 2001; Greil, 1991a; Letherby, 1999; Sandelowski & Jones, 1986). For instance, women might feel reluctant to reveal a fertility problem because doing so might involve discussing highly personal information about bodily functions (e.g., ovulation, menstruation) or sexual intercourse. Yet, disclosing infertility can also allow women to access social support from friends and loved ones (Bute, 2007).

Although infertility is not physically debilitating, several scholars have compared the experience of infertility to that of a chronic illness or disability (Becker, 1997; Exley & Letherby, 2001; Greil, 1991b). "Infertility is similar to chronic illness in that it is long-term in nature, it becomes a focal point in sufferers' lives, and its 'illness' trajectory is uncertain" (Greil, 1991b, p. 17). Like a serious or chronic illnesses, infertility is often marked by significant emotional distress, particularly for women (Abbey, 2000; Greil, 1997). Coping with infertility

can mean undergoing expensive and invasive medical diagnosis and treatment procedures (for those who can afford such treatments), managing the potential for social stigma associated with childlessness, dealing with uncomfortable social interactions when discussing intimate relationships and biological functions, and adjusting to a disrupted lifecourse in which the desire to procreate is challenged (Becker, 1997; Exley & Letherby, 2001; Greil, 1991b).

Indeed, the infertility experience can be framed as a particular type of illness trajectory (Corbin, 1998; Corbin & Strauss, 1987; 1991) marked by periods of stability/instability, certainty/uncertainty, and crisis/recovery. Women and couples have described the transitions required as they resolve their infertility by seeking medical intervention (Sandelowski, Harris, & Black, 1992), waiting for adoption processes to unfold (Sandelowski, Harris, & Holditch-Davis, 1991), or choosing to remain childless (Daniluk, 2001). In each case, coping with infertility is marked by "progressive adaptation" (Daniluk, 2001, p. 439).

As communication scholars, we are particularly interested in how women's talk about a fertility problem changes over time as they manage the ebb and flow of struggles connected to infertility. Although we know from previous studies that women use a variety of information management techniques as they make efforts to reveal or conceal a fertility problem (Bute, in press; Miall, 1986; Sandelowski & Jones, 1986), we know little about how the management of private information surrounding infertility progresses over time. The current paper provides empirical evidence that describes the nature of changes in talk about infertility.

Communication Privacy Management

Although scholars have produced a plethora of research on disclosure and related topics, explorations that emphasize the ways that privacy management processes unfold (e.g., how conversations progress, how communicative tendencies evolve over time) remain in the

minority. Recent studies have enhanced our knowledge of the features of disclosure messages (Caughlin et al., 2008; 2009) and the strategies that people use to keep (Caughlin, Scott, Miller, & Hefner, in press) and reveal (Afifi & Steuber, 2009) secrets. Moreover, work by Petronio, Reeder, Hecht, and Ros-Mendoza (1996) suggested that disclosure of a highly sensitive topic, such as sexual abuse, can be incremental in nature; likewise, Afifi and Steuber (2009) found that incremental disclosure is one means of secret revelation. In other words, people have reported testing the waters before disclosing private information more fully. Despite the efforts of scholars to enhance our understanding of the processual nature of privacy management, temporality, or the notion that whether and how individuals discuss a particular issue can shift dramatically over time, often remains in the background of such investigations. Our goal in this paper is to advance scholarship on privacy management by drawing greater attention to the ever-changing nature of disclosure, topic avoidance, and secret keeping. Such an approach encourages scholars to think of privacy management not in terms of singular communicative acts but to consider privacy management as an evolving endeavor comprised of multiple conversations that are part of a fluid and emergent chain of interactions (Bakhtin, 1981).

To accomplish our goal, we used CPM (Petronio, 2002) as a theoretical backdrop for exploring the evolving nature of women's talk about infertility. CPM is an applied theory that views the management of private information as an ongoing process (Petronio, 2007; Petronio & Ostrom-Blonigen, 2008). Thus, CPM provides an appropriate lens for understanding the complicated and continuing talk that accompanies infertility. The theory proposes that individuals "consider private information something they own, and over which they desire control" (Petronio, 2002, p. 9). CPM uses a boundary metaphor to represent how individuals control others' access to private information by postulating that individuals create boundaries

around information that vary in their level of permeability. Levels of permeability are guided by privacy rules that individuals develop through experiences, and when individuals disclose private information to others, those confidants become co-owners of that information. As individuals encounter new circumstances, privacy rules can change, and boundaries can shift, becoming more or less permeable, depending on the demands of the situation.

