PSYCHOLOGICAL EFFECTS OF SPIRITUALLY INTEGRATED THERAPY FOR INFERTILE WOMEN

by

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Like other medical conditions, infertility is often unforeseen and difficult to resolve. Though both genders are impacted, women exhibit the most psychological distress following the diagnosis. Among other coping strategies, some women use their religious or spiritual beliefs to cope with the crisis of infertility. While projects investigating the role of spirituality in mental and physical health are growing in momentum, none has integrated religious or spiritual beliefs into a formal psychological intervention for infertile women. This project aimed to evaluate the efficacy, feasibility, and acceptability of such a 6-week, phone-based, spiritually-integrated therapy (SIT) program for infertile women.

In the initial phase of this two-phase project, the SIT program was developed after literature review and consultation with panel of interdisciplinary professionals and a community-based panel of women who had been diagnosed with infertility. In Phase II, 25 women from a university-affiliated infertility clinic were recruited and randomized to the SIT program or to a similarly structured cognitive-behavioral therapy (CBT) program. Anxiety, depression, fertility-related stress, religious coping, and spiritual transformation were assessed at baseline, immediately post-intervention, and at 3 months post-intervention to note between-group and within-group differences.

Though participant response to the program was positive, no significant reductions in depression, anxiety, or fertility related distress were observed. Likewise, no
significant changes in religious coping or spiritual transformation were noted.

Suggestions for future research were discussed, including strategies to maximize recruitment in this population and considerations for future studies.
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CHAPTER 1

INTRODUCTION

It is estimated that 10-15% of American couples have been diagnosed with infertility, or the failure to conceive after 12 months of frequent, unprotected sexual intercourse (Jose-Miller, Boyden, & Frey, 2007). The condition is generally attributable to male factors, ovarian dysfunction, or tubal factors, with a smaller percentage of cases attributed to endometriosis, uterine, or cervical factors (Burt & Hendrick, 2005). For about one-fourth of couples, however, the medical cause of infertility may be multifactoral or “medically undetermined,” further complicating successful medical treatment (Jose-Miller et al., 2007). Infertility treatment is not only expensive and time-consuming, but also somewhat uncertain. Some couples need multiple rounds of treatment to successfully conceive (Luke et al., 2012). Eventually, half of infertile couples must eventually confront the reality of never being able to bear a child (Burt & Hendrick, 2005).

Psychological Aspects of Infertility for Women

Infertility is often unforeseen and difficult to resolve medically. The psychological sequelae of infertility mirror other serious chronic diseases like cancer, HIV, and other chronic health conditions (Domar, Zuttermeister, & Friedman, 1993). Moreover, women are reportedly more emotionally impacted by infertility than men (Downey, 2001; Greil, 1997; Wright et al., 1991). In a study of 545 couples undergoing infertility treatment, mood disorders were present in only 9% of the men as compared to 26% of the women in the sample (Volgsten, Svanberg, Ekselius, Lundkvist, & Poromaa, 2008). Likewise, anxiety disorders were present in 15% of women in that sample as
opposed to 5% of males. Similarly, Peterson and colleagues (2006) found, in their study of 1026 men and women referred for fertility treatment, that women reported significantly more fertility-specific distress than men. Though typical prevalence estimates for depression and anxiety in women are around 10% and 15% respectively (Strine et al., 2008), estimates increase to 27%-37% for depressive disorders and 15%-29% for anxiety disorders in infertile women (Chen, Chang, Tsai, & Juang, 2004; Volgsten et al., 2008). Thus, it can be assumed that psychological distress is elevated in infertile women as compared to women without fertility issues (Domar et al., 1993; Downey & McKinney, 1992; Wright, Allard, Lecours, & Sabourin, 1989).

Gender roles may give insight into why women evidence more distress than men. Though women’s social roles have broadened in past 50 years, motherhood is still viewed as a woman’s primary social role (Parry, 2005). Girls are socialized almost from birth to be caretakers. Arguably, one’s fertility status is almost taken for granted (Bunting & Boivin, 2008). Modern young women often first consult their gynecologist to prevent unwanted conception as opposed to understanding or discovering barriers to fertility. Coming to terms with the loss of an expected milestone, or, at best, the loss of the ease at which one presumed they would reach that milestone, can be difficult. Thus, women who face this unanticipated challenge may experience identity crises (Gonzalez, 2000), grief (Gibson, 2008), and negative emotional reactions (Faramarzi et al., 2008; Verhaak, Smeenk, van Minnen, Kremer, & Kraaimaat, 2005; Wirtberg, Möller, Hogström, Tronstad, & Lalos, 2007). Further, women tend to cope with infertility differently than men, accepting more responsibility for infertility and engaging in escape/avoidance (Jordan & Revenson, 1999; Peterson, Newton, Rosen, & Schulman, 2006). Incidentally,
these coping styles are associated with greater distress than other forms of coping (e.g., active coping, positive reappraisal, and use of emotional support) (Kraaij, Garnefski, & Schroevers, 2009).

Though psychological symptoms tend to peak 2-3 years post diagnosis (Domar, Broome, Zuttermeister, Seibel, & Friedman, 1992), some women continue to suffer from anxiety, depression, and relational problems decades after unsuccessful treatment (Wirtberg et al., 2007). Without intervention, these symptoms may increase with time (Berg & Wilson, 1991; Domar, Clapp, Slawsby, Kessel, et al., 2000), compromising quality of life. Isolation may occur, contributing to interpersonal and/or marital discord (Schmidt, Holstein, Christensen, & Boivin, 2005). Afraid of stigma, uncomfortable inquiries, and unwanted advice, women may also withhold their reproductive health status from others (Slade, O’Neill, Simpson, & Lashen, 2007), unwittingly cutting themselves off from sources of social support.

**Benefits of Psychological Interventions for Infertile Women**

Support groups, psycho-educational programs, and psychotherapeutic interventions have shown promise in alleviating the immediate and long-term distress associated with infertility and infertility treatment, albeit with mixed results on which intervention is the most beneficial. Participants in support groups (Cousineau et al., 2008; Malik & Coulson, 2008; Valentine, 1990) and brief stress management groups (McNaughton-Cassill et al., 2000) reported reduced feelings of isolation. Indeed, it can be a very cathartic experience to be understood, supported, and validated by other women or couples with similar experiences. Boivin (2003) completed a meta-analysis of the outcomes of 25 psychosocial programs for infertile populations. These programs differed
in focus (psychoeducational versus counseling based), format (i.e., group versus couples), and duration. She found that the interventions were effective in reducing negative affect. Specific results varied between interventions, but reductions in measures of anxiety were more frequently observed than reductions in measures of depression. Educational and skills-based training programs were significantly more effective in producing positive change than process-based programs, which emphasized emotional expression and support. However, there is support for using both emotion-focused and problem-focused coping skills in reducing psychological distress in infertile populations (McQueeney, Stanton, & Sigmon, 1997).

Cognitive behavioral therapy (CBT) has been demonstrated as an efficacious treatment for depression and anxiety in a variety of populations, including infertile women. Faramarzi et al. (2008) compared the effectiveness of a 10-week, two-hour group-based CBT program to psychopharmacological intervention in reducing depression and anxiety in this population. Participants randomized to pharmacotherapy were administered 20 mg of fluoxetine daily for 90 days. Though significant reductions in both depression and anxiety were demonstrated in both groups, women who participated in CBT demonstrated greater reductions in distress than women who participated in pharmacotherapy. Other studies have demonstrated similar findings in terms of the beneficial effect of CBT (Chan, Ng, Chan, Ho, & Chan, 2006; de Liz & Strauss, 2005; Domar, Clapp, Slawsby, Kessel, et al., 2000; Nilforooshan, Ahmadi, Abedi, & Ahmadi, 2006) and other forms of formal psychotherapy (Wischmann, 2008) on the reduction of psychological distress. Some have even suggested that psychological evaluation,
consultation, and referral be a regular part of infertility counseling (Hart, 2002; Katz, 2008).

Aside from the psychological and interpersonal benefits of therapy, there is evidence to suggest that regulating stress levels increases fertility (Campagne, 2006). In a study of 110 women who participated in a behavioral medicine program for infertility, 37% of the patients undergoing in vitro fertilization treatment conceived within 6 months of program completion, twice the national average (Domar, Clapp, Slawsby, Dusek, et al., 2000).

Religion/Spirituality and Infertility

Just as therapy can be beneficial in learning to cope with infertility, women may also use their religious and/or spiritual beliefs to cope (Kress, 2005; Mahajan et al., 2009; Ventura et al., 2007). Incorporating religious or spiritual beliefs into coping is not uncommon. Most Americans endorse religious and/or spiritual beliefs (Gallup & Lindsay, 1999; Pew Research Center's Forum on Religion & Public Life, 2008). Those beliefs are used to make sense of life’s events and guide personal decisions (Carone & Barone, 2001; Pargament et al., 1988; Siegel, Anderman, & Schrimshaw, 2001). One’s religion or sense of spirituality can foster hope, resilience, and optimism in otherwise difficult situations (Fredrickson, 2002; George, Ellison, & Larson, 2002; Koenig, 2005; Pargament, 2002; Pargament et al., 1990). Noting the benefits of their faith, some individuals even want their sense of spirituality or faith to be addressed in medical and mental health treatment (MacLean et al., 2003; McCord et al., 2004; Pargament, Murray-Swank, & Tarakeshwar, 2005).
There appears to be a relationship between spirituality and distress in infertile women. In the only American investigation of its kind, Domar et al. (2005) found that women with high spiritual well-being reported fewer depressive symptoms and less fertility-related distress. In terms of religious or spiritual coping techniques, infertile women may rely on private prayer, meditation, spiritual counseling, or fellow parishioners for support. Some may use positive methods of religious coping, such as seeing the stressful situation as meaningful and ultimately beneficial (Gibson, 2008). Some even drew on their beliefs to negotiate different paths to parenthood (Jennings, 2010).

However, religion may exacerbate suffering for some women (Ryan, 2005). For the religious or spiritual woman, the infertility experience represents more than a medical or emotional crisis, but a spiritual crisis, a threat to the very core of one’s beliefs about self, life, and ultimate truths (Saake, 2005). Plagued by thoughts of divine punishment or judgment, some women find it challenging to draw on their faith in trying to resolve their condition (Flowers, 2002). Baptisms, baby dedications, and other religiously-based events only serve as painful reminders of their current condition. Moreover, modern-day infertility struggles often remain unaddressed and unacknowledged in religious services (Jones, 2001; Smith & Smith, 2004). Infertile women who belong to religious groups may feel invisible and ignored, left to their own devices to make sense of their infertility experience. They may use negative methods of religious coping, such as being angry at God. If this is the case, it is tantamount that psychologists engage religiously- or spiritually-inclined women to challenge counterproductive, maladaptive beliefs associated with their faith and infertility.
Intuitively linked to religious coping is spiritual transformation, the process of spiritual growth or decline following significant life events (Cole, Hopkins, Tisak, Steel, & Carr, 2008). Research has established the link between religious struggle and poor mental health (Berg, Fonss, Reed, & VandeCreek, 1995; Exline, Yali, & Lobel, 1999; Exline, Yali, & Sanderson, 2000; Trenholm, Trent, & Compton, 1998). Interventions addressing spiritual struggle can result in improved mental well-being; thus, changes in spiritual well-being following significant life events deserve attention in their own right (Murray-Swank & Pargament, 2005).

Given the religious or spiritual undertones associated with infertility, it should follow that incorporating aspects of religion or spirituality into therapy may be especially beneficial for some patients. Yet, spiritual issues often remain unaddressed during the course of infertility treatment, as well as in traditional psychotherapy. Perhaps negative religious coping would be replaced with more positive methods if infertile women were offered a spiritually-based psychological intervention that allows them to explore spiritual conflicts while also learning more traditional psychotherapeutic techniques.

**Spiritually-Integrated Therapy**

Spiritually-integrated therapies (SITs) are psychotherapeutic treatments that are based on a theory of spirituality, are empirically-oriented, are ecumenical in nature, and incorporate greater sensitivity and explicit attention to the spiritual dimension in clients’ lives (Pargament et al., 2005). At their most basic level, spiritually-integrated treatments recognize that spirituality cannot be compartmentalized or ignored within the course of treatment because, for some clients, spirituality is an integral part of the presenting
problem (Hodge, 2004). Spiritually-integrated therapy may involve a variety of techniques and interventions, including the use of religious arguments to counter maladaptive beliefs, the use of religious imagery during relaxation, the promotion of religious or spiritual practices (e.g., prayer or meditation) as behavioral activation strategies, discussing sacred writings, involving resources available in religious communities, and encouraging moralistic actions such as forgiveness (Martinez, Smith, & Barlow, 2007; Smith & Smith, 2004). It is also important to note that SITs do not aim to convert clients to a certain religion or instill new values. Rather, the goal is to rekindle lost or forgotten spiritual values and promote resilience (D’Souza & Rodrigo, 2004).

With respect to the efficacy of SITs, Smith and colleagues found that SITs are as effective as their secular counterparts in improving quality of life (Smith, Bartz, & Richards, 2007). Spiritually-integrated treatments have been developed for breast cancer survivors (Cole & Pargament, 1999; Liu et al., 2008), female survivors of sexual abuse (Murray-Swank & Pargament, 2005), adults living with HIV/AIDS (Tarakeshwar, Pearce, & Sikkema, 2005), and persons with drug addiction (Avants, Beitel, & Margolin, 2005). Though each of these unique programs target common psychological outcomes (i.e., depression and anxiety), it is important that each program is tailored to the specific target population for greater relevancy. In terms of potential mechanisms of action, the addition of spiritual elements to therapy may boost engagement and cultivate deeper rapport, leading to greater investment in therapy (Hodge, 2008; Martinez et al., 2007; Post & Wade, 2009). SITs may also alter religious coping styles by enriching the role of the client’s Higher Power in their coping process (Siegel et al., 2001) or by helping clients resolve feelings of anger, abandonment, and spiritual disconnection and gain hope,
connection, and spiritual renewal (Carrico, Gifford, & Moos, 2007; Mutter & Neves, 2010).

Theoretical Rationale for a Spiritually-Integrated Intervention for Infertile Women

Though differing theoretical rationales have been offered to explain the general effectiveness of SITs, two models may prove especially relevant to the conceptualization of how SITs may prove effective with infertile women. Typically, problem-solving and emotionally focused coping are both suggested as effective coping strategies for infertile women (McQueeney et al., 1997). Yet, another type of coping may be appropriate. The Meaning-Making Coping Model (Park & Folkman, 1997) provides a theoretical rationale for the creation of a spiritually-integrated therapy for infertile women. The model includes two levels: the global system of meaning (fundamental ways of construing reality to make inferences about the world) and the appraised meaning of specific events (appraisals of threat, causal attributions, discrepancy determinations, and decisions about how best to cope). Religious or spiritual beliefs can inform either level of this system (see Figure 1).

When an event presents a large enough discrepancy between global and appraised meanings, people experience a loss of control, identity threat, and incomprehensibility of the world. To resolve distress, people will either change their views of the stressful event or change their views of the world to accommodate the new information, in effect, making new meaning of the once-discrepant event. In the case of infertility in religious women, infertility may be distressing because it can be seen as representing a punishment from God for some form of immorality. To cope, the woman must either change her
global meaning system ("infertility is not a punishment from God") or specific appraisals ("God is not punishing me for some sin").

To facilitate this type of meaning-making coping, a more open approach to psychological treatment that would readily elicit clients’ spiritual beliefs may be warranted. Tan and Johnson (2005) suggest using the Explicit Integration model of integrating psychology and spirituality. In this model, religious or spiritual issues are directly, systematically, and intentionally addressed in treatment. By overtly incorporating client spirituality, clinical rapport is strengthened because the client recognizes the clinician’s desire to understand and respect their belief system. This strengthened rapport may influence the client to be more receptive to truly confronting their internal spiritual or religious struggles, facilitating meaning-making. In light of the role that spirituality sometimes plays in coping with infertility (Roudsari, Allan, & Smith, 2007), a psychotherapeutic modality that takes into account both the emotional and spiritual sequelae of the infertility experience would be ideal.
Study Aims

Investigations of the ways in which religion and spirituality promote mental and physical health are growing in quantity. However, outcome studies of the effectiveness of spiritually-integrated interventions are still in their infancy (Post & Wade, 2009). As researchers gain knowledge about the beneficial role that religion or spirituality can play in coping, spiritually-based interventions should accompany those findings (Harris, Thoresen, McCullough, & Larson, 1999). Moreover, spiritual or religious issues often arise in infertility, yet remain unaddressed. Explicitly integrating religious and spiritual beliefs into therapy may help facilitate coping in the context of infertility.

The goal of this exploratory study was to develop and evaluate a brief, spiritually-integrated, CBT-based psychological intervention for women with infertility (heretofore referred to as SIT). This study represented the first attempt to create a manualized, therapeutic intervention to bridge the gap between meeting both the psychological and

Figure 1. Adapted meaning-making coping model including religious/spiritual beliefs.
As such, this was considered a Stage 1 behavioral research study, with focus on manual development and pilot testing to assess the acceptability of the intervention within the population and feasibility of the proposed intervention for potential replication (Rounsaville, Carroll, & Onken, 2001). As is typical in the assessment of new interventions, this project evaluated feasibility and efficacy on a relatively small sample. Although it was decided that a total sample size of 40 participants (20 per treatment condition) would be most practical, consideration was given to the relationship between sample size and power. Assuming that 20% of enrolled participants would be lost to follow-up, our effective sample size would have been reduced to 32, or 16 participants per condition. In a study of a ten-week CBT intervention for infertile women (Domar et al., 2000), investigators saw a mean decrease in Beck Depression Inventory scores of 3.8 (SD=1.2). Using these estimates for the standard deviation and the aforementioned sample size, a two-sample, two-sided, t-test with alpha of 0.05 revealed that we would expect to see a difference of 1.2 with 80% power. That is, using a difference of difference approach (delta CBT vs. delta SIT), the net difference would have been 1.2.

This study had three specific aims: (1) develop a spiritually-integrated therapy (SIT) intervention for infertile women; (2) recruit 40 women diagnosed with infertility from university-affiliated gynecology and infertility clinics to implement the intervention; and (3) to evaluate participant response as well as the efficacy of the intervention for psychologically- and spiritually-based outcomes. These aims were addressed in two phases. In Phase I, the intervention was developed after literature review and consultation with two advisory panels. In Phase II, women were recruited and
randomized into either the spiritually integrated therapy (SIT) group or the cognitive-behavioral therapy comparison group, baseline data was gathered, and the interventions were implemented and evaluated. Participants in the SIT intervention group participated in six weekly sessions addressing common themes relevant to infertility, integrating participants’ religious beliefs into the activities. Those in the CBT-only comparison group also participated in six weekly sessions addressing the same themes, but with no explicit attention incorporation of religion or spirituality into session content. Both groups were compared on measures of depression, anxiety, fertility-related stress, religious coping, and spiritual transformation at baseline, after the intervention and at 3 months post-intervention.

The primary outcome of interest was psychological distress as measured by the Beck Depression Inventory and the State-Trait Anxiety Inventory. Secondary outcomes of interest included religious coping style, spiritual transformation, and fertility-related stress. Participants also provided feedback about the duration, content, and personal relevance of the intervention.

Hypotheses

Women who receive spiritually integrated therapy, as compared to those who receive cognitive-behavioral therapy, will:

1) Report significantly lower levels of depression, anxiety, and fertility-related stress post-intervention and at 3-months follow-up.

2) Report significant increases in positive religious coping and decreases in negative religious coping post-intervention and at 3-months follow-up.
3) Report significantly greater spiritual growth and less spiritual decline post-intervention and at 3-months follow-up.
CHAPTER 2

METHODS

After obtaining Institutional Review Board approval (see Appendix A), this project was conducted in two phases. In Phase I, the spiritually-integrated treatment (SIT) intervention and cognitive-behavioral therapy intervention (CBT) were developed after literature review and consultation with two advisory panels. In Phase II, participants were recruited, randomized into one of two experimental conditions, completed treatment, and completed all assessments.

Phase I: Intervention Development

Literature review. CBT was chosen as the psychotherapeutic basis for this intervention. Research suggests that religious clients are especially receptive to CBT because both religion and CBT are highly belief-oriented and emphasize changes in mind and behavior (Tan & Johnson, 2005). Thus, treatment activities were conceptualized based on recommendations for using CBT with faith-based infertile couples (Smith & Smith, 2004) and an exploration of religious or spiritual considerations in the experience of infertility (Flowers, 2002; Gibson, 2008; Glahn & Cutrer, 2004; Jones, 2001; Layne, 2006; Peoples & Ferguson, 1998; Ryan, 2005). Moreover, both Recreating Your Life, a spiritually-integrated CBT-based psychotherapeutic intervention for people diagnosed with cancer (Cole & Pargament, 1999) and the Mind/Body Program for Infertility, a behavioral medicine program for infertile women (Domar, 1997) served as organizational models from which this program was created. Both the SIT and CBT treatment protocols were thematically organized to address issues empirically identified
as important to infertile women, including control (Tennen, Affleck, & Mendola, 1991), identity (McCarthy, 2008), meaning (Gibson, 2008), and interpersonal relationships (Spector, 2004). These four themes were the focus of the four content sessions of the intervention. Most activities employed are frequently employed in CBT, including examining cognitive appraisals, challenging negative or dysfunctional thoughts/beliefs, and encouraging participation in activity.

The SIT intervention reflects a Christian religious orientation. Since intimate expertise of a variety of orientations was needed to make the intervention more religiously inclusive, it was advised that the initial version of the intervention be developed based on the faith that is most familiar to the author (H. Koenig, personal communication, August 19, 2009). It was confirmed that such an approach is proper; just as psychotherapeutic interventions are based on a particular approach or orientation, the intervention should also be based on a specific theological orientation (K. Meador, personal communication, August 19, 2009). Because there are different denominations within the Christian religion, the intervention was designed to be broadly based, allowing participants to discuss their own specific religious backgrounds and beliefs and consider how their beliefs may affect their views of infertility, as well as how their spirituality intersects with the themes addressed in the intervention. As such, spirituality was generally incorporated into the intervention by referencing specific scriptures and religious figures, as well as eliciting participants’ beliefs and interpretations of religious text.

Expert review panel. An initial draft of the SIT protocol and participants’ workbook was reviewed by an advisory panel of professionals in intervention research,
cognitive behavioral therapy, religion/spirituality, and infertility. Most board members held terminal degrees in their respective fields; all but one had clinical or research experience in working with infertile women or women who had experienced pregnancy loss. After a focus-group type feedback session via in-person meeting was held, revisions were made to the original protocol. Those revisions included changes in terminology, the expansion of one identity activity, the elimination of one treatment activity, the addition of a boundary-setting component in the relationships module, and the addition of a book resource list for participants.

Specifically, as this population might be sensitive to perceptions of blame, mindful use of language was encouraged. The term thinking distortion was used instead of thinking error, as the latter might insinuate that women were doing something “wrong” that might be contributing to their distress. A homework activity designed to elicit religiously-based conceptualizations of womanhood was expanded to emphasize intrinsic, rather than role-based, self-esteem and self-worth. Moreover, discussions of the changes in modern women’s expected roles and the potential impact of those changes were added to the identity section. Also, a discussion of the concept of mothering and displaying those qualities regardless of parenthood status was added to the in-session discussion during the identity session. After review, a more spiritually-based assertiveness activity was eliminated in favor of introducing boundary setting to complement the discussion of assertiveness in the relationships module. Finally, several panel members suggested adding a resource list with books covering infertility coping, boundaries, sexual intimacy, and faith-based coping.
Panel members provided notes for the facilitator as well. Specifically, the facilitator was encouraged to acknowledge and normalize participants’ grief secondary to failed conception and pregnancy loss, as these events are often not as recognized as the loss of a child. The facilitator was also encouraged to elicit scriptural references and salient religious models during sessions to highlight participants’ religious or spiritual beliefs rather than solely present references and models for interpretation. Finally, panel members wanted the facilitator to mention pursuing further therapy as desired at treatment termination.

