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# The Lived Experiences of Nigerian Women Diagnosed With Infertility and Residing in the United States

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2024

Abstract

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MA, Argosy University, 2014

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## Abstract

According to recent studies, infertility remains one of the largest and most important reproductive health concerns among Nigerians. Despite the growing awareness of infertility in Nigerian women, there remains a significant gap in the research addressing the prevalence of the psychological and sociocultural experiences associated with involuntary childlessness in Nigerian women over age 50 who are living in the United States. The purpose of this qualitative phenomenological study was to investigate the psychological and sociocultural lived experiences of eight Nigerian women diagnosed with primary infertility, age 50 years and older, who currently reside in the United States and who have completed their reproductive journey. Using a qualitative approach with a phenomenological research design, this study employed semistructured interviews, yielding resultant data that were analyzed and coded. Four prominent themes and nine subthemes were identified: (a) relational issues with others (subthemes of discrimination, marital conflict, and social pressure); (b) emotional impact (subthemes of sense of loss, internalized beliefs about self/questioning self, depression, and anxiety, (c) barriers (subthemes of lack of support or understanding from others and cultural beliefs and expectations_; and (d) treatment experiences (subthemes of finding the right representation in counseling and psychotropic medications). Nigerian women with infertility may benefit from the results of this study through the growing awareness of the psychosocial impact of inferility. Furthermore, the results of this study can inform the design of culturally appropriate counseling interventions to help diminish the stigma around help-seeking. This inclusion could enhance the initiation and sustainability of positive social change.

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## Dedication

First, I want to thank God, who granted me the knowledge, wisdom, and strength to complete this work and the doctoral program. I dedicate my dissertation to my family, friends, and select cohort members. A special dedication goes to my older brother, Saidi Oseni, who has always believed in me, supported me, and encouraged me to keep going in life and throughout this process, even in the face of adversity. All accomplishments that I will achieve in my life will be forever indebted to you. Thank you, Tunde! I also dedicate this dissertation to a few of my outstanding and memorable cohort members, without whom I could not have accomplished this endeavor. I am forever grateful for the support, guidance, and assistance provided by Shakita Bruce-Robinson, Dr. Tandrea Elmore, Dr. LaTisha Wood, and Dr. Crystal Smith. Finally, I dedicate this dissertation to ME for all my hard work, effort, and commitment to pursue my goals! I did a big one, Mom and Dad!!!

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# Chapter 1: Introduction to the Study

Infertility is a life event that significantly affects an individual's psychological, physical, social, and environmental functioning and health (Zurlo et al., 2019). Pagan-Romney (2014) reported that infertility is ranked as high as losing a child or spouse in terms of anxiety. Research has shown that women with reproductive problems have a higher prevalence of psychological disturbances, including depression, anxiety, stress, and self-blame (Ho et al., 2020). However, there is limited research on the psychological and sociocultural effects of infertility on women of diverse ethnic groups who originated from underdeveloped foreign countries and are now living in the United States.

Hasanpoor-Azghady et al. (2019) states that most of the existing studies addressed the experiences of White upper-class women seeking treatment from local fertility clinics along with the support and challenges they have endured during their reproductive journey. Yet infertility affects all women of diverse backgrounds in many ways. Issues of infertility are perceived as a life crisis by many women (Hasanpoor-Azghady et al., 2019). This crisis gradually increases psychological disturbances, such as depression, anxiety, diminished self-worth, social isolation, and even thoughts of suicide (Malina & Pooley, 2017).

Although women of most cultures are expected to uphold the unique and important obligation of motherhood, this expectation remains particularly dominant within Nigerian culture, with elevated expectations for couples to procreate (Bello et al., 2021). For several women of African descent, childbearing holds significant social and cultural value and is considered essential to the family. Large family size is often

emphasized in African culture, specifically within the Yoruba tribe of southwest Nigeria, where the size of the family implies increased wealth and opportunity. According to Adewole et al. (2020), Nigeria maintains one of the highest fertility rates in the world, with seven children per woman. Though the fertility rate in Nigeria implies that the average woman can expect to have many children during her life, some Nigerian couples experience infertility at alarmingly high rates because of primarily risky sexual behavior and poorly treated sexually transmitted diseases (Ikechebelu et al., 2003). Nigerian women are responsible for developing the family and economic structure (Olonade et al., 2021). Regarding kinship, the Nigerian woman is expected to get married and, within 1 year of marriage, bear her first child, preferably a son, to ensure the family's legacy and lineage (Ameh et al., 2022).

From a young age, women of the Yoruba tribe in Nigeria are raised with these central expectations and a responsibility to the family (Aladesanmi & Ogunjinmi, 2019). They are trained during childhood to perform certain roles that will prepare them for lives as wives and to assume motherhood. Yoruba women traditionally reside within their father's house until they are chosen for marriage. In their father's home, they learn how to become the perfect homemaker through experiences of caring for siblings and watching the women of seniority maintain the household responsibilities (Naab et al., 2019). Upon being selected for marriage, women are expected to be well developed and ready to move into their husbands' homes while relinquishing their role as daughters to become wives and mothers.

Though motherhood is the ideal life course for numerous women of Nigerian descent and is the social expectation of close family, friends, and in-laws, this is not the reality for many women experiencing reproductive issues. Nieuwenhuis et al. (2009) reported that since the early 1990s, the prevalence of infertility has increased among Nigerian women. Data collected in the United States show that infertility affected more than 30% of Nigerian women in 2005, compared to women of various ethnic groups living in the United States, including African American, 12%; Native American, 25%; Hispanic/Latino, 9.2%; and Asian American/Pacific Islanders, 8.4% (Practice Committee of the American Society for Reproductive Medicine, 2008). The Centers for Disease Control and Prevention (2022) confirmed that in the United States, among heterosexual women, 19% are unable to get pregnant after 1 year of trying, resulting in primary infertility. Because of the social expectations of pregnancy and the emphasis placed on family in Nigerian culture, infertility may potentially cause psychological damage to women suffering from its hardship (Swanson & Braverman, 2021).

Because of the importance placed on motherhood and childbearing, women of Nigerian descent who do not have children are often overtly ostracized and treated as inferior. Among the Ngwas tribe of Eastern Nigeria, being childless or having difficulties in childbearing is the greatest calamity that can befall a woman (Ofovwe & Agbontaen-Eghafona, 2009). According to the Reproductive Medicine Associates of New Jersey (2016), there is a significant gap in research between people's beliefs about their fertility and basic biology. The psychological and social consequences of infertility in Nigerian women are associated with the procreation potential among women suffering from

involuntary childlessness. In other words, women of Nigerian background not only experience the emotional and psychological effects of infertility but remain at a higher risk of social consequences such as marital instability, community stigmatization and abuse, immense social pressure, and lack of societal support. Infertility within African culture is considered taboo and shameful.

I used a phenomenological approach to explore the experiences of first-generation immigrant Nigerian women living in the United States who have been through infertility treatment. Through an investigative approach, I explored these women's psychological and sociocultural experiences of infertility. I further explored the perceptions of infertility in African culture while defining the meaning of infertility to these women.

## Background

Research in Nigeria and South Africa has shown that women suffer from the social and psychological implications of infertility (Fehintola et al., 2017). In 2016, Nigeria had 206,000,000 people, with Nigerian women, on average, having five to seven childbirths (Odusina et al., 2020). Cultural constructions of infertility in Africa have made the experience among African women burdensome (Naab et al., 2019). According to Fehintola et al. (2017), the prevalence of infertility is generally higher in sub-Saharan Africa than in most other African regions. There is a high premium placed on fertility within marriages, which has placed an even larger proportion of women under pressure from their husbands, mothers-in-law, and the community (Hollos & Whitehouse, 2014).

Hess et al. (2018) explained that infertility-related psychological distress is conceptualized as a mental and emotional upset or turmoil grounded in the inability to

conceive and bear children. Depression, anxiety, and high marital conflicts experienced by infertile couples and low psychosocial support may reinforce this distress in Africans, who place a high premium on childbearing (Obajimi et al., 2019). Despite the growing numbers of women dealing with distressing psychosocial issues related to infertility in Nigeria, poor societal attitudes towards mental illness and inadequate resources, facilities, and mental health professionals remain current issues (Ugochukwu et al., 2020). Eaton et al. (2017) reported that mental health services in Nigeria consist mainly of large government-operated institutions, which provide poor access to services and inadequate care to native residents. There are few mental health professionals to serve the large population of the country and even fewer mental health professionals trained in the psychological and emotional treatment of infertility. Ugochukwu et al. (2020) stated that Nigeria faces a global human rights emergency in mental health and needs mental health counseling professionals to address the growing concerns.

## Problem Statement

Many Nigerian women consider infertility issues a life crisis (Ashraf et al., 2014). This crisis gradually increases psychological disorders and consequences, such as depression, anxiety, diminished self-worth, social isolation, and suicidal thoughts (Karimzadeh et al., 2017). Muhammed-Durosinlrun et al. (2019) confirmed that infertility in African culture is associated with several negative psychosocial consequences, such as stigma, deprivation and neglect, violence, marital problems, and mental health issues. Moreover, Okafor (2017) reported a high rate of infertility among couples in Nigeria.

However, there remains a dearth of research related to Nigerian women diagnosed with infertility living in the United States.

Patel et al. (2018) noted the need to address emotional needs in infertility treatment and further explore the supports and challenges of infertile women within routine fertility care. In addition. Lasebikan (2016) explained the importance of culturally appropriate counseling services, stating that the culture of a patient, clinician, and mental health service system are important determinants of how the client navigates through diagnosis and treatment services. Mental health providers are expected to be able to serve individuals of diverse ethnic and racial backgrounds (Lasebikan, 2016). The United States has been called a "melting pot," where diverse cultures, including African Americans, Asian Americans/Pacific Islanders, and Hispanic Americans, have come together to form what is depicted as the American immigration system (Masovic, 2018). This means that mental health providers in the United States need to understand specific cultural experiences of various populations.

The United States has experienced an unprecedented influx of Nigerian immigrants in several of its largest cities. Accordingly, individuals of Nigerian ancestry are rapidly migrating to the United States and have grown from an estimated population of 25,000 in 1980 to an estimated population of 461,695 in 2019 (American Community Survey, 2020). Like numerous sub-Saharan Africans and individuals belonging to diverse minority groups, Nigerians migrated to the United States hoping for higher education and to pursue what has been described as "the American Dream" (Arowolo, 2010). Due to the rapidly growing numbers of Nigerian immigrants in the United States, further attention is

needed to explore the specific experiences and worldviews of first-generation Nigerian women who have received infertility treatment. Like other immigrants and minority groups in America, Nigerian women's experiences are vastly affected by the support or challenges faced during their reproductive journey, some of which are related to cultural norms and expectations (Bhamani et al., 2020).

In Nigeria, psychological resources provided to women with infertility issues are limited. According to Ugochukwu et al. (2020), the 2013 Nigerian Mental Health Act legislation highlights the principles for delivering care to people with mental, neurological, and substance abuse problems. Unlike mental health services available in the United States, those in Nigeria remain outdated, illuminating the lack of mental health services and ushering in calls for an improvement in this area (Ugochukwu et al., 2020). The bill has not become law, affecting the quality of care and life for people living with mental health problems in Nigeria. Recent findings show that primary health care workers in Nigeria have poor knowledge of mental disorders and that virtually no mental health services are provided at the country's primary health care facilities (Eaton et al., 2017).

With fewer than 300 psychiatrists for a population of more than 200,000,000 residents, caring for people with mental illness is typically left to family members rather than mental health professionals (Ugochukwu et al., 2020). Although the participants in this study had experienced their infertility journey in the United States, they still were influenced by their cultural backgrounds. Highlighting the Nigerian Mental Health Act can be beneficial in understanding the historical and cultural context in which Nigerian

immigrants develop and their perceptions of counseling services in the United States. Additional research was needed to increase the awareness and understanding of the psychological impact and experiences of Nigerian women diagnosed with infertility.