More specifically, CPM highlights how various criteria, including risk-benefit ratios, cultural and contextual criteria, gender, and motivations, can influence the formulation and revision of privacy rules. Although all of these criteria influence the development of privacy rules, two of them are particularly relevant to the goals of the present study. The notion of risk is highly relevant, particularly in the context of a potentially stigmatizing condition like infertility. In the case of infertility, disclosure can involve a number of risks, such as risking an awkward or uncomfortable conversation about the biological cause of infertility or risking a loss of control over the private information if others gossip after a revelation. On the other hand, concealing the information could mean women risk missing out on social support from those unaware of their situation or offending close relational partners, such as parents, who might feel they have a right to co-own the information (Bute, 2007).

The notion of contextual criteria is also highly relevant to the case of infertility, highlighting the temporal nature of privacy management and the potential for communication about private information to change over time as privacy boundaries shift. Examples of contextual criteria that can prompt the modification of boundaries include traumatic events, therapeutic situations, and life circumstances (Petronio, 2002). Based on the wealth of research documenting the potential for infertility to be a major life stressor (Abbey, 2000; Greil, 1997), we could conceptualize infertility as a traumatic life event in which "people cope with disruptive

situations that may change their lives forever" (Petronio, 2002, p. 57). At the very least, infertility represents a changing life circumstance that might not be "traumatic" for all women but that likely requires alterations of privacy boundaries. Regardless of whether we classify infertility as a "traumatic event" or a changing "life circumstance," CPM enables an understanding of the way talk changes by positing that privacy boundaries shift in response to contextual criteria.

CPM's assumptions about the ongoing nature of privacy management and the potential for privacy boundaries to shift are consistent with Duck's (1990) call for a process understanding of relational communication. Duck (1990) argued that relational processes are not featured in figures, nor understood as "cognitive operations that are not directly observable" (p. 17). Rather, relational communication must be understood temporally; such communication is an ongoing, process-based experience, containing turning points and trajectories (Duck, 1990; for related arguments also see Afifi & Keith, 2004; Caughlin, Huston, & Houts, 2000). Thus, privacy management is best conceptualized as a process rather than an event. In this sense, privacy management, like other relational communication, is unfinished business that calls for ongoing attention. To understand privacy management as unfinished business in the context of infertility, we explored the following research questions:

RQ1: What patterns of boundary shifting do women describe as they cope with infertility?

RQ2: What reasons for boundary shifting do women describe?

In the next section, we describe our methods for addressing our research questions.

Methods

Our analysis of shifting privacy boundaries is drawn from in-depth interviews with 23 women who had experienced a fertility problem and volunteered to take part in a study examining how they talked about (or avoided talking about) this issue. Using a qualitative lens allowed women to express in their own words how the management of private information about infertility evolved over time.

Participants

Potential participants learned about the study through advertisements in an electronic newsletter sent to all faculty and staff at a large, Midwestern university or through talking to other women who had participated in the study. Interested women contacted the first author via telephone or email to express interest in the study and to schedule a mutually convenient interview time. Phase one of participant recruitment resulted in 11 volunteers. After completing these 11 interviews, the first author placed another posting in the university's electronic newsletter and used snowball sampling to recruit another 12 women, for a total of 23 participants. The first author arrived at a final sample of 23 women after noticing recurrent themes in the interviews from which it was possible to make viable knowledge claims about women's experiences (Patton, 2002).

All 23 women in the sample were married at the time of the interview, and participant's ages ranged from 28 to 48 years ($M = 36.36$, $SD = 4.99$). Twenty of the women described themselves as Caucasian or white, one described herself as Jewish, one described herself as European, and one described herself as Hispanic. The women in the sample were highly educated: all had completed at least some college, and fifteen had graduate degrees. Women were employed in a variety of occupations, and a majority of the women who volunteered for the

study were employed by the university in occupations such as professor, administrative assistant, and librarian. Other women held community-based professions including teacher, dentist, and graphic designer.

Each woman had experienced a fertility problem at some point in the five years prior to the interview. Twenty-one of the women had received a medical diagnosis, such as polycystic ovarian syndrome ($n = 11$), unexplained infertility ($n = 3$), age-related infertility ($n = 2$), endometriosis ($n = 2$), and progesterone or thyroid problems ($n = 2$). Additional diagnoses included acidic cervical fluid, anti-ovarian antibodies, anovulation, scarred fallopian tubes, and low ovarian reserve. Of the two women who indicated that they had not received an official medical diagnosis for a fertility problem, one had experienced a miscarriage eventually attributed to a luteal phase defect, and one reported that her infertility was unexplained.