Community review panel. A revised SIT treatment manual and workbook were presented to a community advisory panel of 4 women diagnosed with infertility for further review. Three women were diagnosed with primary infertility (as defined above). One woman had been diagnosed with secondary infertility (inability to achieve pregnancy after the successful conception and birth of at least one child). All were Caucasian and between 21–40 years of age. The women were referred by their physician from a university-based reproductive endocrinology and infertility clinic. After consenting to participate, they received electronic copies of the materials 2 weeks in advance of the feedback session. Phone conference was employed to elicit feedback regarding content and structural aspects of the intervention, perceived usefulness of each activity, perceived burden of participation, and overall spiritual relevance of program. They also provided insight as to the practicality of the group meetings and suggestions to foster greater engagement in the groups.

Only 3 of the 4 women were available to participate in the phone conference. One provided feedback via email due to scheduling conflicts. Feedback was generally
positive. Panel members judged themes to be relevant to the experience of infertility, activities to be appropriate to each theme and easy to complete, and the intervention to be spiritually relevant overall. They found that having a workbook to which to refer back after the program ended especially beneficial. No specific modifications of materials or content were suggested. However, suggestions were made related to meeting scheduling. Specifically, one member suggested that phone-based treatment may make participation more possible for participants outside of the greater Birmingham area (note, this was suggested when treatment was planned as group-based). Others suggested holding sessions during lunch or after 6pm to enable working women to participate. Lastly, one participant noted that childcare might be a barrier to participation for women diagnosed with secondary infertility. This feedback from the community advisory panel suggests that the SIT intervention would be acceptable to infertile women of Christian faith.

Protocol finalization. After completing panel review, the CBT-only manual and workbook were formulated by reviewing the final SIT manual and treatment workbooks and removing all spiritual or religious reference, context, and activities (see both completed protocols in Appendices B and C).

Intervention Program Description

Program overview. All program sessions were planned to last 45 to 60 minutes. Sessions were structured to include didactics and discussion, at least one in-session activity, and homework. All treatment materials were included in participants’ workbooks. Homework from the previous session was reviewed at the start of each session. Lastly, each session was closed with participants sharing what they were
thankful for in the preceding week and what they were looking forward to in the coming week.

**Session one.** The goals of the first session were to introduce the intervention and program materials to participants, to clarify the overall goals of the program, to introduce the cognitive behavioral model, to establish treatment expectations, and to build rapport between the participant and facilitator. To build rapport, the facilitator encouraged the participant to share general information about herself, as well as her experience with infertility. In the SIT protocol, the participant also shared a brief synopsis of her religious/spiritual beliefs. The facilitator then reviewed a document listing “treatment norms,” or what the participant could expect of the treatment experience. Limitations of confidentiality were included in that discussion. Didactics for the first session included introducing the cognitive behavioral model by reviewing a worksheet that gave an example of the connection between thoughts, feelings, and behaviors. First session homework encouraged participants to write their expectations of the program to reflect back on at the completion of the intervention. Participants were also encouraged to provide personal examples of the cognitive behavioral model at work, by documenting how their thoughts contributed their actions or feelings throughout the week.

**Session two.** The goals of the second session were to discover one’s current identity conceptualizations, to understand the potential origins of those conceptualizations, to challenge irrational or negativistic self-concepts, and to acknowledge “forgotten” aspects of the self through behavioral activation. Didactics of this session centered largely on a discussion of the meaning and formation of individual identity. Participants constructed pie charts displaying aspects of their “current selves”,

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including how much they felt infertility was a part of their identity, and “desired selves”, in which they could freely manipulate identity elements. Feedback was given to participants who dedicated a significant portion of their identity to infertility, with the purpose of underscoring other aspects of identity that might be minimized or neglected. After identifying their desired selves, participants were instructed to note behaviors that correspond to the identity aspects they noted. For example, if a participant values her identity as a wife, she might identify going on a date with her husband as a corresponding behavior. In the SIT protocol, the general discussion of identity was closed by eliciting participants’ interpretations of Psalm 139:14 (“I praise you because I am fearfully and wonderfully made; your works are wonderful, I know that full well”) as it pertains to identity. Finally, the impact of infertility on femininity and womanhood was discussed by eliciting reactions to two quotes from women who were coping with infertility.

Homework for session two included two items: (1) a behavioral activation exercise that instructed participants to document their engagement in activities that encouraged the growth of the “desired self” aspects of their identity noted in session and (2) a worksheet further discussing femininity. Whereas SIT program participants’ worksheets considered feminine identity or perceptions of womanhood from a scriptural perspective, CBT participants’ worksheets allowed for further consideration of societal conceptualizations of womanhood through popular media portrayals of women.

Session three. Acknowledging important relationships and learning strategies to improve those relationships through effective communication were the goals of the third session. Boundary setting and assertiveness training comprised the bulk of the session. To underscore the didactic portion of assertiveness training, the facilitator and participant
engaged in a brief role play. For the SIT participants, there was also a discussion of religious models of assertiveness and the acceptability of assertiveness from a religious or spiritual perspective. The session ends with a guided imagery exercise. SIT participants focused on their relationship with God as they completed the activity. CBT participants were instructed to concentrate on a loved one during the exercise. Homework for the third session encouraged participants to practice assertive communication techniques and guided imagery.

Session four. The goals of the fourth session were to find or create meaning in the infertility experience, as well as to recognize cognitive distortions. During session, a quote was presented to segue into a discussion of Kübler-Ross’ (1969) stages of grief model. This quote either referenced God or did not depending on group membership. The stages of grief were presented as a way to both elicit beliefs about the personal meaning of infertility and to introduce the concept of acceptance. Discussion questions also evoked SIT participants’ beliefs about the religious or spiritual meaning of infertility. After beliefs were elicited, thinking errors were explained, with emphasis on the normal human tendency to try to find meaning in difficult situations. The connection between thoughts or beliefs and distressing feelings was made to underscore how distorted beliefs can lead to further unpleasant emotions and irrational behavior. Homework from the fourth session was solely focused on identifying and challenging distorted thinking.

Session five. Coming to terms with the limits of personal control and/or feelings of helplessness about infertility was the goal of the fifth session. During the session, participants completed an exercise that allowed them to consider realistic limits of control. SIT participants were instructed to indicate whether certain problems or life
situations were within their control or within God’s control. Those in the CBT program were to indicate whether problems were within or outside of their control. Participants received feedback about their attributions of control and potential ramifications of these attributions. The focus of session then turned to surrendering the “need” or compulsion to control difficult situations, taking care to juxtapose this with the concept of resignation. Making the distinction between surrendering the need for control and passive resignation was especially important, as the goal of the session was not to influence women to give up their desire for motherhood, but rather, to balance that desire with acceptance in order to release the anxiety and frustration associated with feeling powerless. While women might not have any control over the occurrence of infertility, they do have the power to choose how they experience or cope with the condition. The homework from this last content session reinforced the message of acceptance by presenting practical, everyday examples of practicing acceptance and asking them to identify an area of current worry in which to apply acceptance. For SIT program participants, a biblical example of acceptance was also provided.

Session six. The goal of the sixth and final session was to review participants’ progress and to encourage continued work towards gains made while in the program. Participants shared their initial program expectations, which they wrote after the first session, with the program facilitator and were allowed to reflect on whether or not those expectations were met. All participants were encouraged to engage in continue therapy or supportive services if so desired. Finally, the program was closed by allowing both the facilitator and participant time to share good-byes and well wishes.
Phase II: Participant Recruitment and Intervention Implementation Procedure

Participant inclusion and exclusion criteria. Women between 21-40 years old with medically-diagnosed primary or secondary infertility were eligible to be included in the Phase II sample. Participants were eligible regardless of their infertility treatment status (i.e., whether or not they are using fertility drugs or assistive reproductive technologies). Due to the nature of the SIT intervention, women who identified themselves as Christian and were comfortable with discussing their religious or spiritual views were included. Lastly, women who were non-English speaking and members of the community advisory panel were excluded from this study.

Recruitment. Participants were recruited from a university-affiliated reproductive endocrinology and infertility clinic in Birmingham, Alabama. Though attempts were made to recruit from a general gynecology and obstetrics clinic in a public health hospital and other private gynecology and infertility clinics in the Birmingham area, as well as a large, multi-site, private infertility clinic in the Houston, Texas metropolitan area, no participants were successfully recruited from those sources. Recruitment brochures and flyers (see Appendix D) were strategically placed in the patient waiting area as well as in examination rooms. These materials instructed patients to either inform their physician if interested in the study or contact the principal investigator directly by calling a university-affiliated private office number. Additionally, the principal investigator participated in direct patient recruitment in the clinic, meeting with patients who met inclusion criteria and expressed interest in learning more about the study following consultation with their doctor. Lastly, a clinical trial advertisement was placed in the campus newspaper outlining inclusion criteria and contact information.
Consenting, assessment, and intervention. After eligibility screening and randomization into intervention groups, participants were scheduled for an in-person meeting with the principal investigator to review and sign the informed consent document, which provided greater detail about the project and emphasized the possibility of being assigned to either group as a result of randomization. Once participants gave their consent to participate, they completed the baseline assessment packet during that same session. After baseline assessment, a treatment start date and session appointment time was established and participants were informed that treatment materials would be mailed. Participants were randomly assigned to intervention groups using a computerized random list generator. The principal investigator and participants were blind to condition assignment until after baseline assessment. After condition assignment, treatment packets were mailed to participants, including a reminder letter listing the day and time of sessions, a crisis resource list of local facilities and organizations that provide psychiatric care in emergent situations, and the appropriate treatment workbook based on condition assignment.

Both intervention protocols were facilitated by the principal investigator, a clinical psychology doctoral student with experience in cognitive-behavioral therapy. Prior to intervention implementation, the facilitator completed training with a licensed clinical psychologist with experience in the practice of CBT, as well as experience with working with infertile women. Training involved review of the principles of CBT, familiarization with the protocol, role-plays, and readings. The clinical psychologist provided ongoing individual supervision during the course of the intervention.
All treatment sessions were held by telephone as scheduled by each participant. In the event of a missed session, the facilitator contacted the participant to arrange for a make-up session. In the event of 3 failed attempts to reschedule a missed session, the participant was counted as withdrawn and an exit interview form (Appendix E) was mailed to the participant to understand reasons for withdrawal.

After intervention completion, phone-based post-intervention surveys were administered by senior level undergraduate psychology students IRB-certified in human subjects research and trained by the PI in survey administration for this study. Reminder cards were mailed a month before participants’ scheduled 3-month assessment date. Participants again completed phone-based assessment at the 3-month post-assessment period. The UAB Survey Research Unit was also used to complete phone-based assessment for participants who were scheduled for 3-month assessment after May 2012. Appreciation cards were mailed to all participants who completed the study.

Participants

A total of 37 participants were screened for the two experimental conditions (see Figure 2). Three participants were deemed ineligible to participate due to pregnancy. One was ineligible due to age. Of those 33 eligible participants, 6 were unable to be contacted to schedule baseline assessment. Thus, baseline assessment was scheduled with 27 participants. Twenty-five participants completed baseline assessment and were randomized into intervention groups. Two participants failed to appear for baseline assessment. Of the 13 participants randomized to the SIT program, 9 participants completed treatment. Only 5 of the 12 CBT participants completed treatment. All 14
participants who completed treatment completed follow-up assessments. Twelve of the 14 who completed follow-up assessments also completed 3-month assessment.

**Figure 2.** Participant randomization and disposition.

Overall, participants were married, middle-income, and held at least a post-secondary degree (see Table 1). Mean age was $32.36 \pm 4.76$. Racial composition was evenly split between Caucasian and African-American. Only a minority were participating in any other supportive services for infertility, such as psychotherapy (12%),
pastoral counseling (8%), or support groups (8%). Eighty percent of the sample reported that their infertility was due to female factors, including endometriosis, poly cystic ovarian syndrome, blocked tubes, and premature ovarian failure. Three women (12%) reported infertility of mixed etiology (i.e., both male and female factors). Two women (8%) did not know the cause of infertility. The average time since infertility diagnosis was about four years with variability (mean = 47.27 ± 44.99 months). Only nine women (40%) were currently participating in medical infertility treatment. Three were undergoing hormone therapy only, 3 were participating in intrauterine insemination (IUI), and 2 were either actively participating in or preparing for vitro fertilization (IVF). One woman was undergoing exploratory surgery to determine the extent of intratubal scarring before pursuing further treatment. Fifty-six percent of the women reported receiving infertility treatment in the past.

In terms of religious and spiritual beliefs and practices, most women were either Baptist (40%) or non-denominational Christian (32%). Other participants identified themselves as Catholic, Methodist, Angelican, Lutheran, or Seventh Day Adventist. One woman indicated that she ascribed to no formal religious group. Most (68%) attended religious services at least once weekly. The overwhelming majority (80%) reported praying at least once daily. However, there was variation in how much they participated in other religious activities, including participating in other church-based activities, reading religious texts, and watching religious television programs (see Table 1). Most women either described themselves as equally spiritual and religious (44%) or more spiritual than religious (44%).
Table 1

Demographic & Religious Characteristics ($n = 25$)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race/Ethnicity</td>
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<td></td>
</tr>
<tr>
<td>African American/Black</td>
<td>13</td>
<td>52</td>
</tr>
<tr>
<td>White/European American</td>
<td>12</td>
<td>48</td>
</tr>
<tr>
<td>Relationship Status</td>
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<td></td>
</tr>
<tr>
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<td>8</td>
</tr>
<tr>
<td>Long-term/committed relationship</td>
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<td>12</td>
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<tr>
<td>Married</td>
<td>19</td>
<td>76</td>
</tr>
<tr>
<td>Separated/Divorced/Widowed</td>
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<td>4</td>
</tr>
<tr>
<td>Annual Household Income</td>
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<td></td>
</tr>
<tr>
<td>&lt;$20,000</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>$20,001 - $40,000</td>
<td>8</td>
<td>32</td>
</tr>
<tr>
<td>$40,001 - $60,000</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>&lt;$60,000</td>
<td>10</td>
<td>40</td>
</tr>
<tr>
<td>Educational Level</td>
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</tr>
<tr>
<td>High School Diploma/GED</td>
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<td>12</td>
</tr>
<tr>
<td>Some College</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>Associate’s/Vocational/Technical Degree</td>
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<td>16</td>
</tr>
<tr>
<td>Bachelors Degree</td>
<td>10</td>
<td>40</td>
</tr>
<tr>
<td>Masters or Terminal Degree (PhD, MD, JD)</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Religious Service Attendance</td>
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<td></td>
</tr>
<tr>
<td>At least once weekly</td>
<td>17</td>
<td>68</td>
</tr>
<tr>
<td>At least once monthly</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>A few times a year</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>Rarely/Never</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Religious Activities Attendance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>At least once weekly</td>
<td>9</td>
<td>36</td>
</tr>
<tr>
<td>At least once monthly</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>A few times a year</td>
<td>3</td>
<td>16</td>
</tr>
<tr>
<td>Rarely/Never</td>
<td>9</td>
<td>36</td>
</tr>
<tr>
<td>Prayer</td>
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<td></td>
</tr>
<tr>
<td>At least once daily</td>
<td>20</td>
<td>80</td>
</tr>
<tr>
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<tr>
<td>At least once monthly</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Religious Reading</td>
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<td></td>
</tr>
<tr>
<td>At least once daily</td>
<td>7</td>
<td>28</td>
</tr>
<tr>
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</tr>
<tr>
<td>At least once monthly</td>
<td>6</td>
<td>24</td>
</tr>
<tr>
<td>Rarely/Never</td>
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<td>12</td>
</tr>
<tr>
<td>Religious TV/Radio Exposure</td>
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</tbody>
</table>
Measures

**Demographic questionnaire.** Age, yearly household income, educational level, race/ethnicity, marital status, cause of infertility (if known), time since diagnosis, status of infertility treatment, and history of infertility treatment was assessed at baseline only (see Appendix E for all measures). Participants also reported religious denomination, frequency of service attendance, and level of spirituality/religiousness. In this sample, questions that assessed religious beliefs and practices produced an alpha co-efficient of .76.

**Support-seeking.** Participants reported the nature, frequency, and level of satisfaction of any psychosocial support received at baseline assessment, post-assessment, and three-month assessment, including psychological services, support groups, and/or pastoral counseling, via a written questionnaire designed for this study.

**Social Desirability Scale (SDS-17).** At baseline, participants’ levels of social desirability were assessed using the SDS-17 (Stöber, 2001). Controlling for socially desirable responding is important in religious populations, as they have a tendency to report behavioral aspirations instead of actual behaviors or attitudes. The measure consists of sixteen items, with true-false answer choices. Examples of items include: “I always eat a healthy diet” and “Sometimes I only help because I expect something in return.” This measure also includes reverse-scored items. Each true answer choice is worth one (1) point and each false is worth zero (0) points. Possible totals range from 0
to 16, with higher scores indicating a tendency to present an unrealistically positive self-image. In this sample, the SDS-17 produced an alpha coefficient of .79, which is commensurate with internal consistency of .72 demonstrated in the original validation study (Stöber, 2001), as well as a three-part validation study in the US, with alphas ranging from .64 to .92 (Blake, 2006).

*Beck Depression Inventory (BDI-2).* Symptom severity was assessed using this well-validated, widely-used 21-item measure of the affective, somatic, and cognitive symptoms of depression (Beck, Steer, & Brown, 1996). Total scores range from 0 to 63, with higher scores indicating more severe depression. The BDI-2 was given at all three assessment points. In this sample, the BDI-2 produced alpha coefficients of .87, .92, and .86 at each time point. Due to copyright restrictions, the BDI-2 cannot be included in Appendix E.

*State-Trait Anxiety Inventory, Form Y (STAI).* Levels of state anxiety (i.e., transient and situationally-induced anxiety) and trait anxiety (a stable, characterological attribute) were assessed using this 40-item measure (Spielberger, Gorsuch, & Lushene, 1970). Sample state anxiety items include “I am tense” and “I feel content”. Sample trait anxiety items include “I am a steady person” and “I worry too much over something that really doesn’t matter”. Total raw scores in each domain range from 20-80, with higher scores indicating greater anxiety. However, raw scores were converted to standard scores based on population (working adults), age (19-39 years old) and gender (female) were used for analyses. Standard scores have a mean of 50 and standard deviation of 10. The STAI was given at all three assessment points. In this sample, the STAI-State produced alpha coefficients of .90, .92, and .93 at each time point. STAI-Trait produced alpha
coefficients of .92, .96, and .90 at each time point. Due to copyright restrictions, the STAI cannot be included in Appendix E.

*Fertility Problem Inventory (FPI).* Perceived infertility-related distress was assessed using this 46-item measure (Newton, Sherrard, & Glavac, 1999). A global score is calculated by summing distress scores in five domains, including social concern, sexual concern, relationship concern, need for parenthood, and rejection of childfree lifestyle. Scale score ranges vary, yet global scores can range from 0 to 230. Higher scores indicate more distress. The FPI was given at all three assessment points. In this sample, Global FPI produced alpha coefficients of .86, .92, and .92 at each time point.

*Brief Religious Coping Scale (Brief RCOPE).* Positive and negative religious coping methods were assessed using this 14-item measure (Pargament, Smith, Koenig, & Perez, 1998). Positive coping and negative coping scale scores range from 7 to 28, with higher scores indicating more use of that particular coping style. This measure has been repeatedly used in religion/spirituality research and has demonstrated adequate validity and reliability (Pargament, Koenig, & Perez, 2000). The Brief RCOPE was given at all three assessment points. In this sample, the Brief RCOPE produced alpha coefficients of .87, .82, and .78 at each time point for positive religious coping and .90, .94, and .82 at each time point for negative religious coping.

*Spiritual Transformation Scale (STS).* Cole and colleagues (2008) created this 40-item measure to assess spiritual transformation following significant events. Specifically, the scale measures spiritual growth (increased utilization of spiritual resources) and spiritual decline (decreased utilization of spiritual resources). The STS demonstrated adequate internal reliability and test-retest reliability and convergent validity with other
measures of spiritual growth. Moreover, hierarchical regression analyses indicated that
the subscales uniquely predicted adjustment beyond spiritual coping, which is especially
relevant for this study. STS was given at all three assessment points. In this sample, STS
produced alpha coefficients of .98, .96, and .98 at each time point for spiritual growth and
.87, .95, and .88 at each time point for spiritual decline.

*Intervention feedback*. Overall intervention satisfaction was measured at the post-
treatment assessment point using 12 questions with likert-type response choices.
Specifically, participants were asked about their overall level of satisfaction with the
program, as well as their satisfaction with the phone-based nature of the intervention,
session frequency and length, treatment activities, the program facilitator, amount of
spirituality included in the intervention, and spiritual relevance of the intervention.
Participants were given the opportunity to provide open-ended feedback as well.
Intervention feedback questions yielded an alpha coefficient of .76.

*Credibility/Expectancy Questionnaire (CEQ)*. The perceived credibility of the
intervention as well as participants’ expectancy for improvement was assessed at the
midpoint of both interventions to control for participant expectancy bias using this 6-item
measure, designed for use in clinical outcome studies (Devilly & Borkovec, 2000).
Respondents indicate on a scale from 1 (not at all) to 9 (very) how logical the program
seems, how useful they think the program will be in reducing distress, how much they
feel the program will help reduce distress, and how confident they would you be in
recommending the program to a friend. They also indicate a percentage for how much
improvement in distress they logically think and intuitively feel will occur. In the original
normative studies, internal consistency for the whole scale ranged from .85 in a sample of
126 male Vietnam veterans and their spouses attending a week-long residential program to .84 in a sample of 69 individuals completing outpatient treatment for anxiety. In this sample, the CEQ produced an alpha coefficient of .65.
CHAPTER 3

RESULTS

Data Analytic Plan

Preliminary analyses were conducted, including descriptive statistics and interclass correlations. All primary analyses were conducted on an “intent-to-treat” basis. Each patient enrolled in the study was analyzed as part of their originally randomized group, regardless of engagement with the intervention. In the case of study withdrawal, participants’ last observed scores were carried forward in analyses. After testing assumptions, separate 2 (group) x 3 (assessment time) ANOVAs were performed to analyze between-group differences in psychological distress and spiritual/religious outcomes. T-tests were used to follow-up significant omnibus univariate results. Planned comparisons were used to compare intervention and control conditions at each assessment period to evaluate significant differences in all outcomes based on group membership. These statistical analyses were performed using IBM SPSS Statistics for Windows, Version 21.0.

Preliminary Analyses

Randomization check. Chi-square analyses and independent samples t-tests were performed on demographic data to insure that randomization worked. There were no significant differences on variables deemed relevant between groups at baseline (i.e., age, race, education, marital status, current or past participation in medical infertility treatment, time since infertility diagnosis, participation in other therapies, self-described religiosity or spirituality, or participation in religious/spiritual activities). However,
concurrent participation in mental health treatment at baseline approached significance (Chi-square = 3.69; \( p = .06 \)), where those in CBT were more likely to be in mental health treatment. Also, income approached significance (\( t = -1.94, p = .06 \)), where women with higher incomes were assigned to SIT.