## Purpose Statement

The purpose of this qualitative transcendental phenomenological study was to explore the experiences of Nigerian women who have received infertility treatment. By interviewing Nigerian women who have sought infertility treatment, I sought to describe the phenomenon of the Nigerian woman's experiences of living with infertility issues. As a result of this study, counselors, educators, and supervisors may better understand how Nigerian women experience the psychosocial consequences of infertility, including the support and challenges during their infertility journey.

## Research Question

What are the lived experiences of Nigerian women living in the United States who received infertility treatment?

## Conceptual Framework

The conceptual framework for this study was transcendental phenomenology, which is also called descriptive phenomenology. Transcendental phenomenology is largely based on the work of Edmond Husserl. According to Creswell (2013), the aim of phenomenology is to gain an understanding of the meaning of everyday experiences and how individuals and groups experience a certain phenomenon. I used transcendental phenomenology to explore the immediate psychological and sociocultural implications of the lived experiences of Nigerian women diagnosed with infertility. By engaging in a

psychosocial exploration of participants' lived experiences, I also sought to determine participants' attitudes, perceptions, and behaviors toward treatment-seeking counseling and mental health services. Transcendental phenomenology worked well for this study because the corresponding methodology entailed a logical, organized, and comprehensible design structure that allowed for a detailed description of the lived experience of research participants. I expound on the conceptual framework in Chapter 2.

## Nature of the Study

The nature of this study involved exploratory transcendental phenomenology. Using the transcendental phenomenological approach, researchers can explore individuals' consciousness to understand life through their own experiences and the meanings derived from these experiences, which are defined in the individual's interpretations (Fuster, 2019). Considering the experiences and interpretations of infertile Nigerian women's lived experiences helped me to explore the psychosocial impact of infertility. This exploration may provide information on resources and challenges related to infertility within Nigerian culture.

I conducted qualitative interviews via videoconference for this research. Additionally, I administered a participant demographic questionnaire to triangulate data sources to enhance the validity and credibility of the findings. Creswell (2018) explained that qualitative interviews can include face-to-face interviews, telephone interviews, or focus group interviews. This study will involve six to eight individual interviewees and will use semistructured and open-ended interview questions.

I anticipated a sample size of six to eight Nigerian women living in the United States who had been diagnosed with primary infertility and were currently in the reflective stage of their reproductive journey, defined as at least 50 years old. For this exploratory research, a Nigerian woman was defined as a woman born or descended from the country of Nigeria and who could speak one of the many Nigerian dialects, including Yoruba, Igbo, or Hausa language. I included women who do not currently have biological children because of primary infertility.

Data analysis involved the verbatim transcription of the collected interviews, data organization, coding, categorizing, and identification of reoccurring themes and interpretations. Ungvarsky (2020) noted that phenomenological analysis is a psychological research design that focuses on understanding how an individual perceives the events they have experienced. The researcher strives to uncover and understand how these experiences affect the individual.

## Definitions

Following are definitions of key terms used in this study:

*Anxiety*: An emotion characterized by feelings of tension, worried thoughts, and physical changes like increased blood pressure related to an imminent event or something with an uncertain outcome (American Psychiatric Association, 2013).

*Depression*: A mood disorder that causes persistent sadness and loss of interest, affecting how individuals think, feel, and behave (American Psychiatric Association, 2013).

*Fertility*: The capacity to establish a clinical pregnancy (Vander Borght & Wyns, 2018).

*Mental health*: An individual's emotional, psychological, and social well-being.

*Primary infertility*: Failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse (Panti & Sununu, 2017).

*Pronatalist*: The policy or practice of encouraging people to have children and promoting childbearing (Benyamini, 2017).

*Secondary infertility*: The inability to achieve a spontaneous clinical pregnancy following a previous spontaneous pregnancy (Ghaffari & Arabipoo, 2018).

*Social stigma*: A negative response to individuals with characteristics different from the social norms (Goar, 2021).

*Stigma*: A negative feeling of being different from others in society and being on the opposite end of social norms (Goffman, 2009).

*Treatment seeking*: The active pursuit of treatment by a person with a disorder or who wishes to improve their general mental or physical functioning.

## Assumptions

Assumptions of this study include the similarity of participant characteristics and truthfulness. I assumed that all study participants would share similar characteristics based on lived experiences because of their geographical background, age, sex, and cultural similarities. However, it is important to recognize unique differences among participants and provide guidelines for participation in research concerning the individual.

Another assumption that I held was the truthfulness of participant responses. I assumed that all research participants would maintain honesty and truthfulness while completing interviews and questionnaires. Ravitch and Carl (2016) stated that trustworthiness in research is necessary to ensure credibility and rigor in qualitative research. One way to ensure truthfulness in the responses of research participants is to provide participants with specific, informed consent for the research and to safeguard participant confidentiality.

## Scope and Delimitations

The scope of this study was limited to the experiences of Nigerian women diagnosed with infertility and did not include feedback from their infertile male counterparts. This frame of reference was due to historical literature suggesting that although Nigerian men and women both suffer from infertility issues, there is a higher prevalence of reported infertility issues among Nigerian women (Rouchou, 2013). The literature also highlights the dominance of psychological and social consequences in infertile Nigerian women compared to their male counterparts (Hollo & Whitehouse, 2014). Furthermore, I focused on women who had completed fertility treatment. Research indicates that women experience higher levels of distress during active infertility treatment and significant psychological and emotional disturbances (Greil et al., 2011).

This study was delimited to Nigerian women living in the United States who self-reported having a previous primary infertility diagnosis. The inclusion criteria for this study served as another delimitation and included participants who were first-generation immigrants to the United States, had completed their reproductive journey in the United

States, and were currently 50 years old and above. These inclusion criteria helped to ensure that participants were able to provide data to answer the study's research question.

## Limitations

Though strengths are considered when conducting phenomenological research, it is equally important to recognize potential limitations. One limitation of this research design was that the data collected was subjective to the research participant's lived experiences and was difficult to generalize because of the small population size. As a result of the subjectivity of the responses provided, qualitative researchers may find difficulty in the trustworthiness of the information due to participant bias and the possibility of false reporting (Creswell & Creswell, 2018). Another limitation of this study was the lack of previous research on the experiences of infertility among this population. A literature review showed that the current research on this topic is limited. Furthermore, the absence of information regarding this topic showed a need for additional investigation into the targeted population.

## Significance

This study's findings could contribute to the development of counselor educators and the counseling field, considering there remains a need to develop more culturally specific counseling services for individuals from Nigeria. The study could help promote insight into the need for effective psychological and emotional counseling related to reproductive trauma within the Nigerian community. Counselors, counselor supervisors, and counselor educators may also use the findings from this study to raise awareness of the harsh stigma of infertility within Nigerian culture.

This study on infertility is an important topic relevant to research because the focus was on the common misperceptions in the knowledge and treatment of infertility. It will also highlight insights from recent research, including the impact on women with infertility issues. The investigation could uncover critical cultural development areas for counselors, educators, and supervisors and improve professional practice. Shreffler et al. (2017) suggested that practitioners who are working with individuals experiencing infertility should provide education and awareness about reproduction and infertility treatment. Practitioners can promote emotional well-being while identifying how to support the decision-making processes among individuals and couples treating infertility. Those experiencing infertility may also be relieved that most infertile individuals who never give birth, regardless of parenthood status, ultimately do not suffer long-term negative psychological consequences if they undergo appropriate counseling (Shreffler et al., 2017). Previous studies support the need for counseling services in Nigeria (Ugochukwu et al., 2020). This research could support professional practice by improving awareness of the need for therapists who can provide additional support in outpatient, primary, and community care settings for women suffering from the psychosocial effects of infertility.

In addition to the biological aspects, fertility and childbearing have always been regarded as social phenomena (Behjati-Ardakani, 2017). Research has shown that infertility stress can lead to increased mental illness and social consequences among women (Mohammed-Durosinlorun et al., 2019). Given this study, reinforcing social acceptance regarding women's challenges struggling with involuntary childlessness could

transform the attitudes and behaviors centered on the stigma of infertility. Malina et al. (2019) confirmed that social acceptance and support processes provide a first step to assisting infertile couples and women and have proven to decrease stress levels and psychological symptoms. The study results could promote social learning, education, and counseling interventions to change Nigerian culture's socioeconomic stigma of infertility.

## Summary

According to the World Health Organization (2015), infertility was considered a life crisis affecting roughly 15% of the general reproductive-age population between the years of 1999 and 2001. In sub-Saharan Africa, the prevalence of infertility is much higher among Nigerian couples, ranging between 10% and 30% in comparison to the regional average (Muhammad-Durosinlorun et al., 2019). Due to the high expectancy and premium placed on procreation in Nigeria, countless women who face involuntary childlessness are subjected to various forms of reproductive trauma (Jaffe, 2017). An extensive literature review highlights the increased prevalence of psychological and emotional disturbances associated with infertility's consequences, including stigma, social isolation, marital conflict, and various forms of abuse (Ho et al., 2020; Okonufua, 2003).

Although significant research focuses on the associated consequences of infertility among Nigerian women, there remains a lack of research on the experiences of women diagnosed with infertility and their perceptions of support and challenges during their infertility treatment. Consequently, I conducted this study to answer the following question: What are the experiences of Nigerian women living in the United States who

have undergone infertility treatment? In the following chapter, a comprehensive literature review further clarifies the concepts presented in this chapter. Additional information is given on the cultural context of infertility for Nigerian women, its meaning, and its treatment. I further discuss the current gaps in the literature related to the experiences of infertility in Nigerian women and treatment. Furthermore, a review of primary and secondary infertility and the associated psychological and sociocultural implications of infertility is provided. Last, I further address the conceptual framework used in this study.

# Chapter 2: Literature Review

The unique experiences of Nigerian women diagnosed with infertility make them highly susceptible to mental health issues and disorders, such as depression, anxiety, and posttraumatic stress disorder (Maduakolam et al., 2021). Due to the high expectancy placed on a woman's ability to bear children, women who suffer from infertility experience stigmatization (Naab et al., 2019). As a result of gender and cultural identity expectations, Nigerian women diagnosed with infertility often experience myriad forms of oppression and discrimination in multiple areas of their lives (Lewis et al., 2017). Oppression may occur in systems, the workplace, the home, and society. Instances of domestic violence, marital instability, verbal abuse, and divorce have been associated with the experiences of infertility (Rahebi et al., 2019). Social discrimination associated with infertility includes social ostracism, social isolation, a disproportionate share of the blame for infertility compared to their male counterparts, and social stigma (Naab et al., 2019). Often, these experiences are internalized due to the stigma of infertility and help-seeking in Nigerian culture. According to Lewis et al. (2017), when perceived discrimination is experienced multiple times over the lifespan and goes untreated, this may lead to depression, anxiety, or further trauma.

Previous research has not considered the support and challenges of Nigerian women living in the United States who are diagnosed with infertility and have undergone infertility treatment. Current research on the prevalence of infertility in Nigerian women associated with sexually transmitted infections, inadequate mental health treatment, and the absence of research on how the stigma of infertility impacts Nigerian women's

psychological and sociocultural experiences authenticate the significance of this study. This qualitative study will discover the experiences of Nigerian women in the United States aged 50 or older who have been diagnosed with and received treatment for infertility. The study aimed to understand how infertility in Nigerian culture impacts these women's support and lived experiences. The in-depth exploration of these lived experiences could improve awareness of how infertility in Nigerian culture impacts Nigerian women.

In this chapter, I will discuss primary infertility, existing fertility treatment in Nigeria, and potential barriers to treatment. Following this section, the different facets of the psychological impact of infertility are cited to include key concepts related to depression, anxiety, posttraumatic stress disorder, and the psychological effects of this experience on Nigerian women. Furthermore, I described sociocultural implications associated with infertility, such as gender identity, cultural identity, pronatalist social norms and stigma, social isolation, instances of abuse, and marital and sexual relationships, as highlighted in previous literature. Additionally, the conceptual framework of this study, phenomenology, was discussed, followed by a chapter summary.