Twenty-two women had sought medical treatment for infertility, such as hormone injections or *in vitro* fertilization. At the time of the interview, 12 of the 23 women had at least one child; two women had adopted a child and ten had given birth (some of whom conceived with the assistance of medical intervention). Four women were pregnant at the time of their interview, three with their first child, and one with her second child. Eight women had never given birth and were not pregnant at the time of the interview. Three of the ten women who had given birth to a child prior to the time of the interview had experienced secondary infertility (i.e., trouble getting pregnant after giving birth to at least one child).

Data Collection

Each volunteer participated in an in-depth interview session focused on her experiences with talking (or not talking) about her fertility problem. The first author conducted interviews at locations convenient for participants; most women chose to conduct the interview in a private

office on campus. In-depth interviews are an appropriate and useful method for studying the management of private information, especially in studies of highly sensitive topics for which ethical considerations impede researchers from directly observing or recording conversations (for examples see Keeley, 2004; Petronio, Flores, & Hecht, 1997; Petronio et al., 1996). Observing or recording women as they disclose or choose not to disclose aspects of a fertility problem in naturally occurring conversations poses both practical and moral dilemmas, as women could feel undue pressure to talk about their infertility or, conversely, could feel less comfortable talking about the issue than they might otherwise. Thus, in-depth retrospective interviews provided a less obtrusive means of learning about women's experiences. Interviews also allow scholars to ask questions about conversations in which people avoid discussing certain topics, a phenomenon not easily observed. Finally, the use of interviews allows researchers to ask questions about how people make privacy management decisions and attribute meaning to social interaction (Baxter & Sahlstein, 2000).

The first author conducted all 23 interviews. At the beginning of the interview, each woman completed a short questionnaire regarding demographics (e.g., age, marital status, background about the fertility problem). The interview guide included a series of questions concerning (a) to whom women had disclosed, (b) the factors women considered when deciding whether to disclose, (c) the details of women's disclosure interactions, (d) the responses women received when they disclosed, and (e) women's perceptions of the interactions. Interview length ranged from 45 to 90 minutes, with an average length of 60 minutes. Interviews were tape recorded and transcribed verbatim.

Data Analysis

Data analysis in qualitative research is an iterative process (Strauss & Corbin, 1990), and we conducted several rounds of analysis to understand the shifting nature of privacy boundaries for women coping with infertility. First, we read each transcript to gain a holistic sense of the data (Keeley, 2004). We then conducted a more focused reading of the entire set of transcripts to determine if women discussed any changes in whether and how they talked about their fertility problem with others. After determining that women did, indeed, talk about changes in their privacy management, we narrowed our focus again and reread all the transcripts with a specific task of identifying any sections in which women mentioned a change in perspective or strategy regarding how they talked about infertility. For example, we were attuned to instances in which women mentioned that they ceased talk with a particular confidant or found themselves growing more comfortable discussing their experience with infertility. In some cases, women discussed particular turning points that prompted shifts (e.g., a highly awkward conversation), and in others women made more global comments about changes in talk (e.g., "I feel more comfortable than I used to."). Thus, we cast a broad net in our initial readings of the transcripts to identify all instances in which women indicated a change in strategy or perspective. We decided to exclude spousal communication and patient-provider communication from our analysis, given that each of these relational contexts would merit a separate analysis and manuscript and based on the fact that such conversations are characterized by unique attributes, such as relational history and dynamics (Lorber & Bandlamudi, 1993), differences in expertise, and power differentials (Thompson & Parrott, 2002). We also excluded from our analysis excerpts in which women recalled their experiences with first-time disclosure conversations. We focused on marked changes in women's strategies or general approaches to privacy management *after* initial disclosure to at least some members of their social network.

As we progressed through this stage of analysis, we each took systematic notes and highlighted specific excerpts representing marked changes in privacy management. We then met to develop initial categories and used techniques of constant comparison (Glaser & Strauss, 1967) to describe patterns of boundary shifting and reasons women gave for making such shifts. Both authors then read all relevant excerpts to refine the initial categories and met again to resolve any inconsistencies and select exemplars to illustrate the categories.

Throughout each phase of analysis, we ensured the trustworthiness of our claims by producing an extensive audit trail (Farley & McLafferty, 2003; Lincoln & Guba, 1985). Each author wrote detailed research memos to record reactions and observations. These research memos, along with the original interview recordings and transcripts, provide a history of our methodological and theoretical decisions (Farley & McLafferty, 2003). To enhance our understanding of participants' perspectives, we conducted a member check by soliciting feedback on early drafts of this manuscript (Taylor & Bogdan, 1998). Three participants who had kept in contact with the first author since taking part in the study volunteered to read our results and provide comments. All of them agreed that our findings reflect their experiences with talking about infertility. One woman encouraged us to highlight the relationship between treatment decisions, successful pregnancies, and changing elements of talk. We are grateful to her for this insight and include a discussion of this issue in the final section of our paper.