**Descriptive statistics.** In terms of response style, the sample as a whole reported average levels of social desirability. The sample reported mild depression, average levels of state and trait anxiety, and mild levels of fertility related distress across all assessment points (see Table 2). Participants reported using more positive than negative religious coping styles. Likewise, participants also indicated that they felt their experience with infertility has led to their spiritual growth more so than spiritual decline. Skewness and Kurtosis statistics were calculated for each continuous variable and all results for all but one were within acceptable ranges, i.e. between -2 and 2. Kurtosis for positive religious coping at the 3-month assessment period was 2.11, yet skewness was within normal limits at -1.39.

Table 2

**Total Sample and Group Means by Assessment Period**

<table>
<thead>
<tr>
<th>Variables</th>
<th>Total Sample Mean(SD) (( n=25 ))</th>
<th>CBT Mean(SD) (( n=12 ))</th>
<th>SIT Mean (SD) (( n=13 ))</th>
<th>( p )-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Desirability</td>
<td>7.28 (3.57)</td>
<td>8.08 (2.35)</td>
<td>6.54 (4.37)</td>
<td>.29</td>
</tr>
<tr>
<td>Depression</td>
<td>15.08 (8.96)</td>
<td>16.00 (10.12)</td>
<td>14.23 (8.06)</td>
<td>.63</td>
</tr>
<tr>
<td>State Anxiety</td>
<td>48.72 (9.36)</td>
<td>50.67 (10.94)</td>
<td>46.92 (7.63)</td>
<td>.33</td>
</tr>
<tr>
<td>Trait Anxiety</td>
<td>55.52 (10.81)</td>
<td>56.75 (9.19)</td>
<td>54.38 (12.39)</td>
<td>.60</td>
</tr>
<tr>
<td>Fertility-Specific Distress</td>
<td>103.36 (29.97)</td>
<td>105.85 (35.22)</td>
<td>101.08 (25.44)</td>
<td>.70</td>
</tr>
<tr>
<td>Pos. Religious Coping</td>
<td>16.00 (4.96)</td>
<td>15.58 (4.98)</td>
<td>16.38 (5.11)</td>
<td>.70</td>
</tr>
</tbody>
</table>
Correlations between outcome variables. Depression, state anxiety, and trait anxiety scores were positively correlated at each assessment point (see Table 3). Those who reported more depressive symptoms, more state anxiety, and more trait anxiety also reported more negative religious coping styles. There was an inverse relationship between spiritual growth and spiritual decline at each assessment period. Participants who reported using more positive religious coping also reported more spiritual growth. Likewise, those who reported using more negative religious coping also reported more spiritual decline. Fertility problem inventory scores were not related to any of the other research outcomes.
Table 3

*Correlations between Outcome Variables*

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*Note. BDI = Depression, STAI-S = State anxiety, STAI-T = Trait anxiety, PRC = Positive religious coping, NRC = Negative religious coping, SG = Spiritual growth, SD = Spiritual decline.
*p < .05  **p < .01*
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**Intervention Analyses**

*Treatment completion.* Of the 25 participants that began treatment, only 14 completed treatment. Nine of 13 SIT participants completed the intervention, while only 5 of 12 CBT participants completed treatment. There were no significant differences in treatment completion based on group assignment (Chi-square = 1.92, \( p = .17 \)). However, women who withdrew were more likely to have participated in other mental health treatment at baseline (Chi-square = 4.34, \( p < .05 \)). Also, women with lower incomes were more likely to withdraw from treatment (\( t = -4.34, \ p < .001 \)). Exit interview surveys were mailed to women who withdrew from the project to ascertain reasons for withdrawal. However, none were returned. All 14 women completed post-treatment assessment via telephone. The six weekly sessions were slated to last 45 to 60 minutes each, totaling 270-360 minutes of total treatment. Actual treatment total averaged 246.64 ± 55.77 minutes.

*Treatment expectations.* At the mid-intervention point, participants completed treatment credibility and expectancy questionnaires that asked about more “logical”, or thought-based, expectations of improvement and more “intuitive”, or feelings-based, expectations. Eleven of the 14 treatment-completing participants returned completed questionnaires. Respondents indicated that the program seemed logical (\( M = 7.91 \pm 1.14 \)), and that it might be somewhat useful in reducing their infertility-related distress (\( M = 6.64 \pm 1.50 \)). Many felt confident in recommending the program to a friend who was experiencing a similar problem (\( M = 7.45 \pm 1.51 \)). The sample thought they would see an average percentage of 63.64 ± 25.01% improvement in infertility-related distress by the end of the program. When asked to think about more of what they felt intuitively
than thought logically, respondents felt that the program would somewhat help reduce infertility-related distress ($M = 5.91 \pm 2.21$) and felt that their infertility-related distress would improve by $54.55 \pm 28.41\%$. There were no statistically significant differences in expectations based on group membership. However, the item that asked about the potential efficacy of the program in reducing infertility-related distress approached significance ($t = -1.89, p = .09$; mean CBT = 5.80 ± .84; mean SIT = 7.33 ± 1.63).

**Intervention feedback.** Most participants who completed the intervention indicated overall satisfaction with the intervention (see Table 4). Twelve indicated that session length was adequate. One noted that sessions were too brief, while another indicated that they were too long. Likewise, 12 participants felt that the number of sessions was adequate. Two responded that there were too few sessions. The overwhelming majority ($n=13$) indicated that the amount of intervention activities was adequate. One wanted more activities. In terms of format, four participants gave open-ended feedback that indicated that face-to-face might be preferable over the phone based format due to phone connectivity issues. However, most indicated satisfaction with the phone format.

While most recognized that the activities did include spiritual elements, participants varied in how much they thought that an adequate amount of spiritual content was included in the intervention (see Table 4). Nevertheless, the majority rated the program as spiritually relevant, that it would help them recognize that God would give them strength to cope with infertility, and that it encouraged them to think about the connection between personal spirituality and coping with infertility.
With respect to differences in feedback based on group membership, participants were asked questions that were more related to the program in general (i.e., satisfaction with the program overall, program length, and activities), as well as questions specifically related to how spiritually relevant the program was and how much it attended to their spiritual beliefs. There were no between-group differences found in general feedback.

Participants in the SIT intervention group reported that the program helped them see that God would give them strength to cope with infertility more than those in the CBT group \((t = -3.96, p < .01; \text{mean } \text{CBT} = 1.60 \pm .89; \text{mean } \text{SIT} = 2.89 \pm .33)\). Perceived between-group differences in the overall amount of spiritual content included in the program approached significance \((t = -2.16, p = .052; \text{mean } \text{CBT} = 1.40 \pm .89; \text{mean } \text{SIT} = 2.33 \pm .71)\). These results were also submitted to non-parametric analyses (i.e., Mann-Whitney's U test), and results were similar.

### Table 4

**Intervention Feedback by Group**

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<td>Satisfaction with phone-based format</td>
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<td>Neither satisfied or dissatisfied</td>
<td>1 (11%)</td>
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<tr>
<td>Satisfied</td>
<td>3 (33%)</td>
<td>2 (40%)</td>
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<tr>
<td>Very satisfied</td>
<td>5 (56%)</td>
<td>3 (60%)</td>
</tr>
<tr>
<td>Satisfaction with intervention activities</td>
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<tr>
<td>Satisfied</td>
<td>4 (44%)</td>
<td>3 (60%)</td>
</tr>
<tr>
<td>Very satisfied</td>
<td>5 (56%)</td>
<td>2 (40%)</td>
</tr>
<tr>
<td>Satisfaction with intervention facilitator</td>
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<td></td>
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<tr>
<td>Neither satisfied or dissatisfied</td>
<td>1 (11%)</td>
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<tr>
<td>Satisfied</td>
<td>0</td>
<td>1 (20%)</td>
</tr>
<tr>
<td>Very satisfied</td>
<td>8 (89%)</td>
<td>4 (80%)</td>
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<tr>
<td>Overall satisfaction with intervention</td>
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<tr>
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<tr>
<td></td>
<td>Satisfied</td>
<td></td>
</tr>
<tr>
<td>------------------------</td>
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<tr>
<td>Amount that spirituality/faith was included in activities</td>
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<tr>
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<td>1 (20%)</td>
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<tr>
<td>Some</td>
<td>4 (44%)</td>
<td>2 (40%)</td>
</tr>
<tr>
<td>Very much</td>
<td>4 (44%)</td>
<td>2 (40%)</td>
</tr>
<tr>
<td>Amount that the program “spoke to” spiritual beliefs</td>
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<tr>
<td>A little</td>
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<td>1 (20%)</td>
</tr>
<tr>
<td>Some</td>
<td>5 (56%)</td>
<td>3 (60%)</td>
</tr>
<tr>
<td>Very much</td>
<td>4 (44%)</td>
<td>1 (20%)</td>
</tr>
<tr>
<td>Helped to recognize that God would give strength to cope</td>
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<tr>
<td>A little</td>
<td>0</td>
<td>3 (60%)</td>
</tr>
<tr>
<td>Some</td>
<td>1 (11%)</td>
<td>1 (20%)</td>
</tr>
<tr>
<td>Very much</td>
<td>8 (89%)</td>
<td>1 (20%)</td>
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<tr>
<td>Encouraged thoughts about connection between spirituality and coping</td>
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<td>Some</td>
<td>2 (22%)</td>
<td>2 (40%)</td>
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<tr>
<td>Very much</td>
<td>6 (67%)</td>
<td>2 (40%)</td>
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<td>Overall amount of spiritual content included</td>
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<td>Little</td>
<td>1 (11%)</td>
<td>4 (80%)</td>
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<tr>
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<td>A lot</td>
<td>4 (44%)</td>
<td>1 (20%)</td>
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**Analyses of Variance**

*Depression.* For this analysis, the assumption of homogeneity of covariances was violated (Box’s M = 33.09; *p* < .001). Thus, it is suggested that one use the Pillai’s trace criterion instead of Wilk’s lambda to determine statistical significance. There was no statistically significant difference in depression between the two groups over time, *F*(2, 22) = 1.65, *p* = .21; Pillai’s Trace = 0.13, partial ε² = .13. As a statistically significant result was not achieved, no further follow-up tests were performed.
Anxiety. For the state anxiety outcome, the assumption of homogeneity of covariances was not violated (Box’s M = 33.09; p < .001). There was no statistically significant difference in state anxiety between the groups over time, F (2, 22) = .16, p = .86; Wilk's λ = 0.99, partial ε² = .01. As a statistically significant result was not achieved, no further follow-up tests were performed for state anxiety. For the trait anxiety outcome, the assumption of homogeneity of covariances was violated (Box’s M = 31.42; p < .001). There was no statistically significant difference in trait anxiety between groups over time, F (2, 22) = 1.83, p = .19; Pillai’s Trace = 0.14, partial ε² = .14. As a statistically significant result was not achieved, no further follow-up tests were performed.

Fertility-specific distress. The assumption of homogeneity of covariances was not violated (Box’s M = 10.65; p = .17). There was no statistically significant difference in global fertility specific distress scores between the groups over time, F (2, 22) = .16, p = .86; Wilk's λ = 0.99, partial ε² = .02. As a statistically significant result was not achieved, no further follow-up tests were performed.

Religious coping. For positive religious coping, the assumption of homogeneity of covariances was not violated (Box’s M = 4.25; p = .73). There was no statistically significant difference in positive religious coping scores between the groups over time, F (2, 22) = .77, p = .47; Wilk's λ = 0.93, partial ε² = .07. As a statistically significant result was not achieved, no further follow-up tests were performed for positive religious coping. For negative religious coping, the assumption of homogeneity of covariances was not violated (Box’s M = 18.02; p = .02). There was no statistically significant difference in negative religious coping scores between the groups over time, F (2, 22) = .11, p = .90;
Wilk's $\lambda = 0.99$, partial $\varepsilon^2 = .01$. As a statistically significant result was not achieved, no further follow-up tests were performed.

*Spiritual transformation.* For spiritual growth, the assumption of homogeneity of covariances was not violated (Box's $M = 9.43; p = .23$). There was no statistically significant difference in spiritual growth scores between the groups over time, $F (2, 22) = .56, p = .58$; Wilk's $\lambda = 0.95$, partial $\varepsilon^2 = .05$. As a statistically significant result was not achieved, no further follow-up tests were performed for spiritual growth. For spiritual decline, the assumption of homogeneity of covariances was not violated (Box's $M = 10.38; p = .18$). There was no statistically significant difference in spiritual decline scores between the groups over time, $F (2, 22) = .12, p = .88$; Wilk's $\lambda = 0.99$, partial $\varepsilon^2 = .01$. As a statistically significant result was not achieved, no further follow-up tests were performed.

*Post-hoc Sensitivity Analysis*

To ascertain if participants degree of participation in the intervention significantly affected outcomes, analyses of variance were re-run isolating only those participants who completed treatment. There were no differences in outcomes.

*Post-hoc Power Analysis*

Power analyses were performed after main analyses were completed to determine if the sample size was sufficient to detect an effect. On the whole, the observed power for all outcome variables was low. The highest observed power was noted for trait anxiety (.34) and depression (.31.) scores. The observed power for both state anxiety and fertility-
specific distress was .07. Observed power for positive and negative religious coping was .17 and .06, respectively. Observed power for spiritual growth was .13, and .07 for spiritual decline.
CHAPTER 4
DISCUSSION

This study built upon the existing literature in infertility-related psychological distress and spiritually-integrated psychotherapeutic interventions to develop a six-session, phone-based intervention to reduce distress and increase coping in women with infertility. The intervention was organized to address four key themes: identity, relationships, meaning, and control. During the development phase, a group of medical, psychological, and theological professionals reviewed the intervention and offered revisions. A small group of women diagnosed with infertility also reviewed the content of the intervention and provided feedback about the activities. After the SIT intervention was finalized, it was compared to a similarly structured CBT intervention to evaluate the effects on depression, anxiety, fertility specific distress, religious coping, and spiritual transformation immediately and 3-months post intervention.

A sample of 25 women was recruited to determine the acceptability, feasibility and efficacy of the intervention. Though this sample size was smaller than expected, similarly small samples have been used in prior studies to test the efficacy of newly formulated SIT interventions, some with as few as 2 participants (Murray-Swank & Pargament, 2005). Whereas other SIT intervention trials have included no comparison group (Avants et al., 2005; Tarakeshwar et al., 2005) or a no-treatment control comparison (Cole, 2005; Liu et al., 2008), this study was unique and contributed to the extant empirical literature in the area, in that it compared the new, spiritually-integrated intervention to a similarly structured, active intervention.
In this study, there were no statistically significant differences found in mental health outcomes between the SIT and CBT interventions at any time point. Further, no significant pre-post treatment differences were noted within groups. Though contrary to our hypotheses, these results support the assertion that psychoeducation and skills-based training may be more effective in producing reductions in anxiety and depression than interventions that focus on emotion-based coping or cognitively-based interventions (Boivin, 2003). Similarly, a meta-analysis of spiritual or religious adaptations to therapy also revealed that spiritual therapy seemed to be more beneficial in fostering patients’ general well-being or quality of life than on reducing frank mental health symptoms (Smith et al., 2007). Lastly, as Pargament and colleagues (2005) suggested, perhaps SIT did not prove superior to CBT, because spiritually integrated interventions were not designed to be “a new form of treatment that stands on its own, that competes with, or replaces, other forms of help” (p.161). Rather, prior studies may have compared SITs to inactive control groups to understand how in integrating client spirituality in other psychotherapeutic orientations might enrich the therapeutic experience for clients, not effect greater change in outcomes per se.

The current intervention was also shorter than other spiritually-based interventions. A group-based spiritual coping intervention for adults living with HIV/AIDS (Tarakeshwar et al., 2005), an individual program for survivors of sexual abuse (Murray-Swank & Pargament, 2005), and a mixed-modality intervention for addiction and HIV risk behavior (Avants et al., 2005) were all eight, 1-2 hour sessions in length. Cole’s (2005) spiritually based intervention for cancer survivors was reduced from eight to six sessions, but session length is not specified. Thus, it could be the case
that this six-session intervention did not provide the proper treatment intensity to produce significant change. However, it should be noted that brief CBT has proved efficacious in reducing depression and anxiety in other populations (Cape, Whittington, Buszewicz, Wallace, & Underwood, 2010).

While treatment efficacy for outcomes cannot be statistically supported, the overwhelming majority of women who completed both interventions were satisfied with the overall programs and treatment activities. Though the phone-based format was adopted for participant convenience, and phone-based interventions have shown demonstrated similar efficacy in reducing distress (Mohr, Vella, Hart, Heckman, & Simon, 2008) to traditional individual therapy, some participants suggested that the traditional individual therapy format might be preferable over the phone based format. Those who were randomized to the SIT treatment indicated that they felt the program was spiritually relevant and helped them see that God would give them strength to cope with infertility. This is well-aligned with the literature that encourages inclusion of client spirituality to improve coping (Carrico et al., 2007; Harrison, Koenig, Hays, Eme-Akwari, & Pargament, 2001; Park, 2007; Plante, 2008; Tix & Frazier, 1998). Thus, this program seemed well-received in the target population, despite its lack of efficacy for reducing psychological distress.

Limitations

Recruitment was unexpectedly slow given the literature noting psychological distress in this population. It seems that women were more concerned with attending to medical treatment for infertility than attuning to any psychological issues that present due
to the diagnosis, or that their current sources of support were adequate to manage whatever distress did arise (Wischmann, 2008). There was significant attrition, in that 44% of the total sample withdrew during the intervention phase of the study. Though this rate of attrition is not atypical in empirical studies of SITs (Smith et al., 2007) or of withdrawal from CBT (Salmoiraghi & Sambhi, 2010), the restricted sample size limits the power of analyses and our ability to determine between and within group differences.

As no participants who withdrew returned completed exit interview forms, we cannot conclusively determine reasons for attrition. Differences in withdrawal based on treatment randomization were not supported statistically. However, the majority of participants initially randomized to CBT did withdraw (58%), as opposed to those randomized to SIT (31%). Though all participants were informed about the process of random assignment, perhaps CBT-only participants withdrew because they expected to participate in the SIT program. There were no differences in participant characteristics at baseline. However, we did see that those who withdrew were likely to be already participating in a form of mental health treatment at baseline. We did not ascertain whether those participants were also receiving cognitive-behavioral therapy, perhaps rendering their participation in treatment for this study redundant. It would be beneficial for future studies to target only infertile women who are without other mental health support. As noted in other studies investigating discrepancies in mental health treatment utilization, perhaps those who withdrew who were not currently in treatment did not perceive themselves to be distressed enough to gain significant benefit from the program (Boivin, Scanlan, & Walker, 1999; Emery et al., 2003; Simon & Ludman, 2010).
Participants who completed treatment also provided data on how much they thought and felt the program would be helpful for them in helping them cope with infertility at the intervention mid-point. Many expected moderate to high levels of improvement. All women who withdrew terminated participation before session three. Therefore it might be assumed that those who withdrew doubted the efficacy of the treatment (Wischmann, 2008). There was also a relationship between withdrawal and income, such that women with a higher income were more likely to complete treatment. If income is thought of as a proxy for leisure time, it could be the case that more affluent participants simply had more time to participate.

Moreover, this sample reported mild to moderate levels of depression, anxiety, and fertility related distress at baseline. They also reported using more positive than negative religious coping, and conceptualizing their infertility experience as contributing to their spiritual growth. It could be the case that significant results were not obtained due to a “floor effect.” It could also be the case that the conservative method of data imputation, last observation carried forward, diminished potential effects.

Suggestions for Future Research

Recruitment was challenging in this study. A number of recruitment techniques consistent with those successfully employed in prior invention trials with infertile women (Domar, Clapp, Slawsby, Kessel, et al., 2000) were used to increase recruitment, including strategically placing study advertisements in patient waiting areas, listing the study on a clinical trials database for participants, and attempting to connect with local churches to inform congregations about the study. However, the most successful strategy
seemed to be in-clinic recruitment, in which patients were informed of the study by their medical doctors before getting further details about the study from the principal investigator. This “warm hand off” recruitment procedure may help validate the study for the potential participant and confer to the investigator the trust and rapport the patient has developed with her doctor onto the investigator. Thus, if replicated, more active rather than passive techniques should be used to maximize recruitment, potentially by soliciting the medical doctors’ involvement in screening the patient and introducing the study to the patient before they are solicited by the investigator.

A number of participants suggested that the treatment be in-person, rather than phone based. This was surprising, as the intervention modality was switched from live, group-based to phone-based to allow women to participate in the program with more flexibility and at hours more convenient for them. If replicated, researchers may consider hosting the program as one would traditional, individual outpatient therapy. Alternatively, in health care clinics that use a more integrated model of care, mental health providers are co-located in the same clinical environment as medical providers. If this intervention was facilitated in an integrated obstetrics and gynecology clinic, it would be seamless to provide the one-on-one therapy that women deemed more desirable, while also circumventing the typical barriers to participating mental health treatment (i.e., time constraints, transportation issues, stigma about reporting to a psychology clinic, etc).

Finally, while this sample was too small to investigate differences in outcomes by severity of distress at baseline, it could be the case that participants’ initially modest levels of distress weakened response to treatment. If replicated, one may consider
recruiting women who report at least moderate levels of depression, anxiety, and fertility related distress. Alternatively, the program may be modified to be more self-guided in nature. Sexton and colleagues (2010) noted that infertile women who were only mildly to moderately distressed, or those who are unlikely to pursue traditional therapy, may view self-help programs more favorably. No matter the treatment modality, it would seem that addressing religion and spirituality in this population is important, as negative religious coping was correlated with depression and anxiety at each time point.

**Conclusion**

The field of psychology, and clinical and health psychology in particular, is growing in its realization that, for some patients, religious and spiritual beliefs are as woven into the fabric of their identity and perspectives as gender, sexual orientation, race, or ethnicity. As therapists seek to create meaningful and impactful experiences for their clients and effect sustaining change, they are now more likely to recognize that ignoring religious or spiritual beliefs as one attends to clients’ other values, beliefs, and thoughts ultimately does the spiritually-inclined client a disservice, as those beliefs might be significantly related to the presenting issue. For example, the women in this study who reported the use of more negative religious coping styles also reported more symptoms of depression and anxiety at each time point. Many women who participated in this program found the inclusion of their spiritual beliefs into the treatment program very relevant. While this study did not substantiate the benefit of spirituality integrated therapy for women who currently face fertility challenges, it does answer the call of completing more
empirically-based research to analyze the comparative value of explicitly attuning to client beliefs in treatment.
REFERENCES


Tarakeshwar, N., Pearce, M. J., & Sikkema, K. J. (2005). Development and implementation of a spiritual coping group intervention for adults living with


APPENDIX A

IRB APPROVAL FORM
Form 4: IRB Approval Form
Identification and Certification of Research Projects Involving Human Subjects

UAB's Institutional Review Boards for Human Use (IRBs) have an approved Federalwide Assurance with the Office for Human Research Protections (OHRP). The Assurance number is FWA00005960 and it expires on January 24, 2017. The UAB IRBs are also in compliance with 21 CFR Parts 50 and 56.

Principal Investigator: ANDREWS, SHIQUINA L
Co-Investigator(s):
Protocol Number: X100322006
Protocol Title: The Effects of Spiritually Integrated Therapy on Psychological Distress in Infertile Women

The IRB reviewed and approved the above named project on 2-27-13. The review was conducted in accordance with UAB's Assurance of Compliance approved by the Department of Health and Human Services. This Project will be subject to Annual continuing review as provided in that Assurance.