## Literature Search Strategy

In this literature review, I used online databases such as PsychArticles, Academic Search, PsychINFO, EBSCO, and ResearchGate, using the Walden Library and Google Scholar to obtain scholarly resources. The topic of infertility has often been regarded as a medical issue in previous literature, prompting my search to include medical journals in

addition to psychological journals (World Health Organization, 2020). In my search, I narrowed my findings by identifying specific publication dates to reflect the last 5 years and marking the qualifier of peer-reviewed journal articles. In the databases, I used key search terms to include *primary infertility*, *secondary infertility*, *mental health*, *mental illness*, *stigma*, *discrimination*, *treatment seeking*, *treatment*, *Nigeria*, *Nigerian women*, *psychosocial*, *anxiety*, *depression*, *abuse*, *psychological*, *sociocultural*, *PTSD*, and *trauma.* As I continued my search, I used combinations of search terms to obtain advanced search results, including *infertility* AND *mental illness* AND *Nigeria*; *treatment-seeking behavior* AND *Nigeria*; *women*, *fertility,* AND *depression;* and *infertility* AND *PTSD*. Furthermore, I searched for seminal literature on infertility in Nigeria, the existing mental health and fertility treatment in Nigeria, and literature specific to the stigma of infertility in Nigerian culture. The entirety of the literature obtained extended from 1994 to 2021.

## Conceptual Framework

Infertility is a life crisis impacting the psychosocial functioning of women who desire motherhood (Akpinar et al., 2019). The conceptual framework used for this study is phenomenology. To explore the psychosocial impact of the lived experiences of Nigerian women diagnosed with infertility, I discussed the origin and development of transcendental phenomenology (also interchangeably referred to as descriptive phenomenology), described the philosophical tenets of this approach, and provided a rationale for using this conceptual framework for this study.

**The Origins of Transcendental Phenomenology**

Lester (1999) defined phenomenology as a form of investigation used to explore phenomena and how they are perceived and experienced by individuals in the phenomenological event. Enyan et al. (2021) reported that phenomenology aims to describe a specific phenomenon as lived experiences that explain how an individual perceives a particular phenomenon. Creswell (1994) proposed that Husserl believed that phenomenology suspended all suppositions, was related to consciousness, and was based on the meaning of the individual's experience. Historians credit Edmund Husserl for defining phenomenology in the early 20th century (Kafle, 2013). Reiners (2012) recognized Edmund Husserl (1859-1938) as a German mathematician who founded the philosophical movement of phenomenology.

In 1900 and 1901, Husserl published a two-part series of his most important work, *The Logical Investigations*, an innovative pathway into the new philosophical era (Patton, 2019). Neubauer et al. (2019) reported Husserl's initial work focused on mathematics as the object of study but then examined other phenomena. According to Beyer (2020), Edmund Husserl referred to his original method as the Husserlian description, which sought to uncover or disclose the structures and forms of conscious experiences.

A Husserlian description typically begins by describing an experience in the first person. Moustakas (1994) suggested that pure transcendental phenomenology is grounded in the concept of setting aside all preconceived ideas (*epoché*) to see phenomena through unclouded glasses, thereby allowing the true meaning of phenomena to emerge with and within their own identity naturally. The use of ranscendental

phenomenology is unique. It requires researchers to remain conscious and self-reflective to focus on participants' lived experiences of a particular phenomenon. Dahlberg et al. (2008) contended Husserl developed transcendental phenomenology, where everyday conscious experiences were described while preconceived opinions were set aside or bracketed. Additionally, his work's key features and understanding of the phenomenological method can be grasped using its philosophical tenets, such as epoché, intentionality, noema, and noesis.

### *Epoché*

Husserl introduced the concept of consciously setting aside current thoughts, beliefs, and judgments, which lend themselves to bias, by using the Greek word "*epoché*" or "bracketing," which "means to stay away from or abstain" (Moustakas, 1994, pp. 890-895). Epoché, introduced around 1906, builds the essential core of the rranscendental phenomenological method and is proposed to be performed from a first-person point of view to ensure that the respective item is described exactly as is experienced or intended by the subject (Neubauer et al., 2019). Husserl broke epoché into two distinct categories: universal and local. Universal epoché requires leaving behind *all* assumptions of existence, whereas local epoché requires setting aside only certain assumptions, requiring an individual to bracket assumptions of existence (Beyer, 2020).

### *Intentionality*

Husserl referred to the study of units of consciousness as intentionality, originally coined by his predecessor, Franz Brentanos. Davidsen (2013) claimed intentionality is the central concept in the philosophy of mind, and Husserl's phenomenology is also regarded

as the “fundamental property of consciousness” and the “principal theme of phenomenology” (p. 318-339). According to Beyer (2020), Husserl labeled the units of consciousness as *intentional acts* and *experiences*. Mabaquiao (2005) suggested intentionality is a directedness or an intentional awareness of what an individual thinks, feels, and acts in a person’s lifeworld.

### *Noema*

Husserl introduces the concept of *Noema*, a social phenomenon considered an intentional thinking object belonging to thinking and thoughts (Shahabi & Rassi, 2015). The noetic-noematic schema is believed to represent the connection between an individual and the world (Sousa, 2014). According to Moustakas (1994), noema ascribes meaning to what one sees, touches, thinks, or feels, observing what each experience means for an individual.

### *Noesis*

Blanchard (2013) described *Noesis* as how noema is experienced through perceiving, feeling, thinking, remembering, or judging. Ashworth and Greasley (2009) identified noesis as the “mental orientation to learning and reported it reflects the noema, which provides the part of an act that gives character to an object or thing.” Shahabi and Rassi (2015) further illuminated that noesis gives meaning to an intentional act, and noema is a meaning given to an intentional act.

## Literature Review Related to Key Concepts and/or Variables

This literature review section will highlight key concepts related to this study. An overview of the cultural identity, cultural meaning of children, and gender identity

specific to Nigerian culture will be discussed. Next, I will review the psychological impact, sociocultural impact, forms of abuse, and stigma of infertility specific to Nigerian culture. Last, I will explore the prevalence of infertility in Nigeria, existing infertility treatment, and existing barriers to treatment.

**Cultural Identity**

Nigeria comprises three major ethnic groups, Hausa/Fulani, Igbo, and Yoruba, all with distinct sociocultural identities (Ayo, 2019). Cultural identity is socially constructed and is a psychological and sociopolitical process that refers to how individuals or groups define themselves along the spectrum of these elements (Nieto, 2010). Nigerian culture encompasses a rich set of beliefs, customs, traditions, and value systems inherited and learned through contributing environmental factors. Bello et al. (2021) proclaimed within Nigerian culture, a high "premium" is placed on childbirth, with an expectation for all couples to procreate. In Nigeria, specifically among the Yoruba tribe, women are not socially accepted into adulthood until the specific milestones of marriage and motherhood have been achieved.

In Mbiti's (1996) book entitled *Introduction to African Religion*, he observed that the birth of a child puts the family on a social, religious, and physical map of the community, which specifically places the woman in a class of relevance as she can now be perceived as a full person. Oul Pearce (1996) confirmed that children enable individuals, extended families, and lineages to be taken seriously and achieve the required status. Koster (2010) reported for Yoruba men and women, the main aim of marriage is to have children, and in fact, a childless marriage is regarded as unsuccessful.

Though couples share the responsibility of infertility, Nigerian culture's perception is that women bear the larger burden of the associated stigma due to sociocultural beliefs that reproduction is the woman´s primary responsibility (Dimka & Dein, 2013; Hollos & Whitehouse, 2014). Studies show that infertile women are more likely to be economically disadvantaged, suffer psychological distress, be socially stigmatized, and suffer intimate partner violence than fertile women (Aduloju et al., 2015; Dimka & Dein, 2013; Hollos & Whitehouse, 2014; Ibisomi, & Mudege, 2014; Omoaregba et al., 2011). Furthermore, studies on Nigerian culture have shown that women experience blame for infertility by other members of the Yoruba community, and they also risk abuse and neglect by their husbands and in-laws, divorce, and accusations of witchcraft (Koster, 2010).

From a socioeconomic standpoint, Yoruba women live with the central focus of their lives being on the family and their economic responsibilities as adults emanating from their kin-based responsibilities as mothers, wives, and daughters (Olu Pearce, 1999). Women who do not bear children often face difficult marital relations that typically end in divorce, permanent separation, or the women being forced to leave the marital home after enduring mistreatment from her husband, his family, and co-wives who reside in the home. According to Hollos and Whitehouse (2014), women who do not bear children are at an economic disadvantage and are plagued with concerns regarding where to live and how to survive in their old age; as quite a few of these women are divorced, they have no rights to live in their husband’s homes.

In Amakiri, Delta State, a large state in Nigeria, infertile women often become homeless during late adulthood because they have no legal rights to reside in the home of

their deceased husband unless a son has been born (Hollos, 2009). If a woman faces this tragedy, she is left to return to her father's dwellings. If her father is no longer living, she may be tasked to live with a sibling upon gaining permission from their spouse and may assume the role of a caregiver or housemaid for that home and the children within the home (Hollos & Whitehouse, 2014).

Similarly, fertility has been the cornerstone of important developmental life stages in other developing countries, impacting a woman's identity, social functioning, and development. For instance, according to Hasanpoor-Azghady et al. (2019), Iranian culture considers children to be divine blessings and childlessness to be unpleasant. Iranian women diagnosed with infertility endure a lack of social and economic support, low chances of remarriage, and condemnation of solitary life (Fahami et al., 2010). A study conducted in Rwanda revealed that women with infertility were verbally harassed by their in-laws, and their husbands were pressured to have extramarital affairs due to the cultural expectation of a woman's responsibility to procreate (Rouchou, 2013). Men in South Africa admitted that members of their community used derogatory terms such as "failure" and "castrated cow" to humiliate women who have infertility and to initiate social isolation (Dyer et al., 2004). A study conducted in Hong Kong revealed the purpose of the family is the continuation of the family line, and women who are unable to bear a child are considered to violate *filial piety* (family goodness) and are viewed as a disappointment in the eyes of their husbands and in-laws (Tiu et al., 2018). Another study in South Asia confirmed that people diagnosed with infertility experience sociocultural pressures for conception. They are perceived to be defective, socially inept, and exposed

to negative social attitudes, contributing to their overall distress (Patel et al., 2018). In Vietnamese culture, emphasis is also placed on childbearing. The family is the most important unit (Inhorn & Balen, 2002). For women in this culture, childbearing stabilizes their marriage and strengthens family bonds (Nga, 2005).

Multiple studies have described the social consequences of infertility in developing countries. One of the main concerns for women diagnosed with involuntary childlessness in developing countries is the social and cultural ramifications (Hollos & Whitehouse, 2014). The sociocultural implications of infertility depend largely on the support provided to women diagnosed with infertility within their specific culture (Nieto, 2010). Women plagued with involuntary childlessness are often left with negative impacts on self-esteem, lack of social acceptance of womanhood, marital discord, and questions regarding their true gender identity.

**Gender Identity**

Gender identity has historically been associated with an individual's biologically assigned genetic makeup and informs biological and social factors in an individual's life. Slavin and Slaughter (2021) proposed our unique gender identity influences our behaviors, attitudes, and understanding of self and further helps to develop our knowledge about cultural expectations for people. Kretchmar (2021) suggested that social-learning theory reinforces positively and negatively gender-appropriate and inappropriate behavior as children learn by observing and imitating the behavior of same-sex adults.

According to Friebel et al. (2021), social and cultural norms significantly influence gender identity and the nature of social interactions between genders. Wharton (2005) believed gender is socially constructed and not grounded in any physiological basis. The concept of gender identity contributes to various gender stereotypes that initiate cultural guidelines and beliefs about gender-specific categories relevant to the social identity of both men and women. According to Arowolo (2010), gender issues are unimportant in traditional African societies because everybody has one role and individual responsibility to perform in the family and community.