Results

Results of our analysis demonstrate that when it comes to talking about infertility, privacy boundaries are dynamic: they shift over time in response to this particular contextual criterion (Petronio, 2002). Even about the same issue and with the same people (e.g., with her parents), the way a woman talks about infertility can evolve over time. The following section

describes common patterns of boundary shifting across the interview transcripts and provides a number of reasons why talk might change over time for women coping with infertility. In some cases, the experience of infertility itself prompted a change in the way women talked. In other cases, women gradually became more open in discussing infertility as their journey progressed, and in yet other cases, women tapered off talking about their fertility problem, often with particular individuals.

Infertility as a Change Agent

Some women indicated that the experience of infertility in and of itself served as a change agent, causing them to make their privacy boundaries more permeable and prompting them to discuss delicate or sensitive topics, such as sex and bodily functions, in new ways. Barbara[1], for instance, described the "bizarre" experience of discussing intimate aspects of her efforts to get pregnant:

> One of the mornings that we tried the IUI procedure, which is an intrauterine insemination procedure, it was the morning of a special holiday in our religion. And we saw our friends later that day for this meal and this whole thing. And so it was like, well, we were late for services. Anything you have to do revolves around your cycle, you know, the whole thing. It's like, so there you are, it's a big day at temple, but there you are in the doctor's office for the first 45 minutes in the morning, and then you're going to temple. So we saw these friends later and we were like, "Well, yeah, we are at the doctor this morning for this IUI procedure," and their eyes kind of just popped out. Like, "Oh, my God, you're telling us that this morning you tried to conceive?" You know what I mean? It just, it creates these situations that, no, we would never have said, "This morning we made love, and we're going to try to conceive this..." You know. [Laughs.]

So I think definitely things come out that normally would not be part of everyday

conversation.

This passage not only indicates that discussing infertility can mean discussing unusual

and sometimes uncomfortable topics, it also suggests that Barbara found herself revealing her

efforts to conceive in a way that she would not have if she and her husband had not been seeking

treatment for infertility. In this case, Barbara was comfortable allowing others to co-own the

information about undergoing a highly invasive treatment, yet she would not have revealed an

intimate sexual encounter with her husband if they had been trying to conceive in a traditional

manner. Similarly, Christy's struggles to get pregnant, which resulted from damage to her

fallopian tubes after she contracted Chlamydia from her husband, compelled her to reveal aspects

of her sexual history that she would not have discussed otherwise.

> In fact, I never even told my mom that, my mom didn't even know that my husband was
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> my only partner. She just assumed that because I'd had different boyfriends through high
>
> school and college, that I slept with them. Well, I didn't. It was actually kind of liberating
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> to tell her, but yet, at the same time, I had to be very careful with that topic, too, because I
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> didn't want people to judge my husband, either…But, yeah, I would say, had the
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> infertility not happened in our life, I would have never told my mom or my sister…It's
>
> like, "Well, you have blocked tubes? Well, how do you get blocked tubes? Can you take
>
> medicine for that?" And then the conversation would lead, "Well, how do you get
>
> blocked tubes?" "Well, there's one really [chuckles] sure way." And I didn't want to lie
>
> and say, "Well, I have no idea." I just felt like they deserved to kind of know, I guess.

As Christy's excerpt demonstrates, women sometimes found themselves discussing

topics with certain confidants that they would never have discussed had they not been in this

particular situation. Christy's reflection also points to her desire to control access to her husband's sexual history; she was highly concerned that people would judge her husband if she revealed this stigmatizing information.

Maria described telling her sister about her husband's reluctance to have sex while she was ovulating because he felt pressured by the constraints of having to schedule intercourse. Maria explained that she would not have revealed such intimate aspects of her personal life to her sister had she not been so frustrated with her husband's behavior and her inability to get pregnant. Likewise, Kelly found herself discussing her sex life with her mother in ways she hadn't prior to disclosing her fertility problem:

> Before, I definitely would have been uncomfortable talking about sex, 'cause I viewed that as so private that they wouldn't need to know. Why would I tell my parents or my mom about my sex life? But then when it became not only, the focus wasn't for pleasure, the focus was for a purpose and an end goal, then it became not embarrassing.

For Kelly, the meaning of talking about sex evolved from a private and potentially embarrassing topic to Kelly sharing with her parents her efforts to pursue a goal (e.g., having a child).