This project received EXPEDITED review.
IRB Approval Date: 2-27-13
Date IRB Approval Issued: 3-8-13

Marilyn Doss, M.A.
Vice Chair of the Institutional Review Board for Human Use (IRB)

Investigators please note:

The IRB approved consent form used in the study must contain the IRB approval date and expiration date.

IRB approval is given for one year unless otherwise noted. For projects subject to annual review research activities may not continue past the one year anniversary of the IRB approval date.

Any modifications in the study methodology, protocol and/or consent form must be submitted for review and approval to the IRB prior to implementation.

Adverse Events and/or unanticipated risks to subjects or others at UAB or other participating institutions must be reported promptly to the IRB.
SESSION 1: WELCOME TO A FULFILLED LIFE!

The purpose of the initial session is to clarify the goals of the program, outline treatment norms, introduce the intervention and materials to participants, and begin to build rapport.

Activities & Suggested Length

Getting to Know Each Other (15 minutes)

The program leader should introduce herself to the participant, give her professional background, and share her motivation for leading the program. Participants may be curious of the fertility status of the leader. Though disclosure is up to the leader’s discretion, sharing this information may effectively model disclosure. Limit the leader’s introduction to 10 minutes.

After the leader introduces herself, participants introduce themselves. Since this is the first meeting, a participant should not be forced to share more information about herself or her background than she is comfortable with. Nevertheless, welcome her to share her infertility story. You may also prompt with marital status, cause of infertility, when they learned of the diagnosis, personal or family reactions, and positive and negative aspects of their infertility experience thus far to encourage dialogue. Further, she may indicate whether or not she has ever participated in any form of therapy and her reasons for interest in this program. This will give the leader an idea of the participant’s expectations. Limit the participant’s introduction to 10 minutes.

Introduction to the Program (10 minutes)

After a small introduction, the leader will explain the goal of the program: to reduce the emotional distress associated with infertility. Some members may assume that the purpose of this group is to boost their fertility outright. This is NOT the case, and assumptions such as these should be directly addressed. While a small body of research does indicate that reducing distress improves pregnancy rates, the goal of this program is to positively impact stress. In keeping with this goal, the program will address four themes over the course of 6 weeks: identity, relationships, meaning, and control. One theme will be addressed per week, with the last session devoted to reflections and gaining closure. By being more aware of how infertility may affect these facets of life, participants may discover an enriched sense of self, develop more satisfying relationships, gain new perspectives on the infertility experience, and understand limits of control.

1 While time limits are suggested in order to adhere to the 1-hour session timeframe, occasionally sessions may run over, particularly if members are especially interested in a given topic or activity. Certainly, it is important to foster discussion and encourage active engagement in the group. Nevertheless, the group leader should limit total session time to no more than 1.5 hours.

To do this, the program will teach members different coping techniques from the cognitive behavioral approach. These techniques will be learned in the 45-minute sessions. Though session time is important for introducing these new skills, the independent exercises help solidify lessons learned during sessions. Again, while participation is not forced, participants should be encouraged to be as involved in the program as they can be. They may also find that their level of involvement or comfort grows over the course of the program. This is natural; participants should be allowed to progress at their own pace. At this point, the leader should explain the cognitive behavioral model to the participant by referring to Worksheet 1. Cognitive-behavioral therapy is based on the idea that thoughts cause our feelings and behaviors. This concept may be hard to grasp initially, because one usually ascribes behavioral and affective reactions to people, situations, and events. Included on Worksheet 1 is the model, as well as an example of the model in action. After explaining the model and reviewing the example, highlight that the benefit of the cognitive model is that if one can change the way one thinks about a situation, one can feel better or behave differently, even if the situation does not change.

*Establishment of Program Norms (10 minutes)*

Refer the participant to Worksheet 2 which lists the program norms. Review these norms with the participant to ensure that she understands the process of treatment. An accepting, non-judgmental atmosphere should be fostered during the sessions so that each member feels comfortable exploring her issues without fear of guilt or shame. Answer any questions about these norms that participants may have.

*Homework (5 minutes)*

Refer the participant to Worksheet 3, entitled “My Expectations.” Tell her to take about 10-15 minutes to complete this exercise independently, preferably within the next day or two after session. She is to reflect on the initial group session and document her expectations of the program. The purpose of this exercise is to be able to reflect back on her expectations at end of the program.

Also, refer the participant to Worksheet 4, entitled “Practicing the Cognitive-Behavioral Model.” The purpose of this exercise is to teach participants to recognize the model at work in their everyday lives. On the worksheet, they are instructed to pick 3 situations or events and go through the model, identifying any thoughts they had in the situation, and subsequent feelings and behaviors. The situations may or may not pertain to infertility. This should take no more than 30 minutes of their time this week. Tell participants to note any questions they may have while completing this exercise.

Lastly, point out the Session Notes page at the end of the workbook. Participants may write quotes or other notes from the session on this page as they so choose.

*Closing (5 minutes)*
To establish a closing ritual, have the participant share something positive that happened to her this week and what she is looking forward to in the next week. The intent of this exercise is not to open additional conversation. Rather, the purpose of this exercise is to further establish leader-participant rapport. At the end of each session, the program leader should thank the participant for her attendance and openness to sharing.
SESSION 2: REDISCOVERING YOUR IDENTITY

The purpose of the second session is to discover current identity conceptualizations, begin to understand where those concepts originate, challenge irrational or negativistic self-concepts, and celebrate often-unacknowledged aspects of the self.

Activities & Suggested Length

Homework Review: Expectations & CBT Model Practice (10 minutes)

Open the floor for feedback on the utility of the homework. Ask for one or two examples of the model items, and ask for a few examples of program expectations. If there are questions, field those. Reinforce participants for completing the homework. Encourage them to continue to recognize the model in their daily lives.

Identity Pie Chart (15 minutes)

The theme of this session is identity. Pose the following question to the member: “What is an identity?” Some women may use words such as self-concept or self-image to define identity. Indeed, one’s identity is the way in which an individual views herself. This can encompass physical descriptions (e.g., tall, curvy, blonde, brown-eyed), relational descriptions (e.g., daughter, friend, wife), role-based or occupational descriptions (e.g., teacher, doctor, lawyer), or sociocultural descriptions (e.g., Black, Dominican, Italian). After she reaches a working definition of identity, have the participant consider where this definition may have originated. For example, for the individual who identifies themselves as smart or intelligent, how did they come to see themselves as such? We often find that we rely on trusted others to impart on us our own conceptualization of ourselves. Alternatively, we may get our identity cues from society at large, filtered through media images. We can either embrace others’ descriptions of us or reject them.

Refer the participant to Worksheet 5, entitled “My Identity Pie.” This in-session exercise is designed to help participants discover what they deem to be important or significant aspects of their current identities, as well as discover which aspects of their identity they would like to change. The first page of this worksheet asks participants to construct a pie chart displaying aspects of their current selves. In this chart, they must include a section dedicated to how much they view infertility as a part of their identity. After the completion of the current self pie chart, instruct participants to proceed to the second page to complete the desired self pie chart. In this second chart, they can reduce or expand elements of their selves that they wish to see reduced, increased, eliminated, or created. They may also choose to negate infertility as an element of their identity all together. Give members about 10 minutes to construct each chart. Percentage scores may be helpful.

After she has finished, the participant reflect on (a) whether or not the amount she dedicated to infertility in the chart was more or less than she expected and, if relevant, (b) how it felt to
realize that she was dedicating a substantial part of her current identity to infertility, as well as any realizations she may have had on how this impacts her daily functioning. For example, what are the emotional costs of placing too much emphasis on any one aspect and minimizing others? If she kept infertility in her desired self chart, process what this means to her. If anyone added “mother” to their desired self and dedicated a substantial portion of their pie to this element, discuss what it might mean if that role was never fulfilled. Before the termination of this activity, help the participant brainstorm ways to begin to working towards being her desired self. At the end of this exercise, the participant should have a greater appreciation for the many things that make her a unique and interesting individual, and understand that her struggle with fertility is just one aspect of their identity. Thus the purpose of this activity is to broaden the self-concept.

Discussion: “Conceptualizations of Femininity & Womanhood” (10 minutes)

Now that the participant has considered the basic concept of identity, have her consider what it means to be a woman, as well as what femininity means. Ask simply: What is femininity? What traits does it encompass? After a few responses have been given, read the following quote:

“You know, I used to be such a good teacher. I loved the kids in my class, and they felt a special relationship with me too... But now I feel myself pulling back from them as if I can’t afford to extend myself emotionally anymore. I mean, after all, if I can’t have a child of my own, what’s the point in taking care of other people’s kids?”

Ask the group the following questions:

1) How has the speaker allowed infertility to impact her?
2) What aspects of femininity are displayed here?
3) Has infertility impacted or compromised your views of your own femininity? In which ways?
4) It sounds like the speaker is talking about the concept of “mothering.” What does that concept mean to you? Can one display mothering qualities without a child of her own?

Now read the following short quote to the participant, related to perceptions of womanhood:

“Don’t take away what is left of my identity, I long for a baby, the chance to prove I am truly a woman.”

Ask the group:

1) Does the ability to bear children truly equal womanhood? If yes, how so? If not, what else does being a woman encompass?
2) What does society have to say about what a true or good woman is?
3) How often do you think like the speaker, that having a child validates your womanhood?

**Homework (5 minutes)**

Refer participants to Worksheet 6, entitled “Doing Things for All of Me.” After completing her identity pie charts, the participant now recognizes areas of her identity that she may be neglecting while overly concentrating on infertility. This exercise is designed to engage participants in behavioral activation to encourage the growth of other aspects of identity. Participants are to identify areas of their identity pie chart that they desired to nurture, as evidenced by growth in these areas on the desired self pie chart. Each day between this session and the next, they are to engage in activities that nurture those desired areas. Two examples are given on the worksheet: painting or drawing to increase artistic identities and spending quality time with a significant other to increase one’s identity as a loving partner. Participants should document their activities. Clarify that they should engage at least 3 different areas during the week, not simply do seven different activities to address one identity area.

Also, refer participants to Worksheet 7, “What is a Woman?” After the discussion of feminine identity or perceptions of womanhood, a discussion of media portrayals of women is presented. This exercise is designed to further stimulate contemplation of aspects of identity, and the formulation of those aspects. Discussion questions are included to that end.

**Closing (5 minutes)**

Close with the same ritual from the initial session, letting the participant share a positive experience that happened this week and what she is looking forward to in the next week. Remember to keep this statement brief. Again, thank her for participating and sharing with you, and that you are looking forward to next week.
SESSION 3: MAINTAINING YOUR RELATIONSHIPS

The purpose of the third session is to acknowledge important relationships, and learn strategies to improve those relationships through effective communication.

Activities & Suggested Length

*Homework Review: Doing Things for All of Me & What is a Woman (10 minutes)*

Open the floor for feedback on the utility of the homework. Ask for one or two examples of activities, and ask for feedback on how she felt while engaged in the activity. Also ask about answers to the “Woman” discussion questions. Reinforce the participant for completing the homework. Encourage her to continue to engage in activities to address their whole identity, rather than focusing solely on one aspect.

*Boundary Setting & Assertive Communication (15 minutes)*

Sometimes, women with fertility challenges experience others’ seemingly well-intentioned comments as cruel or simply insensitive. Women are often challenged with how to respond to such comments without being equally as offensive. Instead they simply ignore the remark or sulk in silence in order to “keep the peace” or “be polite.” Thus, insensitive comments and intrusive questions continue, because the woman has given no indication that these comments have crossed some boundary. Alternatively, women may become so frustrated and enraged by repeated comments that they lash out in anger. This can also negatively affect her relationships, effectively alienating her from her friends and family. By establishing boundaries and learning how to communicate in a more assertive manner, she acknowledges her own feelings as well as potentially refrains from offending the other person.

Initially, participants may seem hesitant to engage in assertive communication. Barriers to assertive communication include: not having clear boundaries, fear of rejection, confusing assertiveness with aggression, discomfort with standing up to certain people, and fear of provoking an aggressive response from others. Indeed, it can be difficult for women to begin to assert their needs, especially when others expect them to not do so. However, bottling in offense, anger, or other negative emotions will eventually take its toll. An especially salient example is that of a carbonated soda in a bottle. If other people constantly shake, stir up, or “offend” the bottle, whomever opens the agitated bottle will be the unfortunate victim of an explosion of all the contents. Process how the build-up of offense or tension led to an aggressive response, even to an unintended victim. Now have the participant think about what happens when the pressure is carefully released before passing the shaken bottle on. The leader should point out how defusing the bottle’s pressure immediately is akin to being assertive in each situation. The leader should also note that the bottle may still be passed. Metaphorically speaking, this symbolizes the fact that hurt or offense may still occur, because one is unable to prevent others from making comments or asking questions, but they can control how they respond.

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At this point, refer participants to Worksheet 8, “Knowing My Boundaries,” and Worksheet 9, “Communicating Assertively.” Some participants may already be quite familiar with these topics. It might be helpful to gauge their knowledge before reviewing the material. The first worksheet helps participants acknowledge their boundaries by understanding what boundaries are, why they are important, and how to recognize boundaries. It also helps them learn how to set and maintain healthy boundaries. It is also important to recognize that healthy boundaries are not rigid either. Context is key. The second worksheet guides participants through the definitions of passive, aggressive, and assertive communication. It also gives suggestions of how to communicate more assertively, both verbally and non-verbally. It ends with some suggestions of ways to practice assertive communication. After reviewing the information on the sheets, role-play a conflict- or communication-related situation that may arise in infertility and boundaries violation. After about 3 minutes, cease the role-play and invite feedback. Ask: Did you think you were being assertive, passive, or aggressive? How did it feel to assert your boundaries? How could communication have been improved?

_Closeness to Others (10 minutes)_

In keeping with our discussion of relationships, have participants ponder how their relationships may have changed after learning about their infertility. Did they become angry or distant? Or did they draw closer to loved ones in their search for comfort? In any event, have the participant consider how they expressed their feelings to friends and family, if they have at all. Ask if she felt comfortable expressing all her feelings to one especially important loved one (like a mother or mate), even the negative ones. If she was to admit to this person that she was angry, hurt, or disappointed, how might they react? Would they criticize her or sympathize?

Invite the participant to participate in the “Envisioning Love” guided imagery exercise as a way of sharing her feelings with loved ones. Have the participant get comfortable, close her eyes, and breathe deeply as you read the text on Worksheet 10. Read the text slowly in a calm, relaxing voice. The room should be quiet; alternatively there may be soothing music playing in softly the background. Some women may cry as they are processing the activity; this is perfectly acceptable. Some may be ashamed to admit that they were angry with their loved one for whatever reason; this too is acceptable. At the end of the exercise, participants will hopefully come to the quiet realization that they are unconditionally supported. After the exercise is complete, have the participant discuss what this exercise was like for her.

_Homework (5 minutes)_

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3 Note that the leader’s version of this worksheet is slightly different from the version in the participant workbook, which instructs participants on how to do the exercise themselves at home. Thus, you should read from the facilitators copy in the appendix of this manual. This will also be more rushed than what members may do on their own.
Refer the participant to **Worksheet 11**, entitled “Practicing the WII Technique.” Just as was discussed in session, the participant is to use the WII technique for assertive communication once daily to resolve conflicts and relate better to others. In addition to noting the elements of the WII technique she used, have her also note her own feelings about using this technique, as well as others’ responses. Also have her practice the “Envisioning” exercise daily. In her Notes section, she can note any reactions to the exercise that she would like to share next time. Also, mention that the impact of fertility challenges on the sexual relationship was not discussed in this section. Refer interested participants to the Resource section for books that discuss that issue.

*Closing (5 minutes)*

Close with the same ritual from previous sessions, in which the participant shares a positive experience from this week and what she is looking forward to in the next week. Again, thank her for being present. Reinforce her consistency. Let her know that the program is half complete, and you are again looking forward to next session.
SESSION 4: FINDING MEANING

The purpose of the fourth session is to consider the possibility of finding or creating meaning in the infertility experience, learn the concept of cognitive distortions, and demonstrate an ability to recognize and label these distortions.

Activities & Suggested Length

Homework Review: Boundary Setting, Assertiveness, & Envisioning Love Exercise (10 minutes)

Open the floor for feedback on the utility of the homework. Ask for one or two examples of new boundaries established or situations in which assertiveness was practiced, including reactions and personal feelings. If the participant wants to share further reactions to the imagery exercise, welcome those. Reinforce her for doing the independent exercises. Encourage her to continue to engage in boundary setting and assertive communication. Refer interested participants to the Engel book about assertiveness in the Resource section for further insights. Also encourage repetition of the imagery exercise, meditation, or whatever methods they were previously employing to reduce anxiety.

Discussion: “Why Me?” and Other Hard Questions (15 minutes)

Consider the following excerpt from a poem about infertility:

“Why me? What did I do? Why does it always seem like my dreams never come true? Is this punishment for something in my past? I do not know how long this pain will last. It’s not like I’m asking to become a millionaire. I just want to be a mom. Is my request so unfair? Why me? Why not another woman? I know that may sound mean, but remember I am human.”

According to Kübler-Ross, individuals often progress through four stages of grief or mourning as they learn to cope with significant losses. The first is denial. As it applies to the infertile woman, denial may take the form of rejecting the initial diagnosis. The next is anger. Women may lash out at others or criticize “undeserving” mothers. The next is bargaining; women may engage in behaviors to seemingly “earn” a baby. Next is the sadness and despair of depression. Finally, women can arrive at acceptance. In this case, acceptance does not mean passively resigning to the unchangeable prospect of being childless. Nor does it mean forgetting one’s desire to ever have children. Rather, acceptance is a choice. Woman can choose to enjoy the other experiences life has offered without dogmatically focusing on what they perceive to be missing. Acceptance is

Be aware that this session may be an especially sensitive topic. Ensure participants that you, as the leader, are not trying to convince them to resign to being childless. Rather, the purpose is to explore whatever personal meaning this experience has for them.

From Joy Bennett-Thomas’s (2007) Infertility Hurts (pp.76).
understanding that infertility may or may not be resolvable, but that life can and must go on despite it. It should be noted that it is natural to endure these emotional reactions during the grieving process. Explain the stages of grief model to the group. You may read the paragraph above verbatim or paraphrase, adding other examples as warranted.

In the above quote, the speaker is questioning the purpose of this experience. Some participants may be able to relate. Pose the following questions:

1. Have difficulties with bearing children changed your view of the meaning of life?
2. How have these challenges affected your beliefs? Does infertility have a deeper meaning to you?
3. How has it changed your views of right and wrong, of the fairness of the world?
4. What have you learned thus far about the personal meaning of infertility? Do you view it as punishment? As a random situation that you just happened to find yourself in, which reflects little on yourself? Or some other way? Why?
5. Does life owe us anything?

**Distorted Thinking and Assigning Meaning (10 minutes)**

As mentioned earlier, grief reactions in response to loss are normal and help facilitate coping. Repeated exposure to the same trigger leads to reductions in the strength of the reaction. This reduction indicates progress. If one feels “stuck” in their grief, it may indicate that there are some deeper thought patterns contributing to one’s emotional response. In our efforts to find meaning in difficult situations, we may make assumptions and logical errors in thinking. These errors are called cognitive distortions. In the context of infertility, women sometimes use these errors to assign meaning to the experience of infertility, leading to unpleasant emotions and irrational behavior. Point the participant to Worksheet 12, entitled “Common Thinking Distortions.” Review each distortion with her, going through the definitions and examples. After the review is complete, field any questions. Participants will use the information on this worksheet to complete the homework assignment for this session.

**Homework (5 minutes)**

The homework for this section is indicated on Worksheet 13, “Challenging Your Thinking.” Now that participants know how to recognize and label their thinking errors, have them identify and label at least 10 of their own thinking distortions related to infertility and/or faith. Next, they are to list the advantages of holding this thought or belief, as well the disadvantages. After they make the list of advantages and disadvantages, have the members weigh these numerically. Finally, the members should revise each statement to form a more flexible or realistic thought. Review the example given on the sheet.

**Closing (5 minutes)**
Close with the same ritual from previous sessions, in which the participant shares some positive experience from this past week and what she is looking forward to in the next week. Thank her for attending and sharing. Acknowledge her willingness to confront some potentially tough issues.
SESSION 5: UNDERSTANDING CONTROL

The purpose of the fifth session is offer a means for coming to terms with the limits of personal control and/or feelings of helplessness about infertility.

Activities & Suggested Length

Homework Review: Challenging Your Thinking (10 minutes)

Open the floor for feedback on the utility of the homework. Ask for one or two examples of thinking distortions and revised thoughts. If the participant has questions, field those. Reinforce her for completing the homework. Encourage her to continue to practice recognizing and modifying thinking distortions as they occur.

Circles of Control (15 minutes)

Refer the participant to Worksheet 14, entitled “Circles of Control.”6 Have her think about problems or situations that she would like to change. Then, have her decide whether this change is within or outside of her control. She should place all things under her control in the first circle, and things outside of her control in the second. This portion of the exercise should last 5-10 minutes. Afterward, have her share the contents of each circle. At this point in the therapeutic process, the participant should trust the leader enough to be receptive to constructive feedback. Use Socratic questioning to respectfully challenge her assignments of control.

Discussion: “The Challenge of Surrendering the Uncontrollable” (10 minutes)

While the above exercise may have helped the participant understand that certain aspects of life are beyond her control, it is another challenge altogether to understand how to let go of the need to control. Read the following quote to the participant:

“I’ve basically gotten most everything I have wanted in my life. I’ve worked hard for it and achieved a lot... But for the first time, no matter what I do, no matter how hard I try, no matter how hard I follow the rules, I can’t seem to get pregnant.”7

Ask her if she identifies with the speaker’s frustration. Ask also if she finds herself trying to exact control in other areas in her life that may be “beyond her reach.” Ask her how she tries to maintain a sense of control over situations. For example, some women may follow strictly regimented treatment plans, exercise, change dietary habits, and much more, hoping that all of those diligent efforts will pay off. After getting a few good answers, segue into what it means to surrender the uncontrollable. Surrendering control involves separating one’s “doing

6 Adapted from Brenda Cole’s (1999) Re-Creating Your Life: During and After Cancer.
self” from the “being” self. It involves silencing the part of you that desires to make things happen and listening to the part that trusts that, one way or another, things will work out, even if not as originally planned. What are the advantages of surrendering? What about the disadvantages? What connotations does the word have for you?

Homework (5 minutes)

The homework for this section is indicated on Worksheet 15, “Toward Acceptance.” On this sheet, participants will find an explanation of acceptance. Be clear that acceptance doesn’t mean giving up on their desire for motherhood. Rather, explain that acceptance means releasing control and letting go of the need to change the current situation. By appreciating and accepting what is, you let go of the anxiety and frustration of feeling powerless.

Closing (5 minutes)

Close with the same ritual from previous sessions, in which the participant shares a positive thing that happened last week and what she is looking forward to in the next week. As always, thank her for attending and sharing. Next week is the last session. Again, reinforce the participant for making it so far.
SESSION 6: ACHIEVING CLOSURE

The purpose of the final session is to review participant progress, allow the sharing of final remarks, and encourage continued work towards gains made while in the program.

Note:

Though saying good-bye can be sad, try to get the participant to focus more on her accomplishments and growth rather than the finality of the situation.