Turbulence does not occur in traditional African societies until gender roles, responsibilities, and expectations are disturbed. Olonade et al. (2021) posit women in Africa reserve the social responsibilities of caring for children, providing for elderly family members, and maintaining cordial relations with relatives and neighbors by exchanging gifts and visits. In the traditional patriarchal social order, African women have two distinct roles and responsibilities based on gender alone: to become mothers and wives. Both are inseparable, with reproduction as the primary purpose (Iwelumor et al., 2020). African culture holds high expectations of both men's and women's responsibility to contribute to the development of society (Afisi, 2010). Nevertheless, African women are expected to reserve the power to organize the family and maintain the family's survival (Iwelumor et al., 2020).

Afisi (2010) confirmed that gender inequality has penetrated all aspects of Nigerian society, especially when women are faced with involuntary childlessness. According to Clark et al. (2006), many women experience infertility as a direct strike

against their self-identity, in contrast to men who experience infertility more indirectly and externally. Kitzinger and Willmott (2002) reported a “cultural disorder,” as infertility threatens a woman’s familial aspirations and gendered sense of self. Reissman (2002) examined how South Indian women with infertility negotiate their womanhood and found that women manage their gender through deflection of blame, maintenance of other identities, and flexible conceptualizations of parenting. In a study conducted in the United States, Bell (2019) explored how a group of 58 infertile women negotiate their gender and found that because of a pronatalist society, many women view infertility as being half of a woman if they cannot bear children, as their reproductive and procreation capabilities are tied to their identities.

The concept of infertility remains complex concerning many women's biological and gender identities. Many women who face unforeseen medical conditions and diseases such as cancer, endometriosis, thyroid disease, and polycystic ovary syndrome may experience the trauma of infertility, posing greater threats to their gender identity (Tschudin & Bitzer, 2009). Invasive treatments such as chemotherapy, radiotherapy, and bone marrow transplants can produce early menopause or uterine damage in women, further contributing to primary or secondary infertility (Tschudin & Bitzer, 2009). According to Benedict et al. (2018), women whose fertility is central to gender identity reported failing to live up to societal expectations of normal adult identity and experiencing biological disruption caused by chronic illness.

Alamin et al. (2020) reported that having a child is essential for developing gender identity for women and adults in many cultures. Zandi et al. (2017) examined a

study conducted on Iranian women that found that women diagnosed with infertility struggle with their gender identity and reported concerns about their distortions of family identity, including doubt, mistrust, and insecurities. Mumtaz et al. (2013) conveyed that in highly pronatalist and patriarchal societies like Pakistan, the social construction of infertility and childlessness strongly impacts a woman's individual and social identity as her ability to bear children is believed to cement bonds that hold a husband and wife together, leaving childless women in unstable and precarious relationships, while often facing harsh social and sometimes physical consequences. Furthermore, previous studies conducted in third-world countries, such as Japan, Kuwait, and Turkey, revealed women diagnosed with infertility described the formation of their gender identity in the absence of childbearing as having a negative identity, in addition to experiencing a sense of worthlessness and inadequacy, feeling of lack of personal control, anger, and resentment, grief, and depression, anxiety, and stress, lower life satisfaction, the envy of another mother, loss of the dream of co-creating,  being overwhelmed with intense emotions, and a sense of isolation (Becker & Becker, 2020; Mumtaz et al., 2013).

The difficulties of involuntary childlessness for many women influence the connection between infertility and the formation of gender identity. Alamin et al. (2020) suggested women in developing countries experience failure in identity building as a challenge of infertility and continue to struggle with the psychological and emotional aspects of the issue. The literature review reveals the overall prevalence of the psycho-emotional consequences associated with infertility in pronatalist societies.

**Cultural Meaning of Children**

Nigeria is a patriarchal society, where men have a dominant influence on fertility and the use of contraceptives, usually resulting in the men deciding on how many children a woman will have (Adewole et al., 2020). Large family size has been a cultural ideal for many families in Nigeria. While exploring contextual factors such as sociocultural norms, beliefs, preferences, and perceptions, researchers have explored the reason for family size and fertility behavior in Nigeria.

In the Nigerian context, childbearing has been considered a large part of marital fulfillment and linked to marital satisfaction. Thompson (2001) further suggested that for most couples, the desire to have multiple children is viewed as a source of honor, wealth, and prestige. Importantly enough, the size of a family could also be a determining factor in a couple's overall wealth in the community and physical health among both the parents and children. From a socioeconomic context, family and childbearing norms are particularly important. Akinyemi and Odimegwu (2021) stated a man's socioeconomic status is a large determinant of family size and fertility behavior among Nigerian men. Hyeladi et al. (2014) reported a strong correlation between family size and poverty levels. Men with nonprofessional occupations and secondary education are likelier to have larger family sizes due to peer pressure and the need to establish themselves in the community (Adewole et al., 2020). Due to this belief, larger families are more susceptible to high poverty levels. Previous research has noted that large family size affects the sustainability of food, shelter, clothing, health care, and education. LeGrand and Mbacke (2003) expressed concerns that large family sizes further contribute to deviance and illiteracy

due to the demands of more resources to maintain the family's upkeep. Sahleyesus (2005) further contended that parents had limited resources to allocate to their children, resulting in less time and money to invest in their children's education and emotional health, ultimately hindering their children's social and emotional growth and development.

From a cultural standpoint, men and women are encouraged to have several children. According to Adewole et al. (2020), a high premium is placed on male children, further encouraging couples to have multiple children until they have obtained the desired sex preference of the child. Religion is another prominent role in the number of children families in Nigeria. According to Diamant (2019), roughly 50% of Nigerians identify as Muslims, while 48.1% identify as Christians. Religions such as Christianity do not all support the use of modern contraceptives and prohibit abortions. At the same time, Islam encourages early marriages, large family sizes, and polygamous marriages with co-wives to increase the family size (Eboh et al., 2017).

Large family size remains a cultural norm in Nigeria. Several contextual factors and the patriarchal family system strongly influence a couple's decision to bear multiple children. Previous studies show that religious orientations and beliefs, education level, and socioeconomic status strongly impact the preference for family size.

**Psychological Impact of Infertility**

The World Health Organization estimates that in sub-Saharan Africa, the prevalence of infertility ranges from 9% to 30%, estimated at 10.5% and 14.6% in Nigeria (Cui, 2010). According to Wiersema et al. (2006), the way many people deal with infertility is influenced by the values and sociocultural norms of the community in which

they live. Historical data has shown that many women have been subjected to psychological crises when reproduction seems impossible. Griel (1997) identified infertility as a multidimensional stressor requiring several kinds of emotional adjustments. According to Ying et al. (2015), many women's infertility is accompanied by extensive psychological changes, such as depression. Nik Hazlina et al. (2022) confirmed infertility has often been associated with the psychological prevalence of distress, anxiety, depression, self-esteem, and other identified stressors. In a study conducted by Galhardo et al. (2011), it was reported that in the context of infertility, regardless of its cause, impaired mental health and, specifically, depression have been associated with negative psychological processes, such as self-judgment and shame deriving from a women's belief of being incomplete, damaged, and being viewed by others as flawed and inferior.

### *Depression*

Depression is considered one of the major psychological disorders associated with infertility. It may significantly affect the lives of infertile individuals, their treatment, and their follow-up to treatment (Al-Homaidan, 2011). It has been described as a major problem associated with infertility, resulting in significant morbidity and mortality, especially in Africa, where children are highly valued for various sociocultural and economic reasons (Alhassan et al., 2014). The prevalence of depression among women diagnosed with infertility in African countries such as Nigeria has ranged from 39.5% to 52.7% (Oladeji & OlaOlorun, 2018). In developing and developed pronatalist societies, most women diagnosed with infertility do not share their experiences with family and

friends due to the social stigma and fear of loneliness, further contributing to social isolation and low self-esteem. Umezulike and Efetie (2004) reported these problems inevitably affect their quality of life, leaving some afflicted females to contemplate suicide and death, given the widespread social pressures and symptoms of depression.

Bailey et al. (2011) noted that women of African descent are more likely to seek help for somatic symptoms than European American women. They provide examples of physical symptoms associated with depression that primary care physicians may overlook. Examples of physical symptoms that manifest as a result of depression include headaches, back pain, muscle aches, joint pain, chest pain, and digestive problems (Bailey et al., 2011). Bailey et al. found that most women of African descent view depression as a sign of weakness and prefer to deal with it themselves. The researchers also found that women of African descent prefer to deal with depression by relying on their faith and prayer.

The psychological impact of infertility has been recognized worldwide. In a study conducted in South Asia in low and middle-income countries, Bhamani et al. (2020) proclaimed depression, anxiety, suicidal ideation, and poor quality of life are exhibited more in infertile women than fertile women. Vo et al. (2019) provided important evidence of the prevalence of depression among Vietnamese women diagnosed with infertility. They found that depression among infertile women in Vietnam was higher than that among the general population. According to Alimohamadi et al. (2020), roughly 86% of infertile couples in Iran reported experiencing shame, guilt, and feelings of low self-esteem, leading to depression. Another study in Sweden reported that major

depression was the most common mood disorder among infertile couples, with 10.9% in women and 5.1% in men (Volgsten et al., 2008). Studies in other developing countries also show a high prevalence of depression in women diagnosed with infertility.

Crawford et al. (2017) provided a closer look into Western society. Most infertile couples believe that infertility induces considerable life stress, and patients with infertility are more likely to suffer from a psychiatric illness than fertile patients. In recent studies, Williams and Zappert (2006) examined the relationship between infertility and grief. They found that women diagnosed with infertility may experience reactions that prolong into pathological grief, leading to major depression. The inability or difficulty to conceive is a major contributor to emotional turmoil. James and Singh (2018) confirmed grief was the most common state of emotion individuals or couples felt after a failure at successful conception. According to Swanson and Braverman (2021), many with infertility experience disenfranchised grief, which is intense grief others perceive as a minor loss. Harvey (2004) describes disenfranchised grief as a lost relationship that is not socially recognized and, therefore, not justified in grieving. The loss creates vulnerability in individuals and couples experiencing infertility, generating a higher risk of disruptiveness of daily life patterns. According to Yazdi et al. (2020), infertility is not life-threatening. However, it maintains intense sociocultural consequences, usually imposing severe stress and anxiety on many women.

**Sociocultural Impact of Infertility**

The sociocultural construction of fertility stems from the importance placed on procreation by individuals and societies (Patel et al., 2018). Sociocultural impacts may be

defined as the impacts of an event on the day-to-day life of people associated directly or indirectly with that event and on the values, attitudes, beliefs, and traditions that determine or guide that day-to-day life (Wall & Mathieson, 2006). A sociocultural environment combines social and cultural factors, including attitudes and beliefs, religion, customs, values, education, and social organizations (Masovic, 2018). The expectation of procreation burdens couples to conceive immediately after marriage, making infertility a socially constructed process where individuals define their inability to give birth as a problem (Griel et al., 2010). Previous literature on infertility highlights the importance of the sociocultural implications shaping the lived experience of women diagnosed with infertility.

According to Caldwell's intergenerational wealth flows theory, the expectation for children to care for their parents in their old age solidifies the significance of procreation in low and middle-income countries, further emphasizing the inability to conceive a child as a negative impact that not only affects the individual but the community as well (Kaplan & Block, 2001). Parry (2005) identified pronatalism as one characteristic of a sociocultural implication influencing infertility. From a religious standpoint, many religious faiths consider the importance of childbearing and fertility. In the Islamic faith, Muslims believe that motherhood is highly regarded, and pronatalist views of procreation are strongly supported (Bhatti et al., 1999). In Christianity, some Christians consider procreation and the ability to bear children a blessing from God (Sewpaul, 1999). Furthermore, Schenker (2005) reported that Judaism encourages

followers of this religion to procreate and even allows for the use of artificial means to promote this purpose.