These comments from Barbara, Christy, Maria, and Kelly indicating that the experience of infertility prompted them to reveal aspects of themselves or their lives or to discuss particular topics in novel ways are consistent with Petronio's (2002) argument that situational demands are change agents when it comes to revealing information. In the context of infertility, it seems that the experience of a fertility problem in and of itself might encourage women to shift their privacy boundaries and discuss new, often more personal, topics with certain others. Moreover, women's perceptions of ownership might transform as the potential risks and benefits of disclosing change in response to contextual criteria. For instance, talking about intimate sexual behaviors and

making confidants co-owners of such incredibly personal information might be less problematic than it would otherwise when framed in the broader context of coping with infertility.

Boundary Shifting Over Time

More open over time. The way a woman discusses her fertility problem can change over the course of her journey with infertility, drawing our attention to the dynamic and shifting nature of privacy boundaries. Some women in the sample described becoming more comfortable or open in their discussions as their privacy boundaries became more permeable. Several women mentioned that *seeking medical intervention* for infertility provided an opportunity to reveal additional information. Although Julie had initially told a few people in her social network about her difficulties conceiving, she shared more extensive details about her fertility problem, including her hesitancy about seeking certain treatments, after she and her husband consulted a physician: "Once we started getting our testing done, I felt like I could be a lot more open, because I knew what was going on, and I remember discussing it with my friends …my apprehensions about fertility drugs." Marissa also became more comfortable discussing her fertility problem after receiving a medical diagnosis. She explained, "Once I had a diagnosis and I knew what we were doing. Once it doesn't feel like your fault, I don't really mind talking about it to whomever." Marissa elaborated on how her diagnosis provided her with linguistic tools to discuss the fertility problem in ways she couldn't before:

> Part of it was that once I had the thing that was wrong, I had something to talk about. I had something to go from. It wasn't just saying, "Well, you know, [husband] and I have been trying to have kids for eight months and we're not," or "[Husband] and I are trying to have kids, and I'm not even having periods regularly." It's, okay, it turns out I have this thing, and it makes it really hard for me to get pregnant, and here's six or seven other

things that I can say, "Well, okay, that's what's the root cause of them." And it not only

gave me some things to try to treat it, but it also gave me a way to say, "Here is what it

is."

Marissa felt that the point she had reached in her journey with infertility at the time of her

interview influenced her level of comfort and openness in discussing the fertility problem. With

the assistance of treatment, Marissa had given birth to two children and expressed that having her

fertility problem "resolved" made it easier to talk about it with others. Barbara made a similar

observation, explaining that her perspective on her fertility problem and her attitude toward

talking about her experience changed once she and her husband had decided to pursue adoption.

Lisa also indicated that the way she talked about her infertility changed over time. She

specifically commented on how her responses to requests for information (see Bute, in press)

about her plans to have a second child had changed in the months prior to her interview. Lisa

frequently dealt with questions about when her son, who was conceived through *in vitro*

fertilization (IVF), would have a sibling. Lisa used to reply to such questions with a vague

response such as, "I don't think that's going to happen" or by using her husband's age as an

excuse not to have more children. But her response to such questions shifted:

But more and more, if people ask, I just tell them that we had a hard time conceiving and

we're not going to have another one…I'm not sure why I don't feel the need to keep it

hush-hush anymore, but I just really kind of don't…And maybe it's just 'cause I've

finally gotten tired of people asking. You know, if you're going to ask, from now on, I'm

going to tell you.

This recent change in Lisa's typical response to inquiries about having a second child

indicates that she became more open in revealing her infertility ("I don't feel the need to keep it

hush-hush anymore."). Thus, a *change in perspective* on the issue of infertility can prompt shifts in privacy boundaries, perhaps because women might grow more comfortable talking about infertility as they resolve their struggles through treatment, adoption, or the choice to remain childless. In other words, some women might view the revelation of a fertility problem as less risky once they themselves have come to terms with this stressor.

Some women also indicated that privacy boundaries became more permeable as their *desire to educate others* about infertility grew. Nancy, who had experienced a miscarriage and then a successful pregnancy, expressed a willingness to share her story with other women who might benefit from hearing about her experience and speculated that she would continue to share her story in the future:

It's the kind of thing that, you know, in the future if I know of someone who has a miscarriage, I would probably let them know, regardless of their status, regardless of whether it's a professional relationship, someone at work or someone I know socially I'd probably let them know.