Activities & Suggested Length

Homework Review: Towards Acceptance (10 minutes)

Open the floor for feedback on the utility of the homework. Ask the participant how she reacted to the notion of acceptance. If there are questions, field those. Reinforce the participant for completing the independent exercise. Encourage her to continue to practice discerning between things she can change and situations that merit acceptance.

Flashback to Expectations (20 minutes)

Have the participant refer back to the expectations that she listed after the first session and comment on whether or not her expectations were met. Has anything changed about her way of thinking? Acknowledge that many sensitive issues were covered in this program in a very brief time frame. Normalize any ambivalence that participants may have felt about engaging in the group fully at first. Encourage them to return to their workbooks in the future, taking the time to revisit helpful things or rework things they may not have been prepared to process at that time. Suggest that they continue using the skills they learned to continue living a rich and fulfilled life. Also emphasize that this should not be the end of their personal journey of exploring how fertility challenges have impacted them and how they can overcome those effects. Encourage further supportive services such as individual therapy or couples counseling, if so warranted.

Saying Good-bye (15 minutes)

Give the participant time to share her feelings about being in this program and feelings about ending this experience. Afterwards, the program leaders should share what she has learned as well and offer sentiments or other well-wishes. Finally, the leader should remind the participant that she will be contacted soon to complete another set of surveys.
PARTICIPANT WORKSHEETS

Worksheet 1: Cognitive Behavioral Model
Worksheet 2: Program Norms
Worksheet 3: My Expectations
Worksheet 4: Practicing the Cognitive Behavioral Model
Worksheet 5: My Identity Pie
Worksheet 6: Doing Things for All of Me
Worksheet 7: What is a Woman?
Worksheet 8: Knowing My Boundaries
Worksheet 9: Communicating Assertively
Worksheet 10: Envisioning Love (Facilitator’s Version)
Worksheet 11: Practicing the WII Technique
Worksheet 12: Common Thinking Distortions
Worksheet 13: Challenging Your Thinking
Worksheet 14: Circles of Control
Worksheet 15: Toward Acceptance
Worksheet 1: The Cognitive-Behavioral Model

People
My co-workers

Events
Emergency staff meeting

Situations
Others are whispering

Thoughts
“They’re talking about me. I’m about to get fired.”

Emotions
Anger
Worry
Fear

Behavior
Withdrawal
Sweating
Heart Racing
Worksheet 2: Group Norms

1) Every effort will be made to ensure sessions occur every week as scheduled and in a timely fashion.

2) Sessions will last usually last 45 minutes. However, the participant will direct the flow. This means that some sessions may run longer or shorter.

3) The program leader will respect participant confidentiality by not discussing what happens with one participant with other participants. However, if the leader determines that a participant is in crisis, the leader will take the proper precautions to keep you safe.

4) The leader will try to foster a warm, accepting, judgment-free atmosphere.

5) Participants will be encouraged to speak freely, but will not be forced to do so.

6) Participants will complete during-session and independent activities to the best of their ability.
Worksheet 3: My Expectations

Instructions: Think about your reasons for joining the program. Also think about your expectations of the program now that the first session is over. In space below, jot down your initial expectations. Save this worksheet to reflect back on your answers at the end of the program.

At this point in the program, I expect to gain:

1. 

2. 

3. 

4. 

5. 

6. 

7. 

8. 

9. 

10. 
Worksheet 4:
Practicing the Cognitive Behavioral Model

Instructions: Write down three (3) situations or events this week that led you to feel or act a certain way. Complete the chart below to understand how that event or situation led to a thought, which led to certain feelings or courses of action. These examples may be positive or negative. They may be fertility-related or not. The purpose of this exercise is to help you understand and recognize the model at play in your daily life. You may do more than 3 situations if you so chose. An example is included to help you.

<table>
<thead>
<tr>
<th>This is the event or situation:</th>
<th>This is what I was thinking at the time:</th>
<th>After I had those thoughts, I felt:</th>
<th>After I had those thoughts, I did these things:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EX:</strong> My friend invited my other friend to dinner, and not me.</td>
<td>“She likes her better than me. No one likes me.”</td>
<td>Sad, lonely, unloved, disappointed</td>
<td>Cried, stopped talking to both friends</td>
</tr>
<tr>
<td>1.</td>
<td></td>
<td></td>
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<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3.</td>
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Worksheet 5: My Identity Pie

**Instructions:** The circle below represents you. Divide the pieces of your identity pie into the elements that represent how you currently view yourself. Pieces of your identity that are more important or central to your identity will be larger than others. However, you **must** include one piece dedicated to how much you think infertility is a part of your current identity. Simply label this piece “infertility.”

*My Current Self*
Now, let the circle below represent your desired self. You may use the same elements you identified in your "current self" pie chart, or you may add new elements. Change the composition of the pie below to represent aspects of yourself that you would like to reduce or emphasize. This time, you may choose whether or not to include infertility in your pie.

In order to get from my current self to my desired self, I can:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
**Worksheet 6: Doing Things for All of Me**

*Instructions*: Earlier, in the session, you identified aspects of your identity that you wanted to focus more on, in order to gain a more balanced self-concept. Each day of this week, identify one of those identity areas and do something to nurture that aspect. For example, if you wanted to increase your identity as an artist, paint or draw one day this week. If you wanted to increase your identity as a loving wife or partner, spend some quality time with your significant other. It doesn’t have to be something grand, just make sure you are consciously engaged in this activity. Document what you did to share during the next session.

<table>
<thead>
<tr>
<th>Day</th>
<th>Identity Area</th>
<th>What I Did</th>
<th>How I Felt Afterward</th>
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</thead>
<tbody>
<tr>
<td></td>
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</table>
Worksheet 7: What is a Woman?

Instructions: Images of popular real or fictional women, most known through popular media, are reproduced below. In the identity session, we talked about what it means to be a woman. Consider the messages about womanhood from the following examples, and answer the enclosed questions.

Below each picture, write 3 characteristics that describe these well-known women:

Claire Huxtable  Mother Theresa  Marilyn Monroe

1. In your opinion, what contributed to these women’s popularity in our culture? Do you think it was looks or behavior? Their relationships with others? Anything else?

2. Do you recognize any similarities or differences between yourself and the women above? What are they?

3. The first example was a TV sitcom mother. Did being a mother alone lead to her appeal?

4. The second example was a missionary who helped many children, yet did not have children of her own. Does her lack of children detract anything from her value? Explain your answer.
5. The last is of an iconic Hollywood star of a previous era. Has anything changed about portray
of women in the modern era in terms of what is valued or treasured about a woman or what
makes up her identity?
What are boundaries?

In a practical sense, boundaries are simply things that separate one object or space from another. They help us distinguish between one thing and another. For example, you probably have walls in your home that distinguish the kitchen from the living room or dining room. If your home had no internal walls, you would probably still arrange furniture and other fixtures in a way that helped to separate the spaces and identify what does where. Boundaries help us feel organized and comfortable.

Though they can’t be physically seen, relational or psychological boundaries play almost the same role as the walls in your home. They differentiate what is acceptable from what is unacceptable. These boundaries will likely vary from one type of relationship to another. For example, there are probably certain things that a family member may know about you that a co-worker would not. You may share certain experiences with your significant other that you wouldn’t with even a very close friend. You have ideas about what is acceptable within these various relationships, and may have even forged an agreement between yourself and the other person about what goes on within the confines of that relationship. Further, there are likely aspects of yourself that are held private, completely hidden from anyone other than yourself.

Why are boundaries important in relationships?

Think about how chaotic and confusing driving would be if multi-lane streets had no lines. A relationship without boundaries is akin to a street without lines. Without boundaries, people are unaware of your standards, or how you expect to be treated. With a clear knowledge of whatever you deem acceptable treatment, you can successfully avoid situations in which you may be hurt or taken advantage of. Not only do boundaries help us protect ourselves from potential emotional harm, but relationships work better when people know each others’ expectations. The lines in the street establish a clear expectation: stay in this lane so that you don’t run anyone over. When boundaries are established in relationships, it minimizes the probability of one person being slighted or “run over.”

How does one discover their boundaries?

This is not as simple a task as it seems. A bit of introspection is in order here. What situations leave you feeling angry, offended, victimized, saddened, disappointed, or anxious? As if you should’ve said something in the moment to defend yourself, or at least let the person know your perspective? In those situations, it may be the case that you have experienced a boundary violation. Ask yourself: What offended me about that interaction? Would my reaction to the same situation have been different in a different type of relationship or context? By gaining honest answers to these questions, you begin to know your boundaries, in general and in different relational contexts.
How does one establish and maintain boundaries once discovered?

This part can also be somewhat of a challenge, especially if you are used to being overly agreeable. Knowing and maintaining your boundaries doesn’t mean that you are rude, cruel, stubborn, or abrasive. Rather, the goal is to be kind but firm. Once people understand that your aim is establishing mutual respect, they are usually cooperative. Listed below are tips to help you establish and maintain your boundaries:

- **First, recognize that you are a person with value, one that deserves to be treated with the same respect that you bestow upon others.** Remember that establishing boundaries isn’t about changing someone else’s behavior; it is about you controlling the way you choose to experience your relationships.
- **Communicate your needs clearly and assertively.** Don’t expect the other party to intuitively understand your expectations. For more information on assertive communication, see the next worksheet.
- Maintaining boundaries will take diligence. No matter how many times you remind someone of your boundaries, they may innocently forget or intentionally keep persisting until they get whatever it is they want. **Be prepared to enforce and reinforce your boundaries.** Draw your line and stick to it because inconsistency only confuses people.
- **Know how you will respond if your boundary continues to be violated and act on it.** Boundary violations should have consequences. Once you’ve asked the other person to respect your boundary, and they continue to refuse, carry out the consequence. This consequence can be temporary (i.e., walking away from the current interaction) or permanent (i.e., dissolving the relationship). Choose a reasonable consequence that you are realistically comfortable with implementing. Empty threats are ineffective. Actions speak louder than words in helping others recognize your boundaries.

*Now that you know more about boundaries, take some time to discover what your personal boundaries are with respect to fertility. They may be related to diagnosis or treatment information disclosure, topics off-limits to those outside of your significant other (i.e., sexual activities with your partner), or activities that you would rather not participate in at this time. Be specific about relational context (i.e., with friends, coworkers, extended family, etc.). An example is provided for you.*

| I will not: | tolerate any discussion of our sexual “techniques” from my parents |
| If this happens, I will: | Ask them to stop talking about our sex life, change the subject |
| I will not: | |
| If this happens, I will: | |
| I will not: | |
| If this happens, I will: | |
| I will not: | |
| If this happens, I will: | |
What is assertive communication?

Assertive communication is the ability to express one’s self honestly, openly, and directly, in a way that also respects the rights of others. It is the balance between being passive and being aggressive.

What are the benefits of using assertive communication?

Being assertive can:

- Help us recognize our feelings and empathize with others
- Reduce stress, anger, depression, and anxiety
- Lead to more authentic relationships
- Reduce unintentional hurt
- Reduce alienation or isolation
- Protect us from being taken advantage of by others
- Help us make wise decisions
What are the initial costs of using assertive communication?

Making this type of change in your communication style may take others by surprise initially. They may not understand or accept the change at first. But given time, most will come to appreciate this change. Moreover, respecting the rights of others may mean that you don’t always get what you want. Yet, the seeds you sow in respecting others’ rights will surely be reaped in others treating you with the same respect.

What does assertive communication sound like?

To begin with, one’s voice should be at a level, well modulated tone. Too soft would imply passivity; too loud, aggression. Using an even, firm voice commands respect and attention. Also carefully consider the timing of your response to ensure that the other person is receptive and your words have maximum impact. Remember, context is usually more important than content in communication. Use your discernment to decide if it is the appropriate time and setting for effective communication. If not, politely table the discussion until later, but be sure to have the discussion eventually. Your emotions may be a red flag that now is not the time. If you find yourself getting overly emotional and unable to remain calm, save the discussion for later and focus on maintaining your composure.

Being assertive involves appropriately expressing your needs and feelings. You can accomplish this by using “I” statements. These indicate ownership, focus on overt behavior, identify the effects of the behavior, are direct and honest, and contribute to the growth of your relationship with the other person. They do not attribute blame or judgment, criticize or put others down, bring up old issues, or sugar-coat the facts to make it easier for others to take. The best “I” statements have three parts: a behavior, a feeling or other tangible effect, and a preferred alternative. To do this, use the WII technique: “When you (insert behavior here), I feel (insert feeling here). I would like it if (insert reasonable alternative here).” For example, “Mom, when you keep asking me why we haven’t had kids yet, it makes me feel guilty, as if I’m doing something wrong or am the one to blame for our fertility problems. It would really make me feel better if you and dad wouldn’t ask anymore, and just wait on me to update you guys about things like that.”

Just as an assertive communicator is willing to share her opinions, she is also open to hearing other’s points of view. She is able to listen and accept what the other person has to say, even if she doesn’t agree. She knows when to say “no.” She apologizes, but only if warranted. She does not react to criticism by counter-attacking, denying, or feeling anxious or inadequate. Rather, she listens to and validates others by reflecting their sentiments. Listening and reflecting may sound something like: “I hear you, love, when you say you’re turned off because sex seems like a chore now.” By listening to others, she can also learn how she may be contributing to miscommunication, and can take responsibility for communication failures. Remember, everyone is entitled to an opinion; it is not our task to convince others that ours is the “right” one.
The assertive communicator should not assume that others also have the same communication skills. Some people may try to change the subject, minimize their behavior, or shift blame to you for the situation in order to avoid the discomfort of conflict. The assertive communicator should be prepared to deal with this by acknowledging others’ statements or opinions, then shifting the focus of the conversation back to the topic at hand: “Mom, I understand that Sister Johnson’s son also had the same issues with fertility and you’re just concerned because they took it so hard… and I thank you for being concerned about us. But right now, I don’t want to talk about the Johnsons’. Can we talk some more about what I said earlier?”

What does assertive communication look like?

Non-verbal communication is just as important as the words that are spoken. Here are a few suggestions to improve your non-verbal assertiveness skills.

- **Make eye contact.** It shows sincerity and demonstrates interest in what the speaker is saying.
- **Smile occasionally.** Maintaining a neutral or slightly positive facial expression is preferable to being too jovial. The listener may not take you seriously. Scowling is definitely something to avoid.
- **Watch your gestures.** Use appropriate and non-threatening gestures. Avoid pointing, flailing the arms, or other shows of aggression. Don’t wring your hands; you will appear nervous.
- **Use welcoming, engaged posture.** Face the speaker; sit upright at the same eye level. Standing above a seated individual can make them feel threatened. If seated, lean forward in your chair a bit; leaning or sitting too far back makes you appear detached or dismissive.
- **Be aware of personal space.** Different individuals have different preferences for the amount of personal space that makes them feel at ease.

How else can I improve my assertive communication skills?

- **First, know your typical communication style.** Those who are passive can learn to assert themselves more, and those who are more aggressive can learn to consider others’ needs more. If you typically say “yes” when you want to say “no,” and are frequently sarcastic, complaining, or gossiping, you may have developed a passive-aggressive style because you’re unable to be direct about your needs and feelings. Knowing yourself is the most important step to change.
- **Learn to say no.** The only way to inoculate one’s self against the guilt one feels when saying “no” is to do it. Don’t beat around the bush; give a firm, direct response. If an explanation is appropriate, keep it brief, and don’t revert into apologies.
- **Practice, practice, practice.** Start by practicing your new skills in low-risk situations, such as with a loved one. Evaluate yourself and make adjustments as necessary. Get feedback on your non-verbal communication style. Start using the WII technique at restaurants and in other customer service situations. Consider role playing with a friend or colleague.
- **Discover the joy of compromise.** When your values or self-respect is not in question, consider the power of workable compromise. An example of this technique would be, “I understand that you want to talk now, but I really need to get this report finished. Do you think I could call you back in about an hour?”
Worksheet 10: Envisioning Love*

Instructions: Find a nice, relaxing, quiet space to practice this exercise. You may do this without background music, or with music playing softly in the background. Get comfortable; wear non-restricting clothes and sit or lay in a relaxing position. Remember to breathe deeply as you are reading the words to yourself. Lay aside your inhibitions. After the exercise is complete, take a moment to process your thoughts. It may be helpful to record your voice reading the text below in order to be able to close your eyes while engaging in the exercise.

Close your eyes and begin to focus on your breathing. Let your body become comfortable and relaxed as you feel your breath move in… and out. As you slowly count to 5, let your body become more relaxed with each number… 1… 2… 3… 4… 5. Imagine yourself now with you loved one in a safe, beautiful, and peaceful place. Just you two are present; no one else is around. As you imagine yourself and them in this place together, begin to pay attention to any feelings that arise. How do you feel about them right now? Share those feelings with them. [pause] What feelings did you have toward them when you first learned about the infertility? Share those feelings now. [pause] Take the time now to share any other feelings that you’ve been keeping hidden. [pause] Now, listen for their response. [pause] Having heard the response, imagine them now smiling at you, with the love and acceptance. Imagine them embracing you, enveloping you in peace. If there are tears, imagine them wiping your face gently, reassuring you that they care for you, and that they will always be there, even in the bad times. Enjoy the feeling of being loved for a few moments. [pause] It is now time to leave this special place, but you may return at any time. As you walk away from this place, hold the unconditional love that you found in your heart. Now, focus on your breathing. Notice how relaxed you feel with each breath. Begin to return your focus to the room as you count backwards from five… 5… 4… 3… 2… 1. When you are ready, open your eyes, feeling comfortable and relaxed.
Worksheet 11: Practicing the WII Technique

*Instructions:* Refer back to the worksheet on assertive communication as needed. Document at least one instance daily of successful use of the WII technique, noting also your reactions to using this technique and the other party’s response. An example is included for you.

<table>
<thead>
<tr>
<th>The listener was:</th>
<th>The situation was:</th>
<th>When you... I feel... I would like it if...</th>
<th>When I used WII, at first I felt:</th>
<th>Afterwards I felt:</th>
<th>It seemed to me like the listener reacted:</th>
</tr>
</thead>
<tbody>
<tr>
<td>My co-worker who is always in others’ business.</td>
<td>My GYN called and left a vague message, and my co-worker asked me what was going on.</td>
<td>When you intrude on my personal business, I feel violated. I would like it if you stopped asking me personal questions.</td>
<td>Awkward, and annoyed that I’d even have to tell her this. She should know to mind her business.</td>
<td>Good about letting her know how I felt. Now I think she was more concerned than just nosy.</td>
<td>Positively…she apologized for offending me and promised not to ask me any more personal questions.</td>
</tr>
</tbody>
</table>
## Worksheet 12: Common Thinking Distortions

<table>
<thead>
<tr>
<th>Thinking Error</th>
<th>Definition</th>
<th>Example(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All-or-Nothing/Black-and-White Thinking</td>
<td>Viewing a situation in only two categories instead of on a continuum. Ignoring the middle ground.</td>
<td>“If God won’t answer my prayer, then I’ll turn my back on Him altogether.”</td>
</tr>
<tr>
<td>Discounting Positives</td>
<td>Believing that positive information somehow “doesn’t count.”</td>
<td>“Even though I have a great, nurturing relationship with my nephew, that doesn’t count... he’s not mine.”</td>
</tr>
<tr>
<td>Fortune Telling</td>
<td>Predicting a negative future without considering other outcomes.</td>
<td>“We will never be happy as a couple without kids.”</td>
</tr>
<tr>
<td>Magnification or Catastrophizing Labeling</td>
<td>Blowing negative events out of proportion. Using fixed, global labels without considering other evidence.</td>
<td>“Being infertile is the worst thing that could ever happen to a person.” “I’m a failure.” “I’m unworthy.” “He is a horrible person.”</td>
</tr>
<tr>
<td>Overgeneralization</td>
<td>Seeing a single, negative event as a never-ending pattern of defeat.</td>
<td>“I didn’t conceive again this month; I’ll never be a mother. “I messed up again. I’ll never get it right.”</td>
</tr>
<tr>
<td>Mind reading</td>
<td>Thinking you know what others are thinking without clear evidence.</td>
<td>“My husband didn’t say anything to me this morning. He must be upset with me.” “It’s all my fault that I’m infertile; I must have done something wrong in the past.”</td>
</tr>
<tr>
<td>Personalization</td>
<td>Thinking all situations revolve around you.</td>
<td></td>
</tr>
<tr>
<td>Using imperatives (i.e., should and must statements)</td>
<td>Holding fixed ideas about behavior and overestimating how bad it is when those expectations aren’t met.</td>
<td>“I must always be right.” “People should always consider everyone else’s feelings.” “I wish I could be her; she has it all.” “Thank God I’m not as bad as her.”</td>
</tr>
<tr>
<td>Unfair Comparisons</td>
<td>Unrealistically focusing on others who are better or worse than you.</td>
<td></td>
</tr>
<tr>
<td>Confusing Choice with Necessity</td>
<td>Not realizing that a certain act is something you choose to do, rather than something you have to do.</td>
<td>“I have to do it all by myself.” “I have to go to the party, even though I don’t want to.”</td>
</tr>
<tr>
<td>Emotional Reasoning</td>
<td>Letting your feelings guide your interpretation of reality. Believing you can’t withstand, tolerate, or cope with a situation, when in fact you can.</td>
<td>“I feel useless, therefore I am useless.” “I can’t take not being able to have kids of my own.”</td>
</tr>
<tr>
<td>Can’t-Stand-It’s</td>
<td>Assigning your own thoughts or motives to others, believing they must think like you.</td>
<td>“She knew I would be embarrassed by that question. She should have known better than to ask that.”</td>
</tr>
</tbody>
</table>
### Worksheet 13: Challenging Your Thinking

**Instructions:** Refer back to the worksheet on thinking distortions as needed. Identify and label at least ten thinking errors you made this week related to infertility and/or faith. You may find that a thought seems to involve multiple thinking errors. Next, list the advantages and disadvantages of holding this thought or belief. Weigh the advantages and disadvantages numerically, and place that number in the small bubble. The weights should sum to 100. Finally, revise each statement to form a more flexible or realistic thought. A short example is included for you.

<table>
<thead>
<tr>
<th>Thought</th>
<th>Type of Thinking Error</th>
<th>Advantages of Thinking this Way</th>
<th>Disadvantages of Thinking this Way</th>
<th>Revised Thought</th>
</tr>
</thead>
<tbody>
<tr>
<td>The reason why God won’t give me a child is because I was wild in college.</td>
<td>Mind Reading</td>
<td>1. At least I have a reason why this is happening.</td>
<td>1. I feel guilty and ashamed. 2. I’m powerless to change the past, so I’ll just keep dwelling on it.</td>
<td>God’s thoughts are not my thoughts. Right now, I don’t know the reason why this is happening, and that’s ok.</td>
</tr>
</tbody>
</table>

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Worksheet 14: Circles of Control

Things Under My Control
Things Outside of My Control
**Worksheet 15: Towards Acceptance**

*Instructions:* Sometimes we worry about things that are beyond our control. One technique that’s useful in those situations is to practice acceptance. You probably already practice acceptance in your daily life. For example, you accept the fact that you have to pay bills or may get stuck in traffic on your way to work. In those situations, you don’t fight the bill collector or worry about the traffic; you simply accept what may happen without judgment and make the best of the situation. Complete the table below to understand what you are worried about and work towards accepting it.

<table>
<thead>
<tr>
<th>The thing that I am worried about is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Costs of acceptance:</td>
</tr>
<tr>
<td>Benefits of acceptance:</td>
</tr>
<tr>
<td>Why I accept these things:</td>
</tr>
<tr>
<td>Describe, in detail, what is actually happening that is causing the worry <em>without</em> judging interpreting or predicting:</td>
</tr>
<tr>
<td>Things to meditate on to help me gain acceptance:</td>
</tr>
</tbody>
</table>
APPENDIX C

SPIRITUALLY INTEGRATED THERAPY TREATMENT MANUAL
SESSION 1: WELCOME TO A FULFILLED LIFE!