From a socioeconomic viewpoint, the consequences of involuntary childlessness in developing countries may also contribute to economic hardship for individuals experiencing infertility. In Asian cultures, many families depend on children for economic survival in later adulthood (Abdallah & Daar, 2002). For instance, in Vietnam, issues concerning inadequate pension provisions for retired individuals contribute to one reason: children play a crucial role in supporting their elderly parents financially or practically (Van Bich, 2013). A study in Iran revealed that infertile women might experience economic deprivation due to infertility's public and unpleasant stigma (Serour, 2008). In sub-Saharan African studies, another major socioeconomic issue related to infertility has been inadequate health care and the impoverishing cost of health care. Dyer and Patel (2012) confirmed infertility might cause impoverishing health costs and economic instability or deprivation, secondary to social consequences.

The economic implications of infertility in developing countries pose several consequences for individuals suffering from involuntary childlessness. Specific to Nigerian culture, social and economic contextual factors strongly influence the local meaning of fertility and infertility. Hollos and Whitehouse (2014) suggested fertility remains crucial to women’s progression through life stages and contributes to their identity into full adult womanhood. The implications of involuntary childlessness in developing countries persist far beyond psychosocial and economic factors. Many forms

of abuse have been associated with female infertility, further complicating the negative consequences associated with this experience.

**Forms of Abuse Against Women with Infertility**

According to Adeyemi et al. (2006), violence against women refers to physical acts of violence, such as domestic abuse, sexual coercion, physical and verbal threats, psychological abuse, and controlling actions, including physical isolation and restricting access to health care or financial resources. Since violence toward infertile women causes serious problems in women's physical and mental health, it remains a major issue in developing countries. When fertile and infertile women were compared, it was found that infertile women are twice as likely to suffer various forms of abuse than women with children (Ardabily et al., 2011; Sis Çelik & Kırca, 2018). Stephenson et al. (2006) stated evidence in developing countries revealed an alarming prevalence of violence against women, suggesting anywhere between 10% to 60% of married women of reproductive age reported experiencing some form of abuse related to infertility issues. Previous studies conducted in Nigeria also lend credence to the prevalence of abuse against women who have infertility.

Effah (2001) identified common forms of abuse against infertile women in Nigeria, including verbal abuse, battery, acid baths, spousal murder, incest, neglect, abandonment, and sexual harassment. A study conducted in Turkey found that one in three Turkish women were exposed to abuse or violence for the first time after being diagnosed with infertility (Ardabily, 2011). In a study by Lotfy et al. (2019), domestic violence was strongly prevalent among infertile Egyptian women. The most common

forms of abuse were psychological violence and verbal abuse. Furthermore, Sheikhan et al. (2014) found a prevalence of domestic violence against infertile Iranian women at 33.6%, including psychological violence, physical violence, and sexual violence in women diagnosed with infertility.

The prevalence of physical, emotional, and sexual abuse in developing countries among women diagnosed with infertility remains a major issue. Violence against women is a universally devastating and consequential experience for those adversely affected. The negative consequences of women suffering from involuntary childlessness remain deeply rooted in infertility's meanings and perceptions. Infertility stigma and its related social and psychological pressures continue to influence the lives and well-being of many women.

**Stigma of Infertility**

In many cultures, the desire to have and have children has been seen as a societal norm, placing people who do not conform to this norm at risk of stigmatization. Infertility stigma is associated with various psychological and social tensions, producing feelings of shame and secrecy for many women (Pacheco & Lourenço, 2011; Fledderjohann, 2012). Stigma is a negative feeling of being different from others in society and being on the opposing end of social norms (Goffman, 2009). According to Mahboubeh Taebi et al. (2021), many women experience infertility as a stigma. Stigma can be profiled in many ways, including social stigmas, verbal stigma, and self-stigma. Stigmatization involves perceiving that the stigmatized individual is labeled, stereotyped, rejected, and isolated from social organizations. Consequently, people may stigmatize themselves, develop

negative beliefs about themselves, experience diminished self-confidence and self-sufficiency, and isolate themselves from social organizations (Sternke & Abrahamson, 2015).

The experience of infertility in Nigeria is culturally constructed to be a woman's problem rather than a problem belonging to the couple. These cultural constructions form various infertility-related stigma sources, often solely experienced by the woman (Naab et al., 2019). Therefore, the stigma associated with infertility among Nigerian women is overwhelmingly experienced, as these women are labeled and perceived negatively by community members (Upkong & Orji, 2007; Damika & Dean, 2013). Despite the advances in fertility treatment, studies in other countries have indicated that the stigma of infertility continues to have negative health consequences (Donkor & Sandall, 2007). Understanding the prevalence of infertility and the associated consequences in developing countries such as Nigeria can create cultural shifts in the perception of infertility, raise much-needed awareness, and break the stigma of infertility.

**Infertility in Nigeria**

Infertility is a public health concern that varies widely worldwide, affecting roughly 5%–8% of couples (Okonofua, 2003). Significant geographical differences affect primary and secondary infertility and can be explained by environmental, cultural, and socioeconomic influences. Several studies have shown that infertility is prevalent in sizeable areas of sub-Saharan Africa. According to Chimbatata and Malimba (2016), the prevalence of infertility in sub-Saharan Africa is higher, with 10%–30% of Nigerian couples being affected during their reproductive lives. Secondary infertility has been

more prevalent than primary infertility, which is higher in other regions of the world (Gerais & Rushwan, 1992). The most common causes of infertility in developing countries are tubal occlusions, sexually transmitted diseases including chlamydia and gonorrhea, complications of unsafe abortions, and pregnancy-related infections (Odunvbun et al., 2018). Additional risk factors increasing the chances of infertility among this population are poor education, poverty, negative cultural attitudes toward women, and lack of access to contraception (Ombelet, 2011). Women suffer from infertility issues in developing countries at alarmingly large rates. The literature on this topic has shown that many variable causes contribute to this issue. The level of existing infertility treatment continues to differ worldwide. Ombelet (2011) confirmed that infertility care is probably the most neglected and underestimated health care concern in developing countries. Consequently, most infertility cases are only accessible and treatable when access to quality care exists.

**Infertility Treatment in Nigeria**

Though significant advances in health care and mental health services have been established over the years in developing countries, the need for adequate infertility-related treatment continues to be explored. The relationship between infertility and psychiatric disorders has been a cause for concern over the past several years. According to Rooney and Domar (2018), despite the prevalence of infertility, it is important to recognize, acknowledge, and assist patients as they cope with their infertility diagnosis and treatment. Determining what health care and mental health services currently exist for women diagnosed with infertility in Nigeria is important.

### *Mental Health Services*

According to the World Health Organization (2017), Nigeria has limited access to available mental health services to accommodate the rising number of individuals with mental health disorders. Currently, there are only eight neuropsychiatric hospitals in the country responsible for teaching and developing psychiatric doctors and managing patients suffering from intellectual impairments and acute psychiatric disorders (Osigbesan, 2021). Individuals diagnosed with psychiatric disorders receive inpatient or outpatient treatment in health care centers within their communities, often managed by psychiatrists, nurses, social workers, occupational therapists, support staff, and religious members of the clergy (Khalid et al., 2020).

The current population in Nigeria is estimated at over 190,000,000 people, with fewer than 300 psychiatrists in the country. Most of them retain poor knowledge of mental health disorders at the primary health care level (Ugochukwu et al., 2020). Odejide and Morakinyo (2003) reported that though mental health services are provided at the primary health care level, the level of care offered is minimal due to deeply rooted negative attitudes and superstitious beliefs about mental disorders. Patients benefit more from receiving services at private general practices or government-owned hospitals. Despite the growing efforts of the mental health profession in Nigeria, the roles of traditional and religious healers are more frequently sought after due to accessibility and cost-effectiveness.

Previous studies have shown the gap between the rising numbers of individuals with mental illness and the need for adequate and quality mental health services. The

needs and challenges of mental health services in Nigeria are diverse and much greater than what is represented in the literature. Though the country strives to elevate the mental health services provided, many individuals and couples are also burdened with challenges to the existing health care system. Due to the alarmingly large numbers of couples and individuals suffering from reproductive issues, additional attention is also needed regarding the availability and accessibility of Nigeria's health care system as it relates to infertility.

### *Health Care Services*

Nigeria's health care system has three tiers following the structure of the Nigerian government: federal, state, and local. All three tiers mutually control the primary, secondary, and tertiary health care system. Wada et al. (2021) explained that the Federal government handles tertiary health care services, managing federal medical centers, specialist hospitals, and teaching hospitals. The tertiary health care system also creates medical regulatory bodies and schemes and invests in the other tiers of health care. The state government controls the secondary health care system, comprising comprehensive health care centers and general hospitals (Koce et al., 2019). Last, the Local government takes care of primary health services, including health centers under their authority and public health care services, such as immunizations.

The health care system in Nigeria faces many challenges and is considered one of the worst globally. According to the World Health Organization, Nigeria's health care system has been ranked the fourth worst medical system globally, at 187th among 191 rankings of medical systems (Akinbode et al., 2019). The problem with Nigeria's health

care system includes a lack of coordination between services, financial resources provided by the government, poor and decaying infrastructures, limited access to care, and little to no health insurance for the country's citizens (Welcome, 2011).

Few fertility management programs exist regarding infertility treatment due to limited access and insufficient resources in Nigeria (Omoaregba et al., 2011; James et al., 2018). There are three main forms of fertility treatment available for individuals who are seeking treatment: the use of medicines, surgical procedures, and assisted conception-including intrauterine insemination and in vitro fertilization. An even bigger obstacle for women and couples diagnosed with infertility in Nigeria is the cost implications of treatment, such as planning, neonatal intensive care, and maternal post-partum care (Gleicher, 2000). Despite the advances in modern medicine, treatment barriers still exist due to inadequate and costly health care, further contributing to the country's prevalence of infertility.

**Barriers to Treatment of Infertility**

Waliyanti et al. (2018) reported that treatment-seeking behavior refers to individuals' and households' actions to bring about a better health condition earlier worsened by illness. In Nigeria, treatment-seeking behavior can be affected by the nature of the Nigerian health care system and other socioeconomic and sociocultural factors (Urama et al., 2021). One of the main barriers that prevent treatment seeking among women diagnosed with infertility is stigma. The stigma of infertility enhances discriminatory behavior and ignorance toward involuntary childlessness, increasing the challenges of sought-after care. Other practical barriers to treatment-seeking behaviors in

women diagnosed with infertility include a general lack of mental health awareness, cost of treatment, poor knowledge of how to access service, and long waiting times.

Many Nigerians living in rural areas are disadvantaged and may not be aware of services to help them understand and treat mental and physical illnesses. Issues with political instability and limited infrastructure often hinder crucial financial resources and legislation from reaching the people needing care. Infertility-related mental health concerns and health care services should be available throughout the health care system to encourage residents to access them locally and affordably (Jack-Ide & Uys, 2013). In a review of the previous literature, there remains a need to raise the visibility of infertility-related issues and barriers to treatment seeking among women diagnosed with infertility.

## Summary

Infertility remains a huge burden on the experiences of Nigerian women. The importance of gender and cultural identity impacts many women struggling with infertility (Alamin et al., 2020). Due to the high value placed on children in developing countries and negative perceptions of involuntary childlessness, many women suffer various forms of abuse. They are disproportionately stigmatized for their inability to meet the societal expectations of motherhood (Cui, 2010). Despite the known consequences of infertility in Nigerian women, the country continues to struggle with expensive health care, inadequate mental health services, and existing treatment barriers to serve this population. The disadvantages discussed in this literature review justify this study of Nigerian women who have undergone infertility treatment.

In this chapter, I highlighted the key variables that informed this study. A description of the cultural and gender identity specific to Nigerian culture was discussed. I also explored the psychological impact, sociocultural impact, forms of abuse, and stigma of infertility witnessed in Nigerian culture. Last, I provided an overview of the prevalence of infertility in Nigeria, current infertility treatment, and current barriers to said treatment. In the following section, Chapter 3 of this study, I will present the methodology used to carry out this study.