In fact, a number of women conjectured that they might become more open about their fertility problem in the future, indicating the ongoing nature of privacy management. Anna speculated that she and her husband might decide to tell his parents, who were unaware of their trouble conceiving at the time of Anna's interview, about their struggles to get pregnant: "I think when we're pregnant, we will tell them." And Sharon suggested that she would someday tell her son, who was conceived through IVF, about her difficulties becoming pregnant. Perhaps citing a particular benefit of disclosing, such as educating others about the trials of infertility, prompts a shift in privacy boundaries as women come to view revelations as less risky or at least discern that the benefits outweigh the risks. Indeed, educating others is an often-cited reason why people

might choose to reveal stigmatizing information about themselves (Greene, Derlega, Yep, & Petronio, 2003)

Less open over time. In contrast, some women described situations in which they diminished talk about their fertility problem, making privacy boundaries less permeable, often with particular others. The risk of *unsupportive responses* triggered some women to stop revealing aspects of their fertility problem. Brenda stopped discussing her infertility with her mother after she was insensitive to Brenda's devastation over a failed IVF attempt. Andrea, who was also unhappy with a perceived lack of support from her family, explained how she and her husband tapered off talking about their fertility problem:

> There are definitely certain members of his family that we don't bring up the topic anymore. And in fact, when we did the second IVF, the first IVF, everybody in the family knew we were doing it. For the second one, we told my mom and my sister, and we told his parents, but we didn't tell anybody else in the family. So as time has gone on and we've just kind of learned we're not going to get the response we want, even though he's gone so far as to have given his mother the literature about this, we've just kind of learned that it's not worth telling them, 'cause you're not going to get the response you want, and then that just upsets you more that you don't get the support.

Once Andrea and her husband learned that potential supportive others did not respond as expected, they stopped revealing aspects of the fertility problem, such as pursuit of additional treatments, to some people. In this way, decreasing talk about the issue also decreased the risk of soliciting unhelpful or unsupportive responses.

Just as a *change in perspective* prompted some women to create more permeable privacy boundaries, for others, a new perspective on infertility meant becoming less open about their

experiences. As her struggle to get pregnant became more emotionally taxing for Cheryl, she found a new desire for privacy and no longer shared the details of every medical appointment with her mother: "There is a point where it gets a little, just difficult to talk to people about different schedules you're on and stuff like that. It is kind of more private, I think." Sharon described a similar experience, explaining, "I, at one point, probably reached a stage where I didn't want to talk about it with anyone because I was sick of having failures."

Some women shifted talk when they sensed that others were uncomfortable with the intimate aspects of the topic or that they had *violated others' privacy boundaries* by sharing aspects of infertility, such as details of invasive treatment plans. As Julie explained, "If I started talking about it, and I got the sense that they just didn't want to know, they just didn't want to hear it, then I would take my cue from that, and not talk to them about it anymore."

Finally, a number of women explained that the *risk of ongoing talk* prompted them to share less information, especially about scheduled medical appointments. In many cases, revealing an upcoming treatment, meant dealing with questions about the outcome of the appointment or delivering bad news when treatments failed. Leah's story provides one such example:

> I mean, there were times when we didn't even tell anybody that we were doing the last *in vitro*. I'm not sure we even disclosed that to anybody. Because I really hated having to go through all the telephone calls afterwards: "No, it didn't work." So at a certain point, we just stopped sharing it, especially with our mothers.

Although many women speculated that they might discuss their fertility problem more openly in the future, others reflected that they might become less open over time. Deborah, who together with her husband choose to resolve her infertility by remaining childless, explained that

if she were to meet a new friend she would not necessarily reveal her fertility problem to that person "'cause it's not a current issue." Yet, most of Deborah's current friends were aware of her trials with infertility. Julie, who was pregnant with twins at the time of her interview, also suggested that she would talk less openly about her fertility problem over time: "I can't really imagine another situation where I would kind of bring it up, because it's a point…a time in my life that really wasn't the greatest. And now I feel like I've moved onto a new phase."

Oscillation over time. Although some women described clear trajectories in which their privacy boundaries became more or less permeable, others described a more complicated pattern of shifting in which privacy boundaries altered dramatically over short periods of time. Susan's experience provides an excellent case study to illustrate this point. After receiving incessant questions from her mother about having a second child, Susan, who experienced secondary infertility, finally revealed her fertility problem to her mother. Once she made the boundary around this information more permeable, Susan continued revealing details about her experience, include upcoming medical appointments. Shortly thereafter, Susan stopped telling her parents about additional treatments because she became irritated by her their relentless questions about whether a particular treatment had been successful and offended when her mother and father shared the news of Susan's treatments with family friends. Susan said, "We started not telling them when we'd go for treatment." In response, Susan's mother started asking specific questions about when the next treatment might be. Initially, Susan responded to these inquiries with vague answers but then finally told her mother, "You know, it's just... We didn't get pregnant here, and I'd rather you didn't tell people, because it's so chancy, and the chances are not in our favor, so I'd rather everyone not be so convinced that we're pregnant." Thus, Susan's talks with her mother progressed from concealment of the fertility problem, to an initial revelation, to

discussions of specific treatments procedures, to Susan responding vaguely to her mother's constant questions about treatment, to Susan explicitly discussing the privacy boundary with her mother and discontinuing talk about her treatments. These interactions with Susan and her mother illustrate the ebb and flow of privacy management and the ways that specific actions from conversational partners prompt changes in privacy management.