The purpose of the initial session is to clarify the goals of the program, outline treatment norms, introduce the intervention and materials to participants, and begin to build rapport.

Activities & Suggested Length

Getting to Know Each Other (15 minutes)

The program leader should introduce herself to the participant, give her professional background, and share her motivation for leading the program. Participants may be curious of the fertility status of the leader. Though disclosure is up to the leader’s discretion, sharing this information may effectively model disclosure. Participants may also wonder if the leader is a religious authority (e.g., ordained minister, deacon, theologian, etc.). In this case, full disclosure is warranted; be forthright and tell the participant what your position is if you hold one in ministry. The leader may also share something about her religious/spiritual background. Keep this statement brief, stating your religious affiliation and denomination if applicable. Limit the leader’s introduction to 10 minutes.

After the leader introduces herself, participants introduce themselves. Since this is the first meeting, a participant should not be forced to share more information about herself or her background than she is comfortable with. Nevertheless, welcome her to share her infertility story. You may also prompt with marital status, cause of infertility, when they learned of the diagnosis, personal or family reactions, and positive and negative aspects of their infertility experience thus far to encourage dialogue. Also encourage her to share her religious affiliation and denomination if applicable. Further, she may indicate whether or not she has ever participated in any form of therapy and her reasons for interest in this program. This will give the leader an idea of the participant’s expectations. Limit the participant’s introduction to 10 minutes.

Introduction to the Program (10 minutes)

After introductions, the leader should explain the goal of the program: to reduce the emotional distress associated with infertility. Some ladies may assume that the purpose of this program is to boost their fertility outright. This is NOT the case, and assumptions such as these should be directly addressed. While a small body of research does indicate that reducing distress improves pregnancy rates, the goal of this program is to positively impact stress. In keeping with this goal, the program will address four themes over the course of 6

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8 While time limits are suggested in order to adhere to the 1-hour session timeframe, occasionally sessions may run over, particularly if participants are especially interested in a given topic or activity. Certainly, it is important to foster discussion and encourage active engagement in the program. Nevertheless, the group leader should limit total session time to no more than 1.5 hours.

weeks: identity, relationships, meaning, and control. One theme will be addressed per week, with the last session devoted to reflections and gaining closure. By being more aware of how infertility may affect these facets of life, participants may discover an enriched sense of self, develop more satisfying relationships, gain new perspectives on the infertility experience, and understand limits of control.

To do this, the program will teach members different coping techniques from the cognitive behavioral approach. These techniques will be learned in the 45-minute sessions. Though session time is important for introducing these new skills, the independent exercises help solidify lessons learned during sessions. Again, while participation is not forced, participants should be encouraged to be as involved in the program as they can be. They may also find that their level of involvement or comfort grows over the course of the program. This is natural; participants should be allowed to progress at their own pace. At this point, the leader should explain the cognitive behavioral model to the participant by referring to Worksheet 1. Cognitive-behavioral therapy is based on the idea that thoughts cause our feelings and behaviors. This concept may be hard to grasp initially, because one usually ascribes behavioral and affective reactions to people, situations, and events. Included on Worksheet 1 is the model, as well as an example of the model in action. After explaining the model and reviewing the example, highlight that the benefit of the cognitive model is that if one can change the way one thinks about a situation, one can feel better or behave differently, even if the situation does not change.

Also discuss the religious aspect of the intervention. Explain that the intervention is based on beliefs and values from the Christian tradition, with no specificity as to the denomination. Make clear that the goal of incorporating religion or spirituality is not to change her beliefs. Rather, reiterate that the goal of the intervention is to support her personal religious or spiritual background, as well as discover how fertility challenges may evoke spiritual or religious issues. For some, this may involve confronting some unpleasant thoughts and feelings about God, their beliefs, their church homes, or a crisis of faith. Ensure the participant that you are there to support her discovery process, not challenge or push her if she is not ready to confront those issues.

Establishment of Program Norms (10 minutes)

Refer the participant to Worksheet 2 which lists the program norms. Review these norms with the participant to ensure that she understands the process of treatment. An accepting, non-judgmental atmosphere should be fostered during the sessions so that each member feels comfortable exploring her issues without fear of guilt or shame. Answer any questions about these norms that participants may have.

Homework (5 minutes)

Refer the participant to Worksheet 3, entitled “My Expectations.” Tell her to take about 10-15 minutes to complete this exercise independently, preferably within the next day or two after session. She is to reflect on the initial group session and document her
expectations of the program. The purpose of this exercise is to be able to reflect back on her expectations at end of the program.

Also, refer the participant to Worksheet 4, entitled “Practicing the Cognitive-Behavioral Model.” The purpose of this exercise is to teach participants to recognize the model at work in their everyday lives. On the worksheet, they are instructed to pick 3 situations or events and go through the model, identifying any thoughts they had in the situation, and subsequent feelings and behaviors. The situations may or may not pertain to infertility. This should take no more than 30 minutes of their time this week. Tell participants to note any questions they may have while completing this exercise.

Lastly, point out the Session Notes page at the end of the workbook. Participants may write quotes or other notes from the session on this page as they so choose.

Closing (5 minutes)

To establish a closing ritual, have the participant tell what she was thankful for this week and what she is looking forward to in the next week. The intent of this exercise is not to open additional conversation. Rather, the purpose of this exercise is to further establish leader-participant rapport. At the end of each session, the program leader should thank the participant for her attendance and openness to sharing.
SESSION 2: REDISSCOVERING YOUR IDENTITY

The purpose of the second session is to discover current identity conceptualizations, begin to understand where those concepts originate, challenge irrational or negativistic self-concepts, and celebrate often-unacknowledged aspects of the self.

Activities & Suggested Length

Homework Review: Expectations & CBT Model Practice (10 minutes)

Open the floor for feedback on the utility of the homework. Ask for one or two examples of the model items, and ask for a few examples of program expectations. If there are questions, field those. Reinforce participants for completing the homework. Encourage them to continue to recognize the model in their daily lives.

Identity Pie Chart (15 minutes)

The theme of this session is identity. Pose the following question to the member: “What is an identity?” Some women may use words such as self-concept or self-image to define identity. Indeed, one’s identity is the way in which an individual views herself. This can encompass physical descriptions (e.g., tall, curvy, blonde, brown-eyed), relational descriptions (e.g., daughter, friend, wife), role-based or occupational descriptions (e.g., teacher, doctor, lawyer), or sociocultural descriptions (e.g., Christian, Black, Italian). After she reaches a working definition of identity, have the participant consider where this definition may have originated. For example, for the individual who identifies themselves as smart or intelligent, how did they come to see themselves as such? We often find that we rely on trusted others to impart on us our own conceptualization of ourselves. Alternatively, we may get our identity cues from society at large, filtered through media images. We can either embrace others’ descriptions of us or reject them.

Refer the participant to Worksheet 5, entitled “My Identity Pie.” This in-session exercise is designed to help participants discover what they deem to be important or significant aspects of their current identities, as well as discover which aspects of their identity they would like to change. The first page of this worksheet asks participants to construct a pie chart displaying aspects of their current selves. In this chart, they must include a section dedicated to how much they view infertility as a part of their identity. After the completion of the current self pie chart, instruct participants to proceed to the second page to complete the desired self pie chart. In this second chart, they can reduce or expand elements of their selves that they wish to see reduced, increased, eliminated, or created. They may also choose to negate infertility as an element of their identity all together. Give members about 10 minutes to construct each chart. Percentage scores may be helpful.

After she has finished, the participant reflect on (a) whether or not the amount she dedicated to infertility in the chart was more or less than she expected and, if relevant, (b) how it felt to
realize that she was dedicating a substantial part of her current identity to infertility, as well as any realizations she may have had on how this impacts her daily functioning. For example, what are the emotional costs of placing too much emphasis on any one aspect and minimizing others? If she kept infertility in her desired self chart, process what this means to her. If anyone added “mother” to their desired self and dedicated a substantial portion of their pie to this element, discuss what it might mean if that role was never fulfilled. Before the termination of this activity, help the participant brainstorm ways to begin to working towards being her desired self. At the end of this exercise, the participant should have a greater appreciation for the many things that make her a unique and interesting individual, and understand that her struggle with fertility is just one aspect of their identity. Close this activity with the following scripture, from Psalm 139:14: “I praise you because I am fearfully and wonderfully made; your works are wonderful, I know that full well.” Reflect on the possible interpretations of that passage.

Discussion: “Conceptualizations of Femininity & Womanhood” (10 minutes)

Now that the participant has considered the basic concept of identity, have her consider what it means to be a woman, as well as what femininity means. Ask simply: What is femininity? What traits does it encompass? After a few responses have been given, read the following quote:

“You know, I used to be such a good teacher. I loved the kids in my class, and they felt a special relationship with me too... But now I feel myself pulling back from them as if I can’t afford to extend myself emotionally anymore. I mean, after all, if I can’t have a child of my own, what’s the point in taking care of other people’s kids?”

Ask the participant the following questions:

1) How has the speaker allowed infertility to impact her?
2) What aspects of femininity are displayed here?
3) Has infertility impacted or compromised your views of your own femininity? In which ways?
4) It sounds like the speaker is talking about the concept of “mothering.” What does that concept mean to you? Can one display mothering qualities without a child of their own?

Now read the following short quote to the participant, related to perceptions of womanhood:

“Don't take away what is left of my identity, I long for a baby, the chance to prove I am truly a woman.”

Ask:

1) Does the ability to bear children truly equal womanhood? If yes, how so? If not, what else does being a woman encompass?
What does your religion or faith have to say about what a true or good woman is?

How often do you think like the speaker, that having a child validates your womanhood?

In their answer to question #2, some may reference the Proverbs 31, which gives a detailed description of a “wife of noble character.” This passage is included in one of the homework assignments in this section, as noted below.

**Homework (5 minutes)**

Refer participants to **Worksheet 6**, entitled “Doing Things for All of Me.” After completing her identity pie charts, the participant now recognizes areas of her identity that she may be neglecting while overly concentrating on infertility. This exercise is designed to engage participants in behavioral activation to encourage the growth of other aspects of identity. Participants are to identify areas of their identity pie chart that they desired to nurture, as evidenced by growth in these areas on the desired self pie chart. Each day between this session and the next, they are to engage in activities that nurture those desired areas. Two examples are given on the worksheet: painting or drawing to increase artistic identities and spending quality time with a significant other to increase one’s identity as a loving partner. Participants should document their activities. Clarify that they should engage at least 3 different areas during the week, not simply do seven different activities to address one identity area.

Also, refer participants to **Worksheet 7**, “What is a Woman?” After the discussion of feminine identity or perceptions of womanhood, a Biblical passage is presented that describes a “noble” wife. One may logically extrapolate this into a description of the general characteristics of a well-rounded woman. This exercise is designed to further stimulate contemplation of aspects of identity outside of motherhood. Discussion questions are included to that end.

**Closing (5 minutes)**

Close with the same ritual from the initial session, letting the participant share what she was thankful for this week and what she is looking forward to in the next week. Remember to keep this statement brief. Again, thank her for participating and sharing with you, and that you are looking forward to next week.
SESSION 3: MAINTAINING YOUR RELATIONSHIPS

The purpose of the third session is to acknowledge important relationships, and learn strategies to improve those relationships through effective communication.

Activities & Suggested Length

Homework Review: Doing Things for All of Me & What is a Woman (10 minutes)

Open the floor for feedback on the utility of the homework. Ask for one or two examples of activities, and ask for feedback on how she felt while engaged in the activity. Also ask about answers to the “Woman” discussion questions. Reinforce the participant for completing the homework. Encourage her to continue to engage in activities to address their whole identity, rather than focusing solely on one aspect.

Boundary Setting & Assertive Communication (15 minutes)

Sometimes, women with fertility challenges experience others’ seemingly well-intentioned comments as cruel or simply insensitive. Women are often challenged with how to respond to such comments without being equally as offensive. Instead they simply ignore the remark or sulk in silence in order to “keep the peace” or “be polite.” Thus, insensitive comments and intrusive questions continue, because the woman has given no indication that these comments have crossed some boundary. Alternatively, women may become so frustrated and enraged by repeated comments that they lash out in anger. This can also negatively affect her relationships, effectively alienating her from her friends and family. By establishing boundaries and learning how to communicate in a more assertive manner, she acknowledges her own feelings as well as potentially refrains from offending the other person.

Initially, participants may seem hesitant to engage in assertive communication. Barriers to assertive communication include: not having clear boundaries, fear of rejection, confusing assertiveness with aggression, discomfort with standing up to certain people, and fear of provoking an aggressive response from others. Indeed, it can be difficult for women to begin to assert their needs, especially when others expect them to not do so. However, bottling in offense, anger, or other negative emotions will eventually take its toll. An especially salient example is that of a carbonated soda in a bottle. If other people constantly shake, stir up, or “offend” the bottle, whomever opens the agitated bottle will be the unfortunate victim of an explosion of all the contents. Process how the build-up of offense or tension led to an aggressive response, even to an unintended victim. Now have the participant think about what happens when the pressure is carefully released before passing the shaken bottle on. The leader should point out how defusing the bottle’s pressure immediately is akin to being assertive in each situation. The leader should also note that the bottle may still be passed. Metaphorically speaking, this symbolizes the fact that hurt or offense may still occur, because one is unable to prevent others from making comments or asking questions, but they can control how they respond.
At this point, refer participants to Worksheet 8, “Knowing My Boundaries,” and Worksheet 9, “Communicating Assertively.” Some participants may already be quite familiar with these topics. It might be helpful to gauge their knowledge before reviewing the material. The first worksheet helps participants acknowledge their boundaries by understanding what boundaries are, why they are important, and how to recognize boundaries. It also helps them learn how to set and maintain healthy boundaries. It is also important to recognize that healthy boundaries are not rigid either. Context is key. The second worksheet guides participants through the definitions of passive, aggressive, and assertive communication. It also gives suggestions of how to communicate more assertively, both verbally and non-verbally. It ends with some suggestions of ways to practice assertive communication. After reviewing the information on the sheets, role-play a conflict- or communication-related situation that may arise in infertility and boundaries violation. After about 3 minutes, cease the role-play and invite feedback. Ask: Did you think you were being assertive, passive, or aggressive? How did it feel to assert your boundaries? How could communication have been improved?

Next, turn the discussion of boundaries and assertive communication towards more religious topics. Explore these questions: How do you think God feels when we are assertive? If He were present when we were being assertive, how would He react? What would He say? Do you think God supports your assertiveness? Why or why not? Consider the example of Moses in the Bible. Despite the Pharaoh’s objections, he remained steadfast in his dedication to removing his people from Egypt. Likewise Joseph was assertive about the vision that was given to him about his future. After a few minutes of discussion, have participants consider how their answers to these questions relate to their ease with being assertive with others.

**Closeness to God (10 minutes)**

In keeping with our discussion of relationships, have participants ponder how their relationship with God may have changed after learning about their infertility. Did they become angry at God or distant? Or did they draw closer in their search for answers or meaning? In any event, have the participant consider how they expressed their feelings to God, if they have at all. Ask if she felt comfortable expressing all her feelings to God, even the negative ones. If she was to admit to God that she was angry, hurt, or disappointed, how might God react? Would He condemn her or sympathize? Would He be just as affected by her sorrow as she is, or would He sit back and merely watch her suffering?

Invite the participant to participate in the “Love of God” guided imagery exercise as a way of sharing her feelings with God. Have the participant get comfortable, close her eyes, and breathe deeply as you read the text on Worksheet 10. Read the text slowly in a calm, relaxing voice. The room should be quiet; alternatively there may be soothing

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10 Note that the leader’s version of this worksheet is slightly different from the version in the participant workbook, which instructs participants on how to do the exercise themselves at home. Thus, you should read from the facilitators copy in the appendix of this manual. This will also be more rushed than what members may do on their own.
music playing in softly the background. Some women may cry as they are processing the activity; this is perfectly acceptable. Some may be ashamed to admit that they were mad at God; this too is acceptable. At the end of the exercise, participants will hopefully come to the quiet realization that God is present and unconditionally supportive. After the exercise is complete, have the participant discuss what this exercise was like for her.

**Homework (5 minutes)**

Refer the participant to **Worksheet 11**, entitled “Practicing the WII Technique.” Just as was discussed in session, the participant is to use the WII technique for assertive communication once daily to resolve conflicts and relate better to others. In addition to noting the elements of the WII technique she used, have her also note her own feelings about using this technique, as well as others’ responses. Also have her practice the “Love of God” exercise daily. In her Notes section, she can note any reactions to the exercise that she would like to share next time. Also, mention that the impact of fertility challenges on the sexual relationship was not discussed in this section. Refer interested participants to the Wheat book in the Resource section for information on sexuality in the context of Christian marriage.

**Closing (5 minutes)**

Close with the same ritual from previous sessions, in which the participant shares what she was thankful for this week and what she is looking forward to in the next week. Again, thank her for being present. Reinforce her consistency. Let her know that the program is half complete, and you are again looking forward to next session.
SESSION 4: FINDING MEANING

The purpose of the fourth session is to consider the possibility of finding or creating meaning in the infertility experience, learn the concept of cognitive distortions, and demonstrate an ability to recognize and label these distortions.

Activities & Suggested Length

Homework Review: Boundary Setting, Assertiveness, & Love of God Exercise (10 minutes)

Open the floor for feedback on the utility of the homework. Ask for one or two examples of new boundaries established or situations in which assertiveness was practiced, including reactions and personal feelings. If the participant wants to share further reactions to the imagery exercise, welcome those. Reinforce her for doing the independent exercises. Encourage her to continue to engage in boundary setting and assertive communication. Refer interested participants to the Cloud & Townsend book about boundary setting in the Resource section for further insights. Also encourage repetition of the imagery exercise as a way to gain intimacy with God, along with private prayer, meditation, or whatever methods they were previously employing to reduce anxiety.

Discussion: “Where is God Now?” and Other Hard Questions (15 minutes)

Consider the following quote from an individual struggling with issues of faith and infertility:

“I wake up every morning wondering who this God is that we believe in so strongly. My parents said He would always be there for me. Where is He now that I need Him?”

According to Kübler-Ross, individuals often progress through four stages of grief or mourning as they learn to cope with significant losses. The first is denial. As it applies to the infertile woman, denial may take the form of rejecting the initial diagnosis or expecting a miraculous conception to occur. The next is anger. Women may lash out at others, criticize “undeserving” mothers, or hold a grudge against God. The next is bargaining; women may pray, negotiate, or engage in other behaviors to seemingly “earn” a baby. Next is the sadness and despair of depression. Finally, women can arrive at acceptance. In this case, acceptance does not mean passively resigning to the unchangeable prospect of being childless. Nor does it mean forgetting one’s desire to ever have children. Rather, acceptance allows women to acknowledge blessings that are

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11 Be aware that this session may be an especially sensitive topic. Ensure participants that you, as the leader, are not trying to convince them to resign to being childless. Rather, the purpose is to explore whatever personal meaning this experience has for them.

unexpectedly acquired or that remain despite the challenge of infertility. Acceptance is understanding that infertility may or may not be resolvable, but that life can and must go on despite it. It should be noted that it is natural to endure these emotional reactions during the grieving process. Explain the stages of grief model to the group. You may read the paragraph above verbatim or paraphrase, adding other examples as warranted.

In the above quote it seems as if the speaker is in the anger stage. Have participants consider which stage they may be in. Pose the following questions related to God and infertility:

1. Have difficulties with bearing children changed your view of the meaning of life? What do you think God thinks of infertility treatment in general?
2. How have these challenges affected your spiritual or moral beliefs? Does infertility have a spiritual meaning to you? Does it mean anything about you as a Christian woman?
3. How has it changed your views of right and wrong, of sin and justice?
4. What have you learned thus far about the personal meaning of infertility? Do you view it as punishment? As a random situation that you just happened to find yourself in, which has little to do with your personality or morality? Or some other way? Why?
5. Does God owe us? Is His “being there” akin to granting our wishes, the “desires of our heart”? Or is it being present in our pain? What is the purpose of prayer? Where does gratefulness fit in to this discussion?

**Distorted Thinking and Assigning Meaning (10 minutes)**

As mentioned earlier, grief reactions in response to loss are normal and help facilitate coping. Repeated exposure to the same trigger leads to reductions in the strength of the reaction. This reduction indicates progress. If one feels “stuck” in their grief, it may indicate that there are some deeper thought patterns contributing to one’s emotional response. In our efforts to find meaning in difficult situations, we may make assumptions and logical errors in thinking. These errors are called cognitive distortions. In the context of infertility, women sometimes use these errors to assign meaning to the experience of infertility, leading to unpleasant emotions and irrational behavior. Point the participant to Worksheet 12, entitled “Common Thinking Distortions.” Review each distortion with her, going through the definitions and examples. After the review is complete, field any questions. Participants will use the information on this worksheet to complete the homework assignment for this session.

**Homework (5 minutes)**

The homework for this section is indicated on Worksheet 13, “Challenging Your Thinking.” Now that participants know how to recognize and label their thinking errors, have them identify and label at least 10 of their own thinking distortions related to

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13 Group members may mention how barrenness is repeatedly associated with sin and can be restored through true repentance and unwavering faith in Scripture. Be prepared to delve into this topic.
infertility and/or faith. Next, they are to list the advantages of holding this thought or belief, as well the disadvantages. After they make the list of advantages and disadvantages, have the members weigh these numerically. Finally, the members should revise each statement to form a more flexible or realistic thought. Review the example given on the sheet.

**Closing (5 minutes)**

Close with the same ritual from previous sessions, in which the participant shares what she was thankful for this week and what she is looking forward to in the next week. Thank her for attending and sharing. Acknowledge her willingness to confront some potentially tough issues.
SESSION 5: UNDERSTANDING CONTROL

The purpose of the fifth session is offer a means for coming to terms with the limits of personal control and/or feelings of helplessness about infertility.

Activities & Suggested Length

Homework Review: Challenging Your Thinking (10 minutes)

Open the floor for feedback on the utility of the homework. Ask for one or two examples of thinking distortions and revised thoughts. If the participant has questions, field those. Reinforce her for completing the homework. Encourage her to continue to practice recognizing and modifying thinking distortions as they occur.

Circles of Control (15 minutes)

Refer the participant to Worksheet 14, entitled “Circles of Control.”14 Have her think about problems or situations that she would like to change. Then, have her decide whether this change is within her control or God’s control. She should place all things under her control in the first circle, and things under God’s control in the second. This portion of the exercise should last 5-10 minutes. Afterward, have her share the contents of each circle. At this point in the therapeutic process, the participant should trust the leader enough to be receptive to constructive feedback. Use Socratic questioning to lovingly challenge her assignments of control.

Discussion: “The Challenge of Surrendering the Uncontrollable” (10 minutes)

While the above exercise may have helped the participant understand that certain aspects of life are beyond her control, it is another challenge altogether to understand how to let go of the need to control. Read the following quote to the participant:

“I’ve basically gotten most everything I have wanted in my life. I’ve worked hard for it and achieved a lot... But for the first time, no matter what I do, no matter how hard I try, no matter how hard I follow the rules, I can’t seem to get pregnant.”15

Ask her if she identifies with the speaker’s frustration. Ask also if she finds herself trying to exact control in other areas in her life that may be “beyond her reach.” Ask her how she tries to maintain a sense of control over situations. For example, some women may engage in bargaining or restitution, in which they repent or attend church more, hoping that God will reward them with a baby for their efforts. After getting a few good answers, segue into what it means to surrender the uncontrollable. Surrendering control involves separating one’s

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14 Adapted from Brenda Cole’s (1999) Re-Creating Your Life: During and After Cancer.
“doing self” from the spiritual self. It involves silencing the part of you that desires to make things happen and listening to the part that trusts that, one way or another, things will work out, even if not as originally planned. What are the advantages of surrendering? What about the disadvantages? How does prayer relate to spiritual surrender?