# Chapter 3: Research Method

This qualitative transcendental phenomenological study explored the experiences of Nigerian women living in the United States who have been diagnosed with infertility and received infertility treatment. By interviewing Nigerian women diagnosed with primary infertility and who have completed their reproductive journey, I describe the phenomenon of the Nigerian woman's experiences of living with infertility issues. As a result of this study, counselor educators, supervisors, and counselors may assist in explaining how Nigerian women experience psychological and sociocultural consequences of infertility and assess the support and challenges of migrant Nigerian women in the United States. The research question for this study was, What are the lived experiences of Nigerian women living in the United States who have been diagnosed with infertility and received infertility treatment? I will begin this chapter by reviewing the research design and rationale. I will also discuss my role as the researcher, the study's methodology, issues of trustworthiness, and ethical procedures for this study.

## Research Design and Rationale

Existing research has validated the relevance of transcendental phenomenology in studies seeking to understand human experiences (Moustakas, 1994). This appropriate design provides in-depth, bounded descriptions within a real-life, contemporary context (Creswell & Poth, 2018). In the methodology section of this study, I also provide logical, organized, and coherent design essentials that contribute to an indispensable description of the experiences gathered in the proposed study. The counseling profession may consider several ways to incorporate cultural relevance and care by reviewing the in-

depth description of the experiences and perceptions of the research participants who have participated in this study. This study provides rich, reflective components to add to a body of research that contributes to understanding how culturally relevant pedagogy is used, retained, and understood.

## Role of the Researcher

As the primary instrument in this qualitative research study, my role as the researcher was to engage and observe research participants during the data collection and analysis process using a semistructured approach to interviewing and questionnaires to capture the rich experiences of research participants while maintaining and controlling researcher bias. I used transcendental phenomenology, a qualitative approach that allows the researcher to practice epoché, a process of suspension of judgment, allowing researchers to set aside their assumptions and beliefs (Creswell, 1998; Merriam, 2009; Moustakas, 1994). Creswell (1998) contended that researchers should relinquish their personal biases and look at the phenomenon with fresh eyes. Moustakas (1994) posited that when using the transcendental phenomenological method, the researcher will practice epoché, describing their own experiences free of bias. Moustakas further reported that it is important that the researcher has experienced the same phenomenon so that the researcher's experiences and the participants' experiences can connect. This methodology allows room for participant subjectivity, encouraging the opportunity for research participants to make meaning of their experiences and feelings.

Understanding the pivotal role of the researcher in light of shared experiences with participants is critical. Qualitative methods facilitate a deeper grasp of participants'

subjective experiences, with reflexivity being key. Rather than overlooking biases, reflexivity urges researchers to acknowledge and articulate their perspectives, enabling readers to comprehend the influence on questions, data collection methods, analysis, and findings (Sutton & Austin, 2015). Engaging in reflection throughout the research process allowed me to offer meaningful context regarding data collection, analysis, and result reporting to enhance reader understanding.

Creswell and Creswell (2018) described positionality as an activity in which a researcher identifies examines, and owns their backgrounds, perspectives, experiences, and biases to strengthen research quality. Like many qualitative researchers, I maintained a delicate connection with this research topic grounded in personal experiences. Based on my heightened awareness of this close connection, I bracketed my presuppositions, potential biases, perceptions, and experiences related to this topic so as not to distort the findings of this study or unintentionally impose them on the research participants' lived experiences. My interest in the issue of infertility in Nigerian women surfaced 10 years ago during my postgraduate studies in pursuit of my master's degree. At that time, I had recently been informed of my mother's previous struggles with secondary infertility. This raised my awareness as a young first-generation Nigerian American woman, also struggling with the experiences of two ectopic pregnancies, both resulting in failed fecundity. My mother and father migrated to the United States as immigrants from Lagos, Nigeria, and held to their traditions, values, and ways of thinking and being. My limited knowledge about the prevalence of infertility in underdeveloped countries, specifically

Nigeria, caused me to reflect on my own experiences and my mother's and other women in the Nigerian community close to our family.

As I matured as a woman in the Nigerian community in the United States, I witnessed the malice projected upon the older "aunties" and "madams" who had not yet borne children and were further exposed to the stigma of infertility by the Nigerian community. I also began to intermittently experience ignominy and dismissive treatment from the Nigerian community for not reaching the significant milestone of motherhood. Despite all other accomplishments, I began focusing on infertility's prevalence and psychosocial implications in Nigerian women.

Considering my familiarity with this research project and my personal experiences, I developed personal and professional awareness of my responsibilities as a licensed clinician and doctoral researcher in the Counselor Education and Supervision program and field of counseling. Through my ability to identify and manage potential biases and implications, I used Edmund Husserl's descriptive phenomenology to investigate the research significance further. Descriptive phenomenology helped me maintain an unbiased perspective of the phenomenon by allowing me to preserve positionality, suspend suppositions, and engage in in-depth self-awareness.

**Means of Addressing Researcher Bias**

To address researcher bias, I constantly contacted my dissertation chair and committee members throughout the process. One way to ensure regular communication with my dissertation chair and committee members is by scheduling biweekly or monthly meetings to address any concerns regarding the dissertation process. Additionally, I

anticipated retaining a relationship like the therapeutic alliance with research participants to ensure impartiality while working with them and engaging in the research process. Furthermore, I engaged in ongoing self-reflection and examination to safeguard my mental and emotional health during the research process. I also incorporated well-defined and established self-care strategies to promote stress reduction, anxiety management, and overall balanced health and wellness.

## Methodology

The nature of this study included an exploratory transcendental phenomenological approach. Using the transcendental phenomenological approach helped to explore a person or person's consciousness to perceive life through experiences and the meanings around them, which are defined in the individual's interpretations (Fuster, 2019). Considering the experiences and interpretations of infertile Nigerian women's lived experiences helped to explore the psychosocial impact of infertility. Despite previous literature on infertility in Nigerian women's psychological and emotional influences, there remains limited information on the support and challenges faced by Nigerian women living in the United States related to their infertility journey (Aiyenigba, 2019).

In this section, I will identify the targeted population and highlight the sampling and recruitment procedure. Further exploration of the data collection process will be provided in addition to the qualitative data collection methods used. Last, I highlighted the data analysis plan, ethical procedures, and trustworthiness issues.

**Participant Selection Logic**

Upon approval, the targeted population for this study included a sample size of 6 to 8 Nigerian women who live in the United States, are diagnosed with primary infertility, have undergone infertility treatment, and have reached the end of their reproductive stage. Although the sample size for this study calls for 6 to 8 participants, the data collection process continued until saturation of the data was reached. For this exploratory research, the participants who have self-identified or have been identified as Nigerian women are defined as women born or descended from the country of Nigeria and who can speak in one of the many Nigerian dialects, including Yoruba, Igbo, or Hausa language. Participants of this study will be aged fifty and above. The study included women who do not currently have children due to primary infertility.

Additional inclusion criteria included willingness to participate in this research study, ability to read and write, willingness to engage in the interviewing process, and access to and willingness to use videoconferencing programs. Research participants were also expected to be able to read and write due to the nature of self-report questionnaires. Demographic data, including age, gender, duration of infertility, and causes of infertility, was collected to include this information in an overview of the women participating in this study. The data collected helped determine the increased comparability with previous research studies on this population.

I used nonprobability purposive sampling based on a non-random inclusion criterion for this transcendental phenomenological study. Etikan et al. (2016) purport that the purposive sampling technique, often called judgment sampling, is the deliberate

process of participant selection because of the participants' qualities. Furthermore, the main emphasis in purposive sampling is to concentrate on individuals with characteristics who can better assist with the relevant research (Etikan et al., 2016). Additionally, consideration will be provided to the method of snowball sampling. According to Ungvarsky (2020), snowball sampling, often called chain sampling, is a method for recruiting research participants for research studies by people who have already participated in the study and are asked to recommend others to participate. This method has helped gather information regarding a specific group of individuals.

**Instrumentation**

I used 90-minute qualitative interviews and demographic questionnaires via videoconference for my research. Another data source used to assist with the data collection process was a participant demographic form, which was used to establish triangulation to enhance the validity and credibility of the findings of this research. Creswell (2018) explained in using qualitative interviews, the researcher conducts face-to-face interviews with participants, telephone interviews, or engages in focus group interviews with six to eight interviewees in each group with unstructured and open-ended interview questions.

**Procedures for Recruitment, Participation, and Data Collection**

For this study, I recruited research participants using social media networking sites, leveraging personal networks, and a group messaging application specific to Black Doctoral students who fit inclusion criteria and are willing to participate in the present study. Research participants were located throughout the United States and were provided

a demographic questionnaire to ensure inclusion criteria were met. Individuals who did not identify as Nigerian women who had not been diagnosed with primary infertility were excluded from this study.

A historical literature review related to the study topic was conducted to determine the appropriate sample size for this qualitative study. According to Vasileiou et al. (2018), the goal of qualitative research should be to set and justify an acceptable sample size to ensure saturation. Historical research suggests that samples in qualitative research tend to be smaller to support information-rich case-oriented analysis (Vasileiou et al., 2018). Sandelowski (1995) recommends that qualitative sample sizes be large enough to allow the discovery of new and richly textured information about the phenomenon yet small enough so that qualitative data's deep, case-oriented analysis is not precluded. Boddy (2016) confirmed theoretical saturation could be useful as a guide in designing qualitative research, with practical research showing that twelve samples may be cases where data saturation occurs. Based on the information found related to the appropriate sample size for qualitative research, the recommended sample size for this study is between six and eight participants to ensure study validity.

To recruit research participants using social media networking sites and group messaging applications, I accessed social media groups specific to Nigerian and Nigerian American women to recruit the sample for this study. Upon accessing each group, I requested permission to recruit participants while explaining the nature of the study. Additionally, I gained approval from my committee and Walden University's

Institutional Review Board (IRB) to engage in the recruitment process. The IRB approval number for this study is 06-06-23-1013046**.**

To gain the attention of prospective participants, I created a research advertisement flyer (see Appendix A) to post in the social networking groups with specifics regarding the research study, inclusionary and exclusionary criteria, and how to contact the researcher upon interest. Prospective participants were required to complete a demographic questionnaire (see Appendix B) to ensure suitability for the research study.

Once prospective research participants met the required inclusion criteria, each participant was provided informed consent. The provided informed consent further details the nature of the study, the purpose of the study, the expected duration of the research participant's involvement in the study, an explanation of the volunteer nature of the study, potential risks and benefits of the study, a statement offering the subject the opportunity to withdraw at any time from the research without consequences and withdrawal procedures, and the parameters of confidentiality and privacy measures protecting participant's anonymity.

The qualitative interviews for this study took place via videoconference and lasted for 90 min. Research participants were asked to find a safe, secure, and private location to conduct the interview. To protect the privacy of each participant, participants were given pseudonyms, and any identifying information was removed or changed to create an alternate persona.

Upon completing the interview process, I transcribed each qualitative interview using a verbatim transcription service. The service used to assist with the transcription

process was Rev.com. The transcribed auto recordings were maintained and securely stored using electronic data storage and can only be accessed using encrypted passwords that are changed often. Furthermore, the transcribed auto recordings were retained and securely stored for up to 3 years according to federal regulations. Only the IRB and I could access the data collected during this time. In conclusion, after three (3) years of data storage, the digital data will be destroyed by deleting or overwriting the information, shredding all physical media, or purging the magnetic media through degaussing, a method to erase data permanently.

**Data Analysis Plan**

Ungvarsky (2020) suggested phenomenological analysis is a psychological research method that focuses on understanding how an individual perceives the events that have been experienced while the researcher strives to uncover and understand how they affect the individual. For this research study, data analysis included the verbatim transcription of the collected interviews, data organization, coding, categorizing, and identifying reoccurring themes and interpretations. I gathered the interviews using a handheld recording device to be placed in earshot of the interview process. To transcribe the recorded interviews, I used the transcription app Rev.com. I transcribed the interviews to expedite the transcription process. I signed up for an app account and selected the Premium Plan for automated transcriptions. Next, I uploaded my recorded interviews one by one separately and selected the “Transcribe” button to begin the transcription process. After a few minutes of waiting, a notification appeared on the

screen informing me that a Word document with the transcribed audio was sent to my email.