Comments Sharon made at the conclusion of her interview also indicate that making decisions about whether and how to discuss a fertility problem is an ongoing, ever-changing process:

> I would say, be very careful about to whom you disclose. Because for one thing, people will ask questions, and people assume you are going to have success. Although the rate of IVF treatments and the rate of success with IVF is still quite low, people only ever hear about successful IVFs. They don't really hear much about unsuccessful IVFs, I think, unless they know the person. So I would be all for full disclosure for your own personal sanity, I guess, 'cause to me, it's easier to get the stuff off your chest and share it with people. That's half the thing. I always find if I tell somebody something, that's difficult for me. Somehow telling them reduces the burden. So I would say telling them is fine, but you have to be very careful about whom you tell, because if you carry on during treatments, people keep asking you, "How are the treatments going?"…So I think you reach a point where you're tired of people asking, and you're tired of telling people you've had no success, and you're tired of people wondering if you're getting pregnant and that kind of thing.

Sharon touched on the array of complex decisions that woman may face as they decide how to talk about their fertility problem with others.

Discussion

Women's accounts of conversations indicated that talk about a fertility problem evolves over time as women shift privacy boundaries in reaction to changing situational demands. The experience of infertility in and of itself can serve as a change agent that prompts women to discuss new topics or discuss particular topics in new ways. For example, a number of women indicated that they found themselves openly discussing sexual intercourse and bodily functions in ways they had not prior to experiencing infertility. Moreover, women's recollections indicated that talk can change over time as women cope with the experience of infertility. Some women found themselves more willing to disclose their fertility problem and to reveal more detailed information with confidants as they pursued medical intervention, gained new perspective on the infertility experience, or sought to educate others about infertility. Other women tapered off talk in reaction to unsupportive responses, changing perspectives on infertility, apparent violation of others' privacy boundaries, and the perceived risk for unwanted interactions. Women clearly recognized the ongoing nature of privacy management as they speculated about the future when making privacy management decisions (e.g., one risk of revealing information to others is the risk of ongoing telling). This evolution of talk demonstrates the complexity of women's disclosure or avoidance of infertility and related topics.

Theoretical Implications

The shifting privacy boundaries described by women in this study bring temporality to the forefront of theoretical discussions of privacy management. Although assumptions of CPM and studies suggesting the unfolding nature of privacy management (e.g., Afifi & Steuber, 2009, Petronio et al., 1996) have provided tools for understanding temporal aspects of such phenomena, the fluid and evolving characteristics of revealing or concealing private information

have received scant attention from scholars. Yet, understanding privacy management as an ongoing process rather than any one singular event supports recent calls from scholars of privacy and disclosure to move beyond conceptualizations and operationalizations of disclosure as a one-time event or a bivariate construct (e.g., Afifi, Caughlin, & Afifi, 2007). In addition, the present study suggests that temporality is about more than just testing the waters through incremental revelations (Afifi & Steuber, 2009, Petronio et al., 1996). Rather, recollections from women in our study provide clear evidence that privacy management involves an array of complex decisions that change and shift over time, even after an initial disclosure is made. The changing nature of talk is especially relevant in health-related contexts and implies that talk trajectories accompany illness trajectories as individuals deal with the temporal aspects of serious and chronic illness (Corbin, 1998; Corbin & Strauss, 1991).

Our findings are consistent with CPM's (Petronio, 2002) assumption that privacy boundaries shift in response to specific contextual criteria, including traumatic events or changing life circumstances. As women coped with infertility, they adjusted their privacy boundaries, making them more or less permeable in response to the demands of specific situations. For instance, when women were bothered by questions about the success of scheduled treatments, they stopped revealing plans for upcoming appointments. These examples of shifting privacy boundaries support Duck's (1990) claim that relational communication is unfinished business. Even after initial disclosures were made to friends and family members, women were faced with seemingly unending decisions about whether and how to continue revealing aspects of their journey with infertility to selected confidants. Moreover, women's abilities to speculate about how their strategies might differ in the future provide additional evidence of the unfinished nature of privacy management. Even women who had resolved infertility by becoming pregnant

speculated that they might make efforts to reveal their fertility problems to others in the future. In contrast, some women expressed a desire to make the information more private over time.