**Homework (5 minutes)**

The homework for this section is indicated on **Worksheet 15**, “Toward Acceptance.” On this sheet, participants will find an explanation of acceptance. Be clear that acceptance doesn’t mean giving up on their desire for motherhood. Rather, explain that acceptance means releasing control and letting go of the *need* to change the current situation. By appreciating and accepting what is, you let go of the anxiety and frustration of feeling powerless.

**Closing (5 minutes)**

Close with the same ritual from previous sessions, in which the participant shares what she was thankful for this week and she is looking forward to in the next week. As always, thank her for attending and sharing. Next week is the last session. Again, reinforce the participant for making it so far.
SESSION 6: ACHIEVING CLOSURE

The purpose of the final session is to review participant progress, allow the sharing of final remarks, and encourage continued work towards gains made while in the program.

Note:

Though saying good-bye can be sad, try to get the participant to focus more on her accomplishments and growth rather than the finality of the situation.

Activities & Suggested Length

Homework Review: Toward Acceptance (10 minutes)

Open the floor for feedback on the utility of the homework. Ask the participant how she reacted to the notion of acceptance. If there are questions, field those. Reinforce the participant for completing the independent exercise. Encourage her to continue to practice discerning between things she can change and situations that merit acceptance.

Flashback to Expectations (20 minutes)

Have the participant refer back to the expectations that she listed after the first session and comment on whether or not her expectations were met. Has anything changed about her way of thinking? Has her relationship with God changed at all? Acknowledge that many sensitive issues were covered in this program in a very brief time frame. Normalize any ambivalence that participants may have felt about engaging in the group fully at first. Encourage them to return to their workbooks in the future, taking the time to revisit helpful things or rework things they may not have been prepared to process at that time. Suggest that they continue using the skills they learned to continue living a rich and fulfilled life. Also emphasize that this should not be the end of their personal journey of exploring how fertility challenges have impacted them and how they can overcome those effects. Encourage further supportive services such as individual therapy, couples counseling, or pastoral counseling if so warranted.

Saying Good-bye (15 minutes)

Give the participant time to share her feelings about being in this program and feelings about ending this experience. Afterwards, the program leaders should share what she has learned as well and offer sentiments or other well-wishes. Finally, the leader should remind the participant that she will be contacted soon to complete another set of surveys.
PARTICIPANT WORKSHEETS

Worksheet 1: Cognitive Behavioral Model
Worksheet 2: Program Norms
Worksheet 3: My Expectations
Worksheet 4: Practicing the Cognitive Behavioral Model
Worksheet 5: My Identity Pie
Worksheet 6: Doing Things for All of Me
Worksheet 7: What is a Woman?
Worksheet 8: Knowing My Boundaries
Worksheet 9: Communicating Assertively
Worksheet 10: Envisioning the Love of God (Facilitator’s Version)
Worksheet 11: Practicing the WII Technique
Worksheet 12: Common Thinking Distortions
Worksheet 13: Challenging Your Thinking
Worksheet 14: Circles of Control
Worksheet 15: Toward Acceptance
Worksheet 1: The Cognitive-Behavioral Model

People
My co-workers

Events
Emergency staff meeting

Situations
Others are whispering

Thoughts
“They’re talking about me. I’m about to get fired.”

Emotions
Anger
Worry
Fear

Behavior
Withdrawal
Sweating
Heart Racing
Worksheet 2: Program Norms

1) Every effort will be made to ensure sessions occur every week as scheduled and in a timely fashion.

2) Sessions will last usually last 45 minutes. However, the participant will direct the flow. This means that some sessions may run longer or shorter.

3) The program leader will respect participant confidentiality by not discussing what happens with one participant with other participants. However, if the leader determines that a participant is in crisis, the leader will take the proper precautions to keep you safe.

4) The leader will try to foster a warm, accepting, judgment-free atmosphere.

5) Participants will be encouraged to speak freely, but will not be forced to do so.

6) Participants will complete during-session and independent activities to the best of their ability.
Worksheet 3: My Expectations

Instructions: Think about your reasons for joining the program. Also think about your expectations of the program now that the first session is over. In space below, jot down your initial expectations. Save this worksheet to reflect back on your answers at the end of the program.

At this point in the program, I expect to gain:

1. 
2. 
3. 
4. 
5. 
6. 
7. 
8. 
9. 
10.
Worksheet 4: Practicing the Cognitive Behavioral Model

Instructions: Write down three (3) situations or events this week that led you to feel or act a certain way. Complete the chart below to understand how that event or situation led to a thought, which led to certain feelings or courses of action. These examples may be positive or negative. They may be fertility-related or not. The purpose of this exercise is to help you understand and recognize the model at play in your daily life. You may do more than 3 situations if you so chose. An example is included to help you.

<table>
<thead>
<tr>
<th>This is the event or situation:</th>
<th>This is what I was thinking at the time:</th>
<th>After I had those thoughts, I felt:</th>
<th>After I had those thoughts, I did these things:</th>
</tr>
</thead>
<tbody>
<tr>
<td>EX: My friend invited my other friend to dinner, and not me.</td>
<td>“She likes her better than me. No one likes me.”</td>
<td>Sad, lonely, unloved, disappointed</td>
<td>Cried, stopped talking to both friends</td>
</tr>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3.</td>
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</tbody>
</table>
Worksheet 5: My Identity Pie

Instructions: The circle below represents you. Divide the pieces of your identity pie into the elements that represent how you currently view yourself. Pieces of your identity that are more important or central to your identity will be larger than others. However, you must include one piece dedicated to how much you think infertility is a part of your current identity. Simply label this piece “infertility.”
Now, let the circle below represent your desired self. You may use the same elements you identified in your "current self" pie chart, or you may add new elements. Change the composition of the pie below to represent aspects of yourself that you would like to reduce or emphasize. This time, you may choose whether or not to include infertility in your pie.

My Desired Self

In order to get from my current self to my desired self, I can:

_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
Instructions: Earlier, in the session, you identified aspects of your identity that you wanted to focus more on, in order to gain a more balanced self-concept. Each day of this week, identify one of those identity areas and do something to nurture that aspect. For example, if you wanted to increase your identity as an artist, paint or draw one day this week. If you wanted to increase your identity as a loving wife or partner, spend some quality time with your significant other. It doesn’t have to be something grand, just make sure you are consciously engaged in this activity. Document what you did to share during the next session.

<table>
<thead>
<tr>
<th>Day</th>
<th>Identity Area</th>
<th>What I Did</th>
<th>How I Felt Afterward</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
Worksheet 7: What is a Woman?

Instructions: The Biblical passage Proverbs 31:10-31 is reproduced below. In the identity session, the group spoke about what it means to be a woman, and here Scripture gives an account of what it means to be a “wife of noble character.” Read the passage below, from the New International Version, and answer the questions at the end.

10 A wife of noble character who can find? She is worth far more than rubies. 11 Her husband has full confidence in her and lacks nothing of value. 12 She brings him good, not harm, all the days of her life. 13 She selects wool and flax and works with eager hands. 14 She is like the merchant ships, bringing her food from afar. 15 She gets up while it is still dark; she provides food for her family and portions for her servant girls. 16 She considers a field and buys it; out of her earnings she plants a vineyard. 17 She sets about her work vigorously; her arms are strong for her tasks.
18 She sees that her trading is profitable, and her lamp does not go out at night. 19 In her hand she holds the distaff and grasps the spindle with her fingers. 20 She opens her arms to the poor and extends her hands to the needy. 21 When it snows, she has no fear for her household; for all of them are clothed in scarlet. 22 She makes coverings for her bed; she is clothed in fine linen and purple. 23 Her husband is respected at the city gate, where he takes his seat among the elders of the land. 24 She makes linen garments and sells them, and supplies the merchants with sashes.
25 She is clothed with strength and dignity; she can laugh at the days to come. 26 She speaks with wisdom, and faithful instruction is on her tongue. 27 She watches over the affairs of her household and does not eat the bread of idleness. 28 Her children arise and call her blessed; her husband also, and he praises her: 29 “Many women do noble things, but you surpass them all.” 30 Charm is deceptive, and beauty is fleeting; but a woman who fears the Lord is to be praised. 31 Give her the reward she has earned, and let her works bring her praise at the city gate.

1. In your view, what seems to be the underlying message in what makes this woman such a treasure? Is it how she looks or how she behaves? Is it how she relates to others? What about how she attends to personal affairs?

2. Where is ability to procreate equated with a woman’s worth or value in this scripture?

3. This passage does mention that the woman’s children “arise and call her blessed” and that her husband also speaks highly of her. Is this because of the act of bearing children or because of other qualities?
4. Do you recognize any similarities or differences between yourself and the woman described above? What are they?

5. Do you note any similarities or differences between women of Biblical times and women of the modern era in terms of what is valued or treasured about a woman or what makes up her identity?

6. To take the conversation a step further, think about the women mentioned throughout the Bible. Though some were not as the Proverbs 31 woman was and were even shunned by society, Christ valued them the same. What does this observation mean to you?
Worksheet 8: Knowing My Boundaries

What are boundaries?

In a practical sense, boundaries are simply things that separate one object or space from another. They help us distinguish between one thing and another. For example, you probably have walls in your home that distinguish the kitchen from the living room or dining room. If your home had no internal walls, you would probably still arrange furniture and other fixtures in a way that helped to separate the spaces and identify what does where. Boundaries help us feel organized and comfortable.

Though they can’t be physically seen, relational or psychological boundaries play almost the same role as the walls in your home. They differentiate what is acceptable from what is unacceptable. These boundaries will likely vary from one type of relationship to another. For example, there are probably certain things that a family member may know about you that a co-worker would not. You may share certain experiences with your significant other that you wouldn’t with even a very close friend. You have ideas about what is acceptable within these various relationships, and may have even forged an agreement between yourself and the other person about what goes on within the confines of that relationship. Further, there are likely aspects of yourself that are held private, completely hidden from anyone other than yourself.

Why are boundaries important in relationships?

Think about how chaotic and confusing driving would be if multi-lane streets had no lines. A relationship without boundaries is akin to a street without lines. Without boundaries, people are unaware of your standards, or how you expect to be treated. With a clear knowledge of whatever you deem acceptable treatment, you can successfully avoid situations in which you may be hurt or taken advantage of. Not only do boundaries help us protect ourselves from potential emotional harm, but relationships work better when people know each others’ expectations. The lines in the street establish a clear expectation: stay in this lane so that you don’t run anyone over. When boundaries are established in relationships, it minimizes the probability of one person being slighted or “run over.”

How does one discover their boundaries?

This is not as simple a task as it seems. A bit of introspection is in order here. What situations leave you feeling angry, offended, victimized, saddened, disappointed, or anxious? As if you should’ve said something in the moment to defend yourself, or at least let the person know your perspective? In those situations, it may be the case that you have experienced a boundary violation. Ask yourself: What offended me about that interaction? Would my reaction to the same situation have been different in a different type of relationship or context? By gaining honest answers to these questions, you begin to know your boundaries, in general and in different relational contexts.
How does one establish and maintain boundaries once discovered?

This part can also be somewhat of a challenge, especially if you are used to being overly agreeable. Knowing and maintaining your boundaries doesn’t mean that you are rude, cruel, stubborn, or abrasive. Rather, the goal is to be kind but firm. Once people understand that your aim is establishing mutual respect, they are usually cooperative. Listed below are tips to help you establish and maintain your boundaries:

- **First, recognize that you are a person with value, one that deserves to be treated with the same respect that you bestow upon others.** Remember that establishing boundaries isn’t about changing someone else’s behavior; it is about you controlling the way you choose to experience your relationships.

- **Communicate your needs clearly and assertively.** Don’t expect the other party to intuitively understand your expectations. For more information on assertive communication, see the next worksheet.

- **Maintaining boundaries will take diligence.** No matter how many times you remind someone of your boundaries, they may innocently forget or intentionally keep persisting until they get whatever it is they want. **Be prepared to enforce and reinforce your boundaries.** Draw your line and stick to it because inconsistency only confuses people.

- **Know how you will respond if your boundary continues to be violated and act on it.** Boundary violations should have consequences. Once you’ve asked the other person to respect your boundary, and they continue to refuse, carry out the consequence. This consequence can be temporary (i.e., walking away from the current interaction) or permanent (i.e., dissolving the relationship). Choose a reasonable consequence that you are realistically comfortable with implementing. Empty threats are ineffective. Actions speak louder than words in helping others recognize your boundaries.

Now that you know more about boundaries, take some time to discover what your personal boundaries are with respect to fertility. They may be related to diagnosis or treatment information disclosure, topics off-limits to those outside of your significant other (i.e., sexual activities with your partner), or activities that you would rather not participate in at this time. Be specific about relational context (i.e., with friends, coworkers, extended family, etc.). An example is provided for you.

| I will not: | tolerate any discussion of our sexual “techniques” from my parents |
| I will not: |  |
| If this happens, I will: | Ask them to stop talking about our sex life, change the subject |
| I will not: |  |
| If this happens, I will: |  |
| I will not: |  |
| If this happens, I will: |  |
| I will not: |  |
| If this happens, I will: |  |
What is assertive communication?

Assertive communication is the ability to express one’s self honestly, openly, and directly, in a way that also respects the rights of others. It is the balance between being passive and being aggressive.

What are the benefits of using assertive communication?

Being assertive can:

- Help us recognize our feelings and empathize with others
- Reduce stress, anger, depression, and anxiety
- Lead to more authentic relationships
- Reduce unintentional hurt
- Reduce alienation or isolation
- Protect us from being taken advantage of by others
- Help us make wise decisions
What are the initial costs of using assertive communication?

Making this type of change in your communication style may take others by surprise initially. They may not understand or accept the change at first. But given time, most will come to appreciate this change. Moreover, respecting the rights of others may mean that you don’t always get what you want. Yet, the seeds you sow in respecting others’ rights will surely be reaped in others treating you with the same respect.

What does assertive communication sound like?

To begin with, one’s voice should be at a level, well modulated tone. Too soft would imply passivity; too loud, aggression. Using an even, firm voice commands respect and attention. Also carefully consider the timing of your response to ensure that the other person is receptive and your words have maximum impact. Remember, context is usually more important than content in communication. Use your discernment to decide if it is the appropriate time and setting for effective communication. If not, politely table the discussion until later, but be sure to have the discussion eventually. Your emotions may be a red flag that now is not the time. If you find yourself getting overly emotional and unable to remain calm, save the discussion for later and focus on maintaining your composure.

Being assertive involves appropriately expressing your needs and feelings. You can accomplish this by using “I” statements. These indicate ownership, focus on overt behavior, identify the effects of the behavior, are direct and honest, and contribute to the growth of your relationship with the other person. They do not attribute blame or judgment, criticize or put others down, bring up old issues, or sugar-coat the facts to make it easier for others to take. The best “I” statements have three parts: a behavior, a feeling or other tangible effect, and a preferred alternative. To do this, use the WII technique: “When you (insert behavior here), I feel (insert feeling here). I would like it if (insert reasonable alternative here).” For example, “Mom, when you keep asking me why we haven’t had kids yet, it makes me feel guilty, as if I’m doing something wrong or am the one to blame for our fertility problems. It would really make me feel better if you and dad wouldn’t ask anymore, and just wait on me to update you guys about things like that.”

Just as an assertive communicator is willing to share her opinions, she is also open to hearing other’s points of view. She is able to listen and accept what the other person has to say, even if she doesn’t agree. She knows when to say “no.” She apologizes, but only if warranted. She does not react to criticism by counter-attacking, denying, or feeling anxious or inadequate. Rather, she listens to and validates others by reflecting their sentiments. Listening and reflecting may sound something like: “I hear you, love, when you say you’re turned off because sex seems like a chore now.” By listening to others, she can also learn how she may be contributing to miscommunication, and can take responsibility for communication failures. Remember, everyone is entitled to an opinion; it is not our task to convince others that ours is the “right” one.
The assertive communicator should not assume that others also have the same communication skills. Some people may try to change the subject, minimize their behavior, or shift blame to you for the situation in order to avoid the discomfort of conflict. The assertive communicator should be prepared to deal with this by acknowledging others’ statements or opinions, then shifting the focus of the conversation back to the topic at hand: “Mom, I understand that Sister Johnson’s son also had the same issues with fertility and you’re just concerned because they took it so hard… and I thank you for being concerned about us. But right now, I don’t want to talk about the Johnsons’. Can we talk some more about what I said earlier?”

What does assertive communication look like?

Non-verbal communication is just as important as the words that are spoken. Here are a few suggestions to improve your non-verbal assertiveness skills.

- **Make eye contact.** It shows sincerity and demonstrates interest in what the speaker is saying.
- **Smile occasionally.** Maintaining a neutral or slightly positive facial expression is preferable to being too jovial. The listener may not take you seriously. Scowling is definitely something to avoid.
- **Watch your gestures.** Use appropriate and non-threatening gestures. Avoid pointing, flailing the arms, or other shows of aggression. Don't wring your hands; you will appear nervous.
- **Use welcoming, engaged posture.** Face the speaker; sit upright at the same eye level. Standing above a seated individual can make them feel threatened. If seated, lean forward in your chair a bit; leaning or sitting too far back makes you appear detached or dismissive.
- **Be aware of personal space.** Different individuals have different preferences for the amount of personal space that makes them feel at ease.

How else can I improve my assertive communication skills?

- **First, know your typical communication style.** Those who are passive can learn to assert themselves more, and those who are more aggressive can learn to consider others’ needs more. If you typically say “yes” when you want to say “no,” and are frequently sarcastic, complaining, or gossiping, you may have developed a passive-aggressive style because you're unable to be direct about your needs and feelings. Knowing yourself is the most important step to change.
- **Learn to say no.** The only way to inoculate one’s self against the guilt one feels when saying “no” is to do it. Don't beat around the bush; give a firm, direct response. If an explanation is appropriate, keep it brief, and don’t revert into apologies.
- **Practice, practice, practice.** Start by practicing your new skills in low-risk situations, such as with a loved one. Evaluate yourself and make adjustments as necessary. Get feedback on your non-verbal communication style. Start using the WII technique at restaurants and in other customer service situations. Consider role playing with a friend or colleague.
- **Discover the joy of compromise.** When your values or self-respect is not in question, consider the power of workable compromise. An example of this technique would be, “I understand that you want to talk now, but I really need to get this report finished. Do you think I could call you back in about an hour?”
Worksheet 10: Envisioning the Love of God*

Instructions: Find a nice, relaxing, quiet space to practice this exercise. You may do this without background music, or with worship or other music playing softly in the background. Get comfortable; wear non-restricting clothes and sit or lay in a relaxing position. Remember to breathe deeply as you are reading the words to yourself. Lay aside your inhibitions; allow yourself to be fully exposed to God. After the exercise is complete, take a moment to process your thoughts. It may be helpful to record your voice reading the text below in order to be able to close your eyes while engaging in the exercise.

Close your eyes and begin to focus on your breathing. Let your body become comfortable and relaxed as you feel your breath move in… and out. As you slowly count to 5, let your body become more relaxed with each number… 1… 2… 3… 4… 5. Imagine yourself now with God in a safe, beautiful, and peaceful place. Just you and God are present; no one else is around. As you imagine yourself and God in this place together, begin to pay attention to any feelings that arise. How do you feel about God right now? Share those feelings with God. [pause] What feelings did you have toward God when you first learned about the infertility? Share those feelings now with God. [pause] Take the time now to share any other feelings that you’ve been keeping hidden. [pause] Now, listen for God’s response. [pause] Having heard His response, imagine Him now smiling at you, with the fullness of all the Love in His heart. Imagine Him embracing you, enveloping you in His peaceful presence. If there are tears, imagine Him wiping your face gently, reassuring you that He cares for you, and that He will always be there, even and especially in the bad times. Rest a few moments in His embrace, reflecting on the significance of God’s love. [pause] It is now time to leave this special place, but you may return at any time. As you walk away from this place, hold your image of a loving and understanding God in your heart. Now, focus on your breathing. Notice how relaxed you feel with each breath. Begin to return your focus to the room as you count backwards from five… 5… 4… 3… 2… 1. When you are ready, open your eyes, feeling comfortable and relaxed.
**Worksheet 11: Practicing the WII Technique**

*Instructions: Refer back to the worksheet on assertive communication as needed. Document at least one instance daily of successful use of the WII technique, noting also your reactions to using this technique and the other party’s response. An example is included for you.*

<table>
<thead>
<tr>
<th>The listener was:</th>
<th>The situation was:</th>
<th>When you... I feel... I would like it if...</th>
<th>When I used WII, at first I felt:</th>
<th>Afterwards I felt:</th>
<th>It seemed to me like the listener reacted:</th>
</tr>
</thead>
<tbody>
<tr>
<td>My co-worker who is always in others’ business.</td>
<td>My GYN called and left a vague message, and my co-worker asked me what was going on.</td>
<td>When you intrude on my personal business, I feel violated. I would like it if you stopped asking me personal questions.</td>
<td>Awkward, and annoyed that I’d even have to tell her this. She should know to mind her business.</td>
<td>Good about letting her know how I felt. Now I think she was more concerned than just nosy.</td>
<td>Positively...she apologized for offending me and promised not to ask me any more personal questions.</td>
</tr>
</tbody>
</table>
## Worksheet 12: Common Thinking Distortions

<table>
<thead>
<tr>
<th>Thinking Error</th>
<th>Definition</th>
<th>Example(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All-or-Nothing/Black-and-White Thinking</td>
<td>Viewing a situation in only two categories instead of on a continuum. Ignoring the middle ground.</td>
<td>“If God won’t answer my prayer, then I’ll turn my back on Him altogether.”</td>
</tr>
<tr>
<td>Discounting Positives</td>
<td>Believing that positive information somehow “doesn’t count.”</td>
<td>“Even though I have a great, nurturing relationship with my nephew, that doesn’t count... he’s not mine.”</td>
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<tr>
<td>Fortune Telling</td>
<td>Predicting a negative future without considering other outcomes.</td>
<td>“We will never be happy as a couple without kids.”</td>
</tr>
<tr>
<td>Magnification or Catastrophizing Labeling</td>
<td>Blowing negative events out of proportion.</td>
<td>“Being infertile is the worst thing that could ever happen to a person.”</td>
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<td></td>
<td>Using fixed, global labels without considering other evidence.</td>
<td>“I’m a failure.” “I’m unworthy.” “He is a horrible person.”</td>
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<tr>
<td>Overgeneralization</td>
<td>Seeing a single, negative event as a never-ending pattern of defeat.</td>
<td>“I didn’t conceive again this month; I’ll never be a mother.” “I messed up again. I’ll never get it right.”</td>
</tr>
<tr>
<td>Mind reading</td>
<td>Thinking you know what others are thinking without clear evidence.</td>
<td>“My husband didn’t say anything to me this morning. He must be upset with me.”</td>
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<tr>
<td>Personalization</td>
<td>Thinking all situations revolve around you.</td>
<td>“It’s all my fault that I’m infertile; I must have done something wrong in the past.”</td>
</tr>
<tr>
<td>Using imperatives (i.e., should and must statements)</td>
<td>Holding fixed ideas about behavior and overestimating how bad it is when those expectations aren’t met.</td>
<td>“I must always be right.” “People should always consider everyone else’s feelings.”</td>
</tr>
<tr>
<td>Unfair Comparisons</td>
<td>Unrealistically focusing on others who are better or worse than you.</td>
<td>“I wish I could be her; she has it all.” “Thank God I’m not as bad as her.”</td>
</tr>
<tr>
<td>Confusing Choice with Necessity</td>
<td>Not realizing that a certain act is something you choose to do, rather than something you have to do.</td>
<td>“I have to do it all by myself.” “I have to go to the party, even though I don’t want to.”</td>
</tr>
<tr>
<td>Emotional Reasoning</td>
<td>Letting your feelings guide your interpretation of reality.</td>
<td>“I feel useless, therefore I am useless.”</td>
</tr>
<tr>
<td>Can’t-Stand-It’s</td>
<td>Believing you can’t withstand, tolerate, or cope with a situation, when in fact you can.</td>
<td>“I can’t take not being able to have kids of my own.”</td>
</tr>
<tr>
<td>Projection</td>
<td>Assigning your own thoughts or motives to others, believing they must think like you.</td>
<td>“She knew I would be embarrassed by that question. She should have known better than to ask that.”</td>
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</tbody>
</table>
**Worksheet 13: Challenging Your Thinking**

*Instructions:* Refer back to the worksheet on thinking distortions as needed. Identify and label at least ten thinking errors you made this week related to infertility and/or faith. You may find that a thought seems to involve multiple thinking errors. Next, list the advantages and disadvantages of holding this thought or belief. Weigh the advantages and disadvantages numerically, and place that number in the small bubble. The weights should sum to 100. Finally, revise each statement to form a more flexible or realistic thought. A short example is included for you.