Once I receive the transcribed audio, I proofread it to ensure accuracy and make any necessary edits while listening to it repeatedly to familiarize myself with the data. Once I ensured the accuracy of the transcribed interviews, I used index cards to list, organize, and classify the collected data. Following this process, I exported the data onto a Microsoft Excel spreadsheet. Using the spreadsheet, I generated themes and categorized patterns to assist with coding and organizing the findings. Next, I recorded all recurring themes and patterns to support the interpretation of the data. Last, the identified themes and patterns were organized in more inclusive domains to reflect the findings of the interviews.

## Issues of Trustworthiness

Trustworthiness means the interviewer must establish a foundation of credibility, reliability, confirmability, dependability, and, with an interviewee, an atmosphere of comfort with the interviewer and the topic (Pilot & Beck, 2014). The goal of establishing credibility is the researcher's job to accurately reflect each participant's views and responses and ensure that each participant's reality is accurately reflected in the transcribed and coded interview question responses. To ensure the interviews were accurately recorded, the researcher obtained participant permission and used the Zoom recording feature and a voice recorder to operate a backup system simultaneously. The researcher also used a preliminary warm-up question to let the participants get comfortable before the interview questions began.

## Ethical Procedures

My primary responsibility was to protect the participants' confidentiality. Researchers are expected to maintain the highest interview ethics, review informed consent before any questionnaires or interviews, and continue member checking to ensure that all participants feel valued and respected for their contribution. It is not an issue of agreement, but more importantly, it is the finding of differing opinions, values, and experiences to share those positions in the research to improve the standard of research in academia.

All participants received a consent form before any data collection should begin. The consent form contained all pertinent information and details relating to the purpose of the study, any possible risk associated with data collection, the benefit of participating in this research, strict confidentiality of their identifying information, and their right to refuse to answer any questions that they feel are uncomfortable and their right to pose questions of the researcher and engage in discussion if desired. Participants were given pseudonyms, and any identifying information for the university or their course of study was removed or changed to create an alternate persona. All IRB protocols were followed and explained to each participant to afford them ethical treatment and minimize any possible harm. All participants were informed that their interview would be video and audio recorded to allow for transcription and coding of the data. The data were stored securely in password-protected files, and no one else had access to the files.

## Summary

I reviewed the study's research design, rationale, and methodology in this chapter. The intended instrumentation for this study was semistructured interviews conducted via videoconference. The recruitment process for this study included using social media networking sites, leveraging personal contacts, and group messaging applications to provide broader access to participants meeting inclusion criteria. Last, to ensure the creditability and reliability of this research, I explored issues of trustworthiness and research ethics. The following chapter includes a review of the data collection process and analysis.

# Chapter 4: Results

## Introduction

The purpose of this qualitative phenomenological research study was to explore the experiences of Nigerian women living in the United States who were diagnosed with infertility and underwent fertility treatment. This chapter includes the study findings and results using transcendental phenomenology. Using qualitative interview, questions helped to uncover the psychosocial experiences of infertility in Nigerian women from a personal perspective and use their own words to capture the essence of their experiences. The results of this study will answer the following research question: What are the experiences of Nigerian women living in the United States who received infertility treatment?

There remains a dearth of research related to this study's targeted population of Nigerian women over the age of 50 years living in the United States diagnosed with infertility. Scholars and writers have paid little attention to infertility's definitions that may depart from the standard Western usage and how such definitions influence how women experience the condition (Whitehouse & Hollos, 2014). The research conducted for this study is paramount to this investigation. To collect meaningful data, full qualitative interviews have been recorded, transcribed, coded, and analyzed to construct core themes of the lived experiences of each participant. Chapter 4 will reflect information to include (a) the setting, (b) participant demographics, (c) data collection, (d) data analysis, (e) evidence of trustworthiness, and (f) the study's results. Finally, I will conclude this chapter by summarizing the results of the study.

## Setting

As the primary researcher, I conducted semistructured interviews via phone with all participants. I coordinated specific days and times with each participant to complete the interview process. Each participant was encouraged to designate 90 min for the interview process and was asked to reserve a quiet, safe, and secure location free of distractions to complete the recorded interviews. I conducted all interviews in the privacy of a secure and quiet home office, also free of distractions. No other individuals were present during the interview process. Participants' locations were not a factor in this research study, as all participants ensured that their locations were safe and private from others. Upon entering the call, I welcomed each participant and introduced myself as the researcher for this study. Following the introductions, I reiterated the call's purpose, reintroduced the research study title, and informed each participant that the interviews would be recorded.

I reminded all participants that their participation was voluntary and could be withdrawn anytime, and they were also informed of the confidentiality parameters during the interview process. Participants were further ensured that their identities would be kept confidential, and all recordings would be securely kept on a password-protected device and stored in a private location. Before beginning the interview process, I engaged each participant in the informed consent process by reading the complete informed consent form aloud. After reading the informed consent form, each participant was encouraged to verbally state, on the recorded audio, "I consent" before proceeding with the interview.

To maintain confidentiality, I assigned all participants an identifier different from their legal names. The specific identifiers used were placed numerically along with the participant's initials in parentheses, for instance, P1 indicating Participant 1, P2 indicating Participant 2, and so forth.

I initiated the interview process by completing a brief demographic questionnaire. Next, I began collecting data to confirm that each participant met the inclusion criteria and that their treatment history was completed in the United States. Once this information was confirmed, I collected more in-depth data using detailed open-ended interview questions to capture the essence of their experiences. The participants appeared to be open, cooperative, and responsive toward the interview process and provided detailed answers to each interview question. I engaged each participant using learned clinical techniques, such as attentive listening, empathy, and providing a warm and non-judgmental safe space.

If participants demonstrated or reported emotional distress during the interview process, I encouraged them to take their time to speak slowly and offered to take a brief break if needed. Three of the seven participants requested a moment to recollect themselves before resuming the interview. I ensured each participant was emotionally stable by assessing the current state of their emotions and their thoughts toward the process. I assisted participants in regulating their emotions by providing supportive encouragement when needed. I displayed attentive listening and understanding, compassion, validated their experience, and allowed them to talk through their emotional state. Furthermore, I received verbal confirmation that they felt calmer and were ready to

reengage the interview process. Each of them agreed to resume the process before proceeding with the interviews.

Toward the end of the interview process, I urged each participant to provide their final thoughts regarding their journey or to the public regarding the topic of the research study. All the participants expressed great gratitude for being able to participate in the study. They expressed their thanks for illuminating such an important yet neglected topic in the Nigerian community. Each of the participants selected for this study completed the entire interview process and provided detailed, open, and honest responses as a contribution to this research project. I thanked each participant for their participation before the recordings were concluded.

## Demographics

In this metaphysical phenomenological study, I selected the participants using nonprobability purposive sampling based on a non-random inclusion criterion. The participants in this study represented a small sample size of seven Nigerian women, 50 years of age or older, currently living in the United States, diagnosed with primary infertility with no living children, who have undergone infertility treatment, and who have reached the end of their reproductive journey. I used social media networking groups, such as three Facebook infertility groups for Nigerian women, and leveraged my network as a recruitment method.

To recruit members from the three Facebook infertility groups, I contacted each group's administrator/moderator, explained my purpose for joining the group, and asked permission to post an invitation letter to existing group members to gain eligible

participants. Upon gaining permission, I posted the initial invitation letter several times to each group's feed, including the recruitment flyer. Participants interested in joining the study contacted me using private messaging and were screened to ensure each met the inclusion criteria. Three of the seven study participants were recruited using Facebook's social media networking groups. I used snowball sampling to recruit the remaining four participants through the Nigerian communities in Atlanta, Georgia; Washington, DC; and Houston, Texas.

Once all the participants were screened for inclusion criteria and confirmed that each met them, I obtained and confirmed their email addresses and phone numbers and made direct contact. The initial contact was by email, where I sent each participant the informed consent for review. Upon receiving the consent forms, two out of the seven participants replied with questions regarding confidentiality and wanted to ensure that their identity would be kept confidential. I reiterated the parameters of confidentiality and assured the participants that their confidentiality would be maintained and they would be ready to proceed with the process. All seven of the participants completed the informed consent form.

The study was open to Nigerian women over 50 who met inclusion criteria in all 50 states and inclusive of all geographical areas. Participants continued to be interviewed until enough data was collected to draw the necessary conclusions for this study and to the point that gathering new data did not produce or reveal new value or insights to the study. I observed the same repeated themes, ideas, opinions, and patterns through the interviews. This led to seven interviewed participants, all sharing similar experiences.

This was paramount to the study to ensure data saturation and a representative sample of Nigerian women's lived experiences with infertility. The eight participants were all female, had Nigerian nationality, and had reported experiencing primary infertility. Table 1 shows participants' ages and places of residence.

**Table 1**

*Participants' Ages and Places of Residence*

| Participant | Age | Place of residence |
|---|---|---|
| P1 | 51 | Houston, TX |
| P2 | 51 | Atlanta, GA |
| P3 | 50 | Houston, TX |
| P4 | 54 | Washington, DC |
| P5 | 54 | Atlanta, GA |
| P6 | 53 | Atlanta, GA |
| P7 | 51 | Houston, TX |

## Data Collection

Data collection began following the obtained approval by Walden University's IRB. IRB approval was granted on June 6, 2023, and received by email. The participant recruitment process began the following day after receiving IRB approval. The following day, I contacted the administrator/moderator of each Facebook infertility group to ask permission to post the recruitment flyer for the research study. It took nearly 1 week to receive a response and approval from each administrator/moderator to post the research study's recruitment flyer and an invitation letter to their Facebook group's feed. Throughout the data collection process, I posted and reposted the invitation letter and recruitment flyer to five different Facebook groups specific to Nigerian women with infertility.

I contacted my networks simultaneously to reserve specific days and times for each interview. The Facebook recruitment process yielded 10 direct messaging responses; however, only three who expressed interest consented to proceed as participants in the research study. Also, I could schedule the remaining four participants for the semistructured qualitative interviews within the initial week following IRB approval.

As discussed in Chapter 3, the intended population for this study was Nigerian women ages 50 years or older, living in the United States with a diagnosis of primary infertility, who have received infertility treatment in the United States. This study is also intended for women who do not currently have biological children and have reached the end of their reproductive journey. The sample size for this study was six to eight participants to assist with data saturation in the research.

I collected the data using one-on-one phone interviews with seven Nigerian women who all met the inclusion criteria. I used email correspondence and telephone communication to schedule the individual interviews. I sent the informed consent form to each participant by email for their review to assist with a better understanding of the research study and their involvement. The first interview was conducted on June 15, 2023, and the last was conducted on July 23, 2023. Each of the semistructured interviews lasted about 30 to 60 min. The semistructured interviews included 16 open-ended questions and additional probing questions, encouraging participants to further elaborate on their initial responses when needed (see Appendix C). Each participant appeared receptive and understanding toward the research questions administered by the

researcher. The data collected analyzed each participant's experiences related to migration to the United States, learning about their diagnosis of infertility, psychosocial experiences related to infertility, and treatment experiences related to infertility. According to Dejonckheere and Vaughn (2019), semistructured interviews allow the researcher to collect open-ended data, explore participant thoughts, feelings, and beliefs about a particular topic, and delve deeply into personal and sometimes sensitive issues.

After completing all scheduled interviews, I emailed each participant a copy of their transcript. By doing this I was able to conduct the process of member checking. I shared with each participant identified themes across the collected data to check for accuracy and resonance of their personal experiences while requesting feedback upon their review to assist with member checking. Six out of the seven participants responded and reported that their experiences closely mirrored the experiences of the other participants. One participant responded that though her infertility experience has been difficult, she has felt supported throughout her journey and experienced minimal psychosocial consequences. During the process of member checking all of the participants showed a great desire to further process their experiences with infertility and attempted to provide the researcher with additional information about their experiences to be added to the study. Based on the participants desire to share more of their experinces this served as an indication that there is a significant need for culturally sensitive counseling for this population of women that provides a safe space to further the dialogue pertaining to the implications of infertility.