Understanding privacy management as a process rather than a unitary act moves us toward a theoretical perspective that stretches beyond the traditional presumption of the sovereign self implied by much scholarship in this area (see Baxter and Sahlstein, 2000) to a notion of self that is social and dialogic. By acknowledging that privacy boundaries shift over time, often in relation to the actions and reactions of others, we can recognize that a communicative act like disclosure or avoidance is not simply the result of an intact decision that the speaker brings to an interaction after a careful weighing of risks and benefits. Rather, recognizing privacy management as unfinished business highlights the evolving and emergent nature of such acts as a "process between parties" (Baxter and Sahlstein, 2000, p. 293; also see Bute, in press; Coupland, Coupland, & Giles, 1991).

Finally, women described a variety of reasons for changing their privacy boundaries, including the experience of infertility itself, unsupportive responses from confidants, and opportunities to educate others. The reasons cited by women in our study are not intended as an exhaustive list of reasons that prompt boundary shifting but are largely consistent with reasons people express for revealing or concealing other potentially stigmatizing health-related information, including an HIV positive diagnosis (Greene et al., 2003) or a history of sexual abuse (Petronio et al., 1996). In terms of broader theoretical explanations for why women might shift privacy boundaries, it seems logical that women's assessments of ownership and risk likely evolve over time. For instance, as women come to terms with a fertility problem, they might feel less vulnerable and find it less risky to reveal their condition to others. Or women who tell loved ones about fertility treatments might feel obligated to continue disclosing the details of

procedures to those individuals after making them co-owners of such information. Future studies could continue to explore the specific factors that make boundary shifts more or less likely.

Practical Implications

In addition to bringing temporality to the forefront of theoretical discussions, the present study also offers practical implications for those facing infertility or other long term stressors. For example, web sites and self-help books offer advice on how to talk about a fertility problem. Recommendations might include guidelines like these:

Discuss with your partner how much detail you want to share.

Pick an appropriate time and place to bring up the topic.

Practice what you're going to say ahead of time.

Let others know how they can support you.

Although such recommendations are generally well-intentioned, they tend to overlook the changing nature of one's desire to talk (Bute, 2008). Based on the current study, scholars and practitioners must acknowledge that such advice is oversimplified and fails to pay credence to the emerging nature of privacy management.

Implications for Future Research

Findings from our study should be interpreted in light of a few limitations. First, the women we interviewed were highly educated and had access to medical treatment for infertility. Thus, their experiences should not be understood as representative of all women with a fertility problem. For instance, almost all women in our sample had sought medical intervention to resolve their infertility, and many of them discussed marked changes in privacy management related to treatment decisions (e.g., women stopped telling relatives about scheduled treatments to avoid revealing bad news when treatments failed). In fact, only one woman in our sample had

chosen to resolve her infertility by remaining childless. At the time our interviews were

conducted, the other 22 women had either given birth, adopted a child, or were still in the

process of seeking medical intervention or pursuing adoption. Our results could be refined

through additional study with a more diverse sample of women, including women from

underserved socioeconomic groups and women who choose to remain childless. Comparing the

talk of treatment seekers to non-treatment-seekers would yield important insights. Many women

in our sample cited the onset of testing and treatment as a turning point that prompted the

modification of privacy rules. What turning points exist for women who do not have access to

treatment or choose not to pursue it?

Future studies of talk about infertility would also benefit from the use of additional

research methods. This study relied on women's retrospective accounts of conversations.

Although we found that women were able to recall conversations readily and in great detail, the

results of this project could be expanded, challenged, and refined using additional methods

(Baxter & Sahlstein, 2000). Because of the practical and ethical challenges involved in observing

naturally occurring conversations about infertility, one particularly promising method is the use

of a diary study combined with qualitative interviews. Such a method would involve asking

women (or couples) to keep an observational diary of their interactions and then combining the

data gathered from the diaries with interviews geared toward understanding participants'

interpretations of social interactions. This method provides a relatively unobtrusive account of

naturally occurring conversations while allowing researchers to explore participants'

perspectives during interviews (Braithwaite, 1991; Zimmerman & Wieder, 1977). A diary-

interview method could build on the findings of this study by offering a longitudinal perspective.

Conclusion

Our study contributes to a broader literature on privacy management by highlighting the complicated nature of shifting privacy boundaries in a socially significant context. The patterns of boundary shifting described by women in this study indicate that whether and how women talk about a fertility problem can change dramatically over time as women and couples resolve their infertility through medical intervention, adoption, or the choice to remain childless. Privacy management in the context of infertility is, indeed, unfinished business.

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Note

[1] We used pseudonyms to protect women's identities.