<table>
<thead>
<tr>
<th>Thought</th>
<th>Type of Thinking Error</th>
<th>Advantages of Thinking this Way</th>
<th>Disadvantages of Thinking this Way</th>
<th>Revised Thought</th>
</tr>
</thead>
<tbody>
<tr>
<td>The reason why God won't give me a child is because I was wild in college</td>
<td>Mind Reading</td>
<td>1. At least I have a reason why this is happening.</td>
<td>1. I feel guilty and ashamed. 2. I’m powerless to change the past, so I’ll just keep dwelling on it.</td>
<td>God’s thoughts are not my thoughts. Right now, I don’t know the reason why this is happening, and that’s ok.</td>
</tr>
</tbody>
</table>

The table continues with more thoughts and their corresponding analyses.
Worksheet 14: Circles of Control

Things Under My Control

Things Under God's Control
Instructions: Sometimes we worry about things that are beyond our control. One technique that’s useful in those situations is to practice acceptance. You probably already practice acceptance in your daily life. For example, you accept the fact that you have to pay bills or may get stuck in traffic on your way to work. In those situations, you don’t fight the bill collector or worry about the traffic; you simply accept what may happen without judgment and make the best of the situation. In Luke 22:42, Jesus prayed, “Father, if you are willing, take this cup from me; yet not my will, but yours be done.” Here, we see that Christ asked for relief from the pain of the Cross, but He ultimately accepted what may happen. Complete the table below to understand what you are worried about and work towards accepting it.

<table>
<thead>
<tr>
<th>The thing that I am worried about is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Costs of acceptance:</td>
</tr>
<tr>
<td>Benefits of acceptance:</td>
</tr>
<tr>
<td>Why I accept these things:</td>
</tr>
<tr>
<td>Describe, in detail, what is actually happening that is causing the worry without judging interpreting or predicting:</td>
</tr>
<tr>
<td>Things to meditate on to help me gain acceptance:</td>
</tr>
</tbody>
</table>
APPENDIX D

RECRUITMENT MATERIALS
Mind... Body... Spirit
All these things are connected... one can affect the other.

If you’d like to talk about your experience with infertility and learn ways to cope, you may be interested in a research study.

Please talk to your doctor to find out more. For more specific questions, call Shiquina at (205) 996-2832.

Study conducted by: UAB Department of Psychology
Would you be open to talking about your experience?

Thanks for reading.

Whatever you decide about the study, we wish you well in your journey in finding peace with this diagnosis.

Feel free to keep this brochure.

If you’re unsure about participating, or want to think more about it, feel free to call at a later time.

For I know the plans I have for you...
Plans to prosper you and not to harm you;
Plans to give you hope and a future...

Are you interested in learning ways to cope with infertility?
First, the basics...

Have you been diagnosed with infertility?

Being diagnosed with infertility can be hard for women. Some find solace in family, friends, and faith. Yet, you may also find it helpful to talk to other women with infertility, whether or not you’re having a hard time coping.

But what if I am having a hard time coping with it? Is that normal?

Some women do find it hard to cope with infertility... so your reaction is normal. However, if you are experiencing emotions that continue to bother you or prevent you from engaging in your normal activities, you should get help. Please let your doctor know how you’ve been feeling, and he/she will help you.

Now, the tough ones...

I believe in God, but lately I’ve been asking questions like “why me?” or “what did I do to deserve this?”... Do other women ask the same questions?

Yes, other women do ask the same questions, and asking them doesn’t make you any less faithful. If faith is important in your life in general, of course faith-related issues will arise in coping with infertility.

Sometimes I feel as if no one understands. I can’t talk to my loved ones or people at church about how I really feel. Is there anyone I can talk to about religion and infertility?

Yes. Please continue reading to find someone you can talk to...

About the study...

If any of those questions spoke to you, we would like to invite you to participate in a research study.

This study involves participating in a group-based program for infertile women. You would be randomly placed in 1 of 2 programs. Both deal with infertility & how it impacts areas of your life, but one also discusses the role of one’s faith in coping with infertility. That program is based on the Christian faith, but all denominations are welcome to attend.

You would also complete a few surveys about yourself, your background, and infertility.

If you would like to be a part of this study, or need more information to decide, please call Shiquina at (205) 996-2832.

Study conducted by
UAB Department of Psychology
APPENDIX E

ASSESSMENT MEASURES
These next few questions are about your religious background. Feel free to be as open and honest as possible. We understand that people differ in their religious faith and practices, and we’d just like to know about yours.

1. We understand that you identify yourself as a Christian, but what is your particular denomination? If the participant is confused, prompt: “like Catholic, Baptist, Methodist, etc.”
2. How often do you attend religious services? *Please choose the best answer.*

[ ] More than once a week   [ ] Once a week   [ ] More than once a month
[ ] Once a month           [ ] A few times a year   [ ] Never

3. How often do you participate in other religious activities than formal church services (ex: chorus meetings, service on ministries/committees, women’s retreats, etc.)? *Please choose the best answer.*

[ ] More than once a week   [ ] Once a week   [ ] More than once a month
[ ] Once a month           [ ] A few times a year   [ ] Never

4. Do you hold a leadership position within your church? If so, what position?

5. How often do you pray privately in places other than church?

[ ] Several times a day   [ ] Once a day   [ ] A few times a week
[ ] Once a week           [ ] A few times a month   [ ] Once a month
[ ] Less than once a month   [ ] Never

6. How often do you read the Bible, devotionals, or other religious literature?

[ ] Several times a day   [ ] Once a day   [ ] A few times a week
[ ] Once a week           [ ] A few times a month   [ ] Once a month
[ ] Less than once a month   [ ] Never

7. How often do you watch religious TV programs or listen to religious radio stations?

[ ] Several times a day   [ ] Once a day   [ ] A few times a week
[ ] Once a week           [ ] A few times a month   [ ] Once a month
[ ] Less than once a month   [ ] Never

8. Which of the following to you think describes you best?

[ ] More religious than spiritual   [ ] More spiritual than religious
[ ] Equally spiritual and religious   [ ] Not sure
Sources of Support Survey

1. Are you currently seeing a psychologist, psychiatrist or other mental health professional?  
   Yes  No

   \textit{If yes: (a) How often do you see this person? Record answer verbatim below.}

   \textit{(b) How satisfied are you with the services you receive? Read answer choices below.}

   [ ] Very Dissatisfied
   [ ] Dissatisfied
   [ ] Neither Satisfied nor Dissatisfied
   [ ] Satisfied
   [ ] Very Satisfied

2. Are you now receiving pastoral or other religious counseling?  
   Yes  No

   \textit{If yes: (a) How often do you see this person? Record answer verbatim below.}

   \textit{(b) How satisfied are you with this counseling? Read answer choices below.}

   [ ] Very Dissatisfied
   [ ] Dissatisfied
   [ ] Neither Satisfied nor Dissatisfied
   [ ] Satisfied
   [ ] Very Satisfied

3. Are you participating in any support groups for infertility?  
   Yes  No

   \textit{If yes: (a) How often do you meet with this group? Record answer verbatim below.}

   \textit{(b) How satisfied are you with this group? Read answer choices below.}

   [ ] Very Dissatisfied
   [ ] Dissatisfied
   [ ] Neither Satisfied nor Dissatisfied
   [ ] Satisfied
   [ ] Very Satisfied
Social Desirability Scale-17

I’m going to read a list of statements. I want you to decide if the statement describes you or not. If it describes you, say “true”; if not, say “false.”

1. I sometimes litter. True False
2. I always admit my mistakes openly and face the potential negative consequences. True False
3. In traffic, I am always polite and considerate of others. True False
4. I always accept others' opinions, even when they don't agree with my own. True False
5. I take out my bad moods on others now and then. True False
6. There has been an occasion when I took advantage of someone else. True False
7. In conversations, I always listen attentively and let others finish their sentences. True False
8. I never hesitate to help someone in case of emergency. True False
9. When I have made a promise, I keep it – no ifs, ands or buts. True False
10. I occasionally speak badly of others behind their back. True False
11. I would never live off other people. True False
12. I always stay friendly and courteous with other people, even when I am stressed out. True False
13. During arguments, I always stay objective and matter-of-fact. True False
14. There has been at least one occasion when I failed to return an item that I borrowed. True False
15. I always eat a healthy diet. True False
16. Sometimes I only help because I expect something in return. True False
I’m going to read you a series of statements. Each represents common challenges reported by women coping with infertility. You will probably agree with some items and disagree with others. We are interested in the extent to which you agree or disagree with these statements. Remember, there are no right or wrong answers. We just want your honest opinion or outlook. Please indicate the extent to which you agree or disagree with the statements using the following responses:

- If you strongly agree, say 5
- If you moderately agree, say 4
- If you slightly agree, say 3
- If you slightly disagree, say 2
- If you moderately disagree, say 1
- If you strongly disagree, say 0

In other words, you will pick a number from 0 to 5, with 0 meaning strongly disagree and 5 meaning strongly agree. If you need these answer choices repeated to you, please let me know.

<table>
<thead>
<tr>
<th></th>
<th>SD</th>
<th>MD</th>
<th>SD</th>
<th>SA</th>
<th>MA</th>
<th>SA</th>
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<td>1.</td>
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<td>2.</td>
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<td>5.</td>
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<td>6.</td>
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<td>8.</td>
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<td>9.</td>
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<td>10.</td>
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<td>11.</td>
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<td>12.</td>
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<td>13.</td>
<td>0</td>
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<tr>
<td>14.</td>
<td>I feel like I’ve failed at sex.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15.</td>
<td>During sex, all I can think about is wanting a child.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16.</td>
<td>Having sex is difficult because I don’t want another disappointment.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17.</td>
<td>If we miss a critical day to have sex, I can feel quite angry.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18.</td>
<td>Sometimes I feel so much pressure, that having sex becomes difficult.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>19.</td>
<td>I can’t show my partner how I feel because it will make him feel upset.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>20.</td>
<td>My partner doesn’t understand the way the fertility problem affects me.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>21.</td>
<td>My partner and I work well together handling questions about our infertility.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>22.</td>
<td>It bothers me that my partner reacts differently to the problem.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>23.</td>
<td>My partner is quite disappointed with me.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>24.</td>
<td>My partner and I could talk more openly with each other about our fertility problem.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>25.</td>
<td>I couldn’t imagine us ever separating because of this.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>26.</td>
<td>When we try to talk about our fertility problem, it seems to lead to an argument.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>27.</td>
<td>Because of infertility, I worry that my partner and I are drifting apart.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>28.</td>
<td>When we talk about our fertility problem, my partner seems comforted by my comments.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>29.</td>
<td>Couples without a child are just as happy as those with children.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>30.</td>
<td>I could see a number of advantages if we didn’t have a child.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>31.</td>
<td>I could visualize a happy life together, without a child.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>32.</td>
<td>At times, I seriously wonder if I want a child.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>33.</td>
<td>Not having a child would allow me time to do other satisfying things.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>34.</td>
<td>Having a child is not necessary for my happiness.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>35.</td>
<td>We could have a long, happy relationship without a child.</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>36.</td>
<td>There is a certain freedom without children that appeals to me.</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td><strong>37.</strong> Pregnancy and childbirth are the two most important events in a couple’s relationship.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td><strong>38.</strong> For me, being a parent is a more important goal than having a satisfying career.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td><strong>39.</strong> My marriage needs a child.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td><strong>40.</strong> It’s hard to feel like a true adult until you have a child.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td><strong>41.</strong> A future without a child would frighten me.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
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<tr>
<td><strong>42.</strong> I feel empty because of our fertility problem.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td><strong>43.</strong> Having a child is not the major focus of my life.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td><strong>44.</strong> I have often felt that I was born to be a parent.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
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<tr>
<td><strong>45.</strong> As long as I can remember, I’ve wanted to be a parent.</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td><strong>46.</strong> I will do just about anything to have a child.</td>
<td>0</td>
<td>1</td>
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</tbody>
</table>
Now I’m going to read you another set of statements, asking you how you have dealt with problems or difficult times in your life in light of your relationship with God. Obviously, different problems evoke different responses, but think about what you usually do when faced with a problem. Choose your answers thoughtfully, and make your answers as true FOR YOU as you can. Once again, there are no right or wrong answers, so choose the most accurate answer for YOU – not would you think “most people” would do or say or how you feel you “should” respond to problems. Please indicate how often each of the following statements applies to you:

- If the statement doesn’t apply to you at all, say 0.
- If the statement applies to you somewhat, say 1.
- If the statement applies to you quite a bit, say 2.
- If the statement applies to you a great deal, say 3.

In other words, you will pick a number from 0 to 3, with 0 meaning “not at all” and 3 meaning “a great deal”. If you need these answer choices repeated to you, please let me know.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Not at all</th>
<th>Somewhat</th>
<th>Quite a bit</th>
<th>A great deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I looked for a stronger connection with God.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>2. I sought God’s love and care.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>3. I sought help from God in letting go of my anger.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>4. I tried to put my plans into action together with God.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>5. I tried to see how God might be trying to strengthen me in this situation.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>6. I asked forgiveness of my sins.</td>
<td>0</td>
<td>1</td>
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<td>7. I focused on religion to stop worrying about my problems.</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>8. I wondered whether God had abandoned me.</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<td>9. I felt punished by God for my lack of devotion.</td>
<td>0</td>
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<td>10. I wondered what I did for God to punish me.</td>
<td>0</td>
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<td>11. I questioned God’s love for me.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>12. I wondered whether my church had abandoned me.</td>
<td>0</td>
<td>1</td>
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<td>3</td>
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<td>13. I decided the devil made this happen.</td>
<td>0</td>
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<tr>
<td>14. I questioned the power of God.</td>
<td>0</td>
<td>1</td>
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</table>
## Spiritual Transformation Scale

Now I would like you to think about how you were spiritually or religiously before you were diagnosed with infertility and how you are now. Please indicate the extent to which the following statements are true for you since your diagnosis of infertility. Indicate the number that best describes any changes that have occurred using the following scale:

- If the statement is not at all true for you, say 0.
- If the statement is a little true, say 1.
- If the statement is somewhat true, say 2.
- If the statement is neither true nor false, say 3.
- If the statement is mostly true, say 4.
- If the statement is quite a bit true, say 5.
- If the statement is extremely true for you, say 6.

In other words, you will pick a number from 0 to 6, with 0 meaning “not at all true” and 6 meaning “extremely true”. If you need these answer choices repeated to you, please let me know.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Not at all</th>
<th>A little</th>
<th>Somewhat</th>
<th>Neither T nor F</th>
<th>Mostly True</th>
<th>Quite a bit</th>
<th>Extremely True</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Spirituality has become more important to me.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>2. My way of looking at life has changed to be more spiritual.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>3. Because of spiritual changes I’ve been through, I’ve changed my priorities.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>4. I pay more attention to things that are spiritually important and forget about the little things that used to bother me.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>5. I pray or meditate more often.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>I spend more time taking care of my spiritual needs.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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</tr>
<tr>
<td>7</td>
<td>I more often experience life around me as spiritual.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8</td>
<td>I more often see my own life as sacred.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9</td>
<td>I have a stronger spiritual connection to other people.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10</td>
<td>I have a stronger spiritual connection to nature.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11</td>
<td>Spiritually, I am like a new person.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12</td>
<td>Taking care of my body has taken on spiritual meaning.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13</td>
<td>My relationships with other people have taken on more spiritual meaning.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>14</td>
<td>I have a stronger sense of God directing my life now.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>15</td>
<td>I act more compassionately toward other people since my diagnosis.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>16</td>
<td>I see people in a more positive light.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>17</td>
<td>I more often express my spirituality.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>18</td>
<td>I spend more time thinking about spiritual questions.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>19</td>
<td>I am more humble since my diagnosis.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>20</td>
<td>I more often think about how blessed I am.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
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<tr>
<td>21. I have grown spiritually.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>22. I am more spiritually present in the moment.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>23. I take part in spiritual rituals more often.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>24. I more often have a sense of gratitude.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>25. I more often pray for other people.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>26. My spirituality is now more deeply imbedded in my whole being.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>27. I am more receptive to spiritual care from others (examples: prayer, healing practices, etc).</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>28. I more often look for a spiritual purpose for my life.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>29. I’m finding it more important to participate in a spiritual community.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>30. In some ways I am spiritually withdrawn from other people.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>31. My faith has been shaken and I’m not sure what I believe.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>32. Spirituality seems less important to me now.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>33. In some ways I have shut down spiritually.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>34. In some ways I think I am spiritually lost.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>35. I feel I’ve lost some important spiritual meaning that I had before.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Question</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
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</tr>
<tr>
<td>36. My relationships with others have lost spiritual meaning.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>37. I am more spiritually wounded.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>38. In some ways I am off my spiritual path.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>39. I more often think that I have failed in my faith.</td>
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<tr>
<td>40. I am less interested in organized religion.</td>
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</tr>
</tbody>
</table>
### Intervention Participant Feedback

Now I’d like to ask you some questions about your experience with the “A Fulfilled Life” program. Please answer the questions as honestly as possible. Your responses are anonymous, and your feedback is very important to us.

1. **How satisfied were you with the phone-based nature of the program?**

<table>
<thead>
<tr>
<th>Very Satisfied</th>
<th>Dissatisfied</th>
<th>Neither Satisfied nor Dissatisfied</th>
<th>Satisfied</th>
<th>Very Satisfied</th>
</tr>
</thead>
</table>

2. **What did you think about the session length, i.e. one hour? Was it too short, too long, or just right?**

<table>
<thead>
<tr>
<th>Too short</th>
<th>Too long</th>
<th>Just Right</th>
</tr>
</thead>
</table>

3. **What did you think about the number of sessions, i.e. six? Were there too many, too few, or was the number of sessions just right?**

<table>
<thead>
<tr>
<th>Too many</th>
<th>Too few</th>
<th>Just Right</th>
</tr>
</thead>
</table>

4. **How satisfied were you with the activities that were a part of the group program?**

<table>
<thead>
<tr>
<th>Very Satisfied</th>
<th>Dissatisfied</th>
<th>Neither Satisfied nor Dissatisfied</th>
<th>Satisfied</th>
<th>Very Satisfied</th>
</tr>
</thead>
</table>

5. **Did you think there should have been more activities, less activities, or was the amount just right?**

<table>
<thead>
<tr>
<th>More</th>
<th>Less</th>
<th>Just Right</th>
</tr>
</thead>
</table>

6. **How satisfied were you with the program leader?**

<table>
<thead>
<tr>
<th>Very Satisfied</th>
<th>Dissatisfied</th>
<th>Neither Satisfied nor Dissatisfied</th>
<th>Satisfied</th>
<th>Very Satisfied</th>
</tr>
</thead>
</table>
7. How much did you feel like the program “spoke to” your spiritual needs & beliefs?

Not at all          A little          Some          Very Much

8. How much did you feel like your spirituality or faith was included in the discussions & activities?

Not at all          A little          Some          Very Much

9. Did the program help you see that God would give you strength to cope with infertility?

Not at all          A little          Some          Very Much

10. Did the program make you think about the connection between your own spirituality and coping with infertility?

Not at all          A little          Some          Very Much

11. Overall, how much spiritual content was included in the program?

None at all          A little          Some          A lot

12. Overall, how satisfied were you with the program?

Very Dissatisfied   Dissatisfied   Neither Satisfied nor Dissatisfied   Satisfied   Very Satisfied

13. Are there any additional comments you wish to make? Record response verbatim.

_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
CEQ

We would like you to indicate below how much you believe, right now, that the program you are participating in will help to increase your coping with infertility. Belief usually has two aspects to it: (1) what one thinks will happen and (2) what one feels will happen. Sometimes these are similar; sometimes they are different. Please answer the questions below. In the first set, answer in terms of what you think. In the second set, answer in terms of what you really and truly feel.

Once you are done, please return this sheet immediately in the addressed, stamped envelope provided. Please don’t put your name on this sheet. Don’t put a return address on the outside. Your therapist will not see look at the responses until after the program is done and the study has ended completely.

1. At this point, how logical does this program seem?
   1  2  3  4  5  6  7  8  9
   not at all logical  somewhat logical  very logical

2. At this point, how successfully do you think this program will be in reducing your infertility-related distress?
   1  2  3  4  5  6  7  8  9
   not at all useful  somewhat useful  very useful

3. How confident would you be in recommending this program to a friend who experiences similar problems?
   1  2  3  4  5  6  7  8  9
   not at all confident  somewhat confident  very confident

4. By the end of the program, how much improvement in your infertility-related distress do you think will occur?
   0%  10%  20%  30%  40%  50%  60%  70%  80%  90%  100%

Now, close your eyes for a few moments, and try to identify what you really feel about the program and its likely success. Then answer the following questions:

5. At this point, how much do you really feel that the program will help you to reduce your infertility-related distress?
   1  2  3  4  5  6  7  8  9
   not at all  somewhat  very much

6. By the end of the program, how much improvement in your infertility-related distress do you really feel will occur?
   0%  10%  20%  30%  40%  50%  60%  70%  80%  90%  100%

Please return this survey in the envelope provided.
Thank you & congrats on reaching the middle of the program!
Exit Interview

It’s our understanding that you’ve decided not to participate in the study anymore. We’re sorry to see you go, and would like to better understand your reasons for withdrawal.

1. What are your reasons for deciding not to participate anymore?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

2. Was there anything that could have been done to keep you in the study?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

3. If yes, what would have helped you remain in the study?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

4. Do you have any general suggestions that would make this study easier to participate in?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

5. Do you have any complaints that you never shared with the PI that you’d like her to know?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

That’s all the questions we have. Again, we hate to see you leave, but **THANK YOU for the time and participation that you did offer.**

We really appreciate it, and wish you well in the future!