## Data Analysis

I manually organized and coded the data following the one-on-one interviews with all seven participants classified as Nigerian women diagnosed with primary infertility, focusing on their psychosocial experiences and experiences in treatment. In this research, I aimed to capture the raw experiences of Nigerian women over 50 years old using transcendental phenomenology. Study participants were coded as P1 through P7 with their initials recorded in parenthesis to maintain confidentiality for each participant. Each participant's audio recordings were transcribed verbatim, where every word, pause, stutter, and filler word was transcribed into a Word document and reviewed several times for accuracy.

I pursued the coding process using inductive coding, a ground-up approach, allowing the research codes to emerge organically. Ozone et al. (2023) suggested that the primary purpose of the inductive approach is to allow research findings to emerge from the frequent, dominant, or significant themes inherent in raw data without the restraints imposed by structured methodologies. In-Vivo coding was used to loosely analyze and identify responses into themes using the participant's words to highlight and extract important and meaningful phrases and words from the interview. Upon reviewing and comparing recurring themes among participant responses, I sorted the common codes into categories based on similarity and those about the same topic.

As I proceeded through this process, I conducted a further round of coding the data by reexamining, recoding, and recategorizing identified codes and categories. I reread the raw data, used the highlighter tool in Microsoft Word to identify and confirm

categorized codes, and made notes using the “New Comment” text boxes feature to notate any new patterns found and developed. After rereading the transcribed data and relistening to the recorded audio several times, I could group recording common statements, experiences, and core themes into categories using thematic analysis.

Moreover, after reducing the number of codes found during the initial rounds of coding, I created an Excel spreadsheet using Microsoft Office to reflect the preliminary categories developed from the coding process, along with participants’ corresponding responses for each category. The participant responses included direct quotes associated with each research question. Finally, core themes related to the significant experiences of this target population were generated and synthesized because of the collected data.

## Evidence of Trustworthiness

Ravitch and Carl (2016) stated trustworthiness is most used to evoke the importance of ensuring credibility and rigor in qualitative research. Trustworthiness in qualitative research is imperative for ensuring the integrity of the research and data analysis process. One way to ensure trustworthiness in phenomenological research is to ensure the researcher demonstrates that the methods used are reproducible and consistent and that the approach and procedures used are appropriate for the research study and can be documented. Qualitative researchers can ensure trustworthiness in the findings by establishing credibility, transferability, dependability, and confirmability.

### Credibility

Ensuring credibility in qualitative research is essential for valid and reliable research outcomes and can also demonstrate the truth of the research findings. Ravitch

and Carl (2016) reported that research credibility promotes truthfulness and accuracy. Nigar (2020) stated several strategies researchers use in qualitative research to confirm credibility include triangulation, multiple repetitions, expert consensual validation from others, member checking, search for disconfirming evidence, checking for representativeness, and thick description.

One way I ensured credibility in this study was through member checking. Upon completing all qualitative interviews, I reviewed each transcription, line-by-line, emailed each participant a copy of their transcribed audio, shared the identified themes found in each interview with each participant, and checked for accuracy and resonance of their personal experiences. Six out of the seven participants responded and validated their experiences and responses to the research questions.

**Transferability**

Transferability, also called generalizability, is a type of external validity that provides evidence that findings described in qualitative studies are applicable or useful to theory, practice, and future research (Moon et al., 2016). The goal of transferability in this research study is to ensure that the findings of this study can be applied to other women diagnosed with primary infertility across varying settings with similar participants in other situations. To meet transferability, I conducted qualitative interviews with all participants until data saturation was met and no new information was presented. To ensure the study could be replicated, I provided detailed and thorough guidelines about the study's demonstrations, including the study’s recruitment process, setting, participant selection, demographics, data collection, and data analysis process.

**Dependability**

Dependability is important to trustworthiness because it establishes the research study's findings as constant and repeatable despite changes within the research. Ravitch and Carl (2016) reported the methods for achieving dependability in qualitative studies are the triangulation and sequencing of methods and creating a well-articulated rationale for these choices to confirm that you have created the appropriate data collection plan given your research. I established dependability by thoroughly reviewing the raw data line-by-line, ensuring the accuracy of participant responses, and conducting an audit trail using field notes kept throughout the data collection and analysis process by highlighting every step of the process to obtain accuracy of the final data set.

**Confirmability**

Confirmability ensures that participant responses are free of potential biases or persuasions of the researcher. Moon et al. (2016) reported confirmability refers to the objectivity of a research study during the data collection process. It verifies that participants shape the findings more so than a qualitative researcher shapes them. To maintain the integrity of participant responses, I engaged in the *epoche* process, eliminating all my biases and assumptions to explain a phenomenon in terms of its inherent system of meaning. One way I ensured the elimination of researcher bias was by engaging in ongoing therapy throughout the research, where I could openly process and express any thoughts and emotions related to the research process. By engaging in ongoing therapy throughout the research process, I ensured confirmability, further contributing to the trustworthiness of the research. Another way I ensured the elimination

of researcher bias was with reflective journaling. Reflective journaling assisted me with maintaining detailed accounts of my thoughts, emotions, and personal interpretations throughout the interviewing and research process. During the process of reflexivity, I could acknowledge my role as the researcher while reflecting on but separating my own previous experiences, assumptions, and beliefs about the content of the research. The reflective journaling process further ensured that my beliefs and judgments did not influence nor interfere with the authenticity of the research.

## Results

This transcendental phenomenological study aimed to interview and analyze the data until saturation was met. Saunders et al. (2018) defined saturation as the point in coding when no new codes occur in the data. For the current study, I interviewed participants until common codes became repetitive. Data saturation was met following seven interviews, resulting in the conclusion of data collection. This transcendental phenomenological research study aimed to answer the following research question: What are the experiences of Nigerian women living in the United States who received infertility treatment?

After analyzing the data obtained following the qualitative interviews, participant responses were used to connect the emerging data to ensure the accuracy of the data's results. Four prominent themes emerged: (a) relational issues with others, (b) emotional impact, (c) barriers, and (d) treatment experiences. Three subthemes emerged under relational issues with others: (a) discrimination, (b) marital conflict, and (c) social pressure. Four subthemes emerged under emotional impact: (a) sense of loss, (b)

internalized beliefs about self/questioning self, (c) depression, and (d) anxiety. Two subthemes emerged under barriers: (a) lack of support or understanding from others and (b) cultural beliefs and expectations. Also, two subthemes emerged under treatment experiences: (a) finding the right representation in counseling and (b) psychotropic medications. Table 2 shows the themes and subthemes.

**Table 2**

*Themes and Subthemes*

| Theme | Subtheme |
|---|---|
| Relational issues with others | Discrimination |
| | Marital conflict |
| | Social pressure |
| Emotional impact | Sense of loss |
| | Internalized beliefs about self/questioning |
| Barriers | Lack of support or understanding from others |
| | Cultural beliefs and expectations |
| Treatment experience | Finding the right representation in counseling |
| | Psychotropic medications |

Table 3 shows the themes and subthemes that were manifested for each participant.

**Table 3**

*Themes and Subthemes Present for Each Participant*

| Participant | Theme | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Relational issues with others | | | Emotional impact | | Barriers | | Treatment experience |
| | Subtheme | | | | | | | |
| | Discrimination | Marital conflict | Social pressure | Sense of loss | Beliefs/ expectations | Lack of support | Cultural beliefs | Psychotropic medication |
| P1 | | | | | X | | | |
| P2 | X | X | | X | X | X | | X |
| P3 | X | | X | | | | | X |
| P4 | | X | X | X | | X | X | X |
| P5 | | X | | | X | | | |
| P6 | | | | X | | | X | |
| P7 | | X | | | | | X | |

**Theme 1: Relational Issues with Others**

The first theme to emerge was relationship issues with others, including family, friends, in-laws, and issues with spouses. Participants often described experiencing discrimination from family members, friends, and in-laws, facing marital conflict with spouses related to their infertility status, and undergoing extreme social pressure. Six out of the seven participants shared that their relationships with others were negatively impacted due to involuntary childlessness. Most participants reported feeling socially outcast, experiencing various forms of abuse, and being stigmatized by others. However, P1 stated, “I know I’m not the only woman in the world with this issue or setback, so I don't think I was discriminated against. My husband and mother supported me, and we did not experience much marital conflict.” P2 explained, “I struggled with not having support from my family, losing my husband, being ostracized by my cousins who didn’t understand the situation I was going through.” P3 stated,

> I noticed that family and friends feel bad for you. It puts a strain on your relationship with friends and family who don’t understand you and your reservations because of your infertility. Infertility really puts a strain on your marriage and your relationship.

P4 explained

> So, at times, it can be very hurtful when people come to visit for the holidays. They don’t understand your purpose if you are married and do not have children. It hurts because you want to do those activities with your friends but cannot. Now, with my husband's family, now it's more like a nightmare.

P5 stated

> I feel like I wasn't accepted as much as other women or family members who had children, so there was nothing I could do. Once other family members started to have children, it was noticed that 'Hey, you aren't pregnant,' 'you don't have any children,' people questioned, 'what's going on,' or 'when are you going to have some children' or they were trying to set me up or introduced to men who were seeking family, seeking a family and a wife.

P6 explained

> Coming from an Islamic African background, it has been depressing and, some days, scrutinizing. It's just not a belief that some women can't conceive, so it's always negative. You just made me feel like you're not enough. In African culture, if you don't have kids, your value and how you're looked at is very low, no matter how successful you are, no matter how educated you are, no matter how much money you have, no matter what you have achieved in life. It doesn't matter if you don't have a husband or kids.

***Subtheme 1: Discrimination***

The subtheme of discrimination arose as many participants spoke about their experiences with relational issues. Many of the participants disclosed feeling discriminated against because of their issues of infertility within their relationships with family and friends.

P2 explained

> I definitely experienced discrimination. People would say, 'You don't even have children,' and exclude me from certain conversations, or they would say, 'Oh, you don't understand because you don't have kids.' People don't realize how those comments are very hurtful, so it was just like all the moms are having conversations. I'm just sitting there, just left out of the conversation because they assume I don't understand, so I felt discriminated against and stigmatized.

P3 stated

> I experience discrimination because I can't have kids, and you're just looked at a different way, and you're not treated the same. You kind of looked at as less than because you can't have children, and women should not be stigmatized based on what they can't do.

***Subtheme 2: Marital Conflict***

As many participants discussed relational issues with others, another subtheme that arose was marital conflict. Several of the participants highlighted marital dysfunction related to issues of infertility.

P2 explained

> Also, I'm not married anymore. I think that was probably the reason for my divorce because we didn't really have any issues until after trying. That's when many issues began in marriage, and I don't see another reason. We would have issues in our marriage, so, again, it seemed like I was that thing that was broken, that thing that didn't work, that wasn't wanted.

P4 explained

> In a Nigerian household, there's a belief that you leave, go to your husband's house, and have children. So that is our culture. Your children are your blessing; they help you when you're old. That's what the woman is supposed to do. 'Because if you don't have children, what are you doing'? That's how we look at it. So, it was very difficult for the family to accept, especially the husband's family. And they still don't accept it. It's almost like they put me in a category. If that makes sense, I feel more like you are a wife on paper. It even brings problems in the bedroom. Sometimes, he does not want to be active because he feels, 'What's the point?' He has even told me that before. P5 stated, "I experienced failed relationships and a failed marriage due to my husband wanting children and me not being able to have them."

P7 explained

> There were challenges in marriage as well. The pressure to have sexual relations, you have to time it just right; it was almost like another job to do to make sure. I just know that the marriage wasn't the same, you know, knowing that I could not have children and that I was the reason.

***Subtheme 3: Social Pressure***

Several of the participants described experiencing immense social pressure related to their experiences of infertility in another subtheme:

P3 explained

> It's the social pressure to engage in children's events. They have children, they keep it going, and don't understand that you may not want to be around children

> all the time because you can't have children yourself; it's not a disrespectful thing; it's just like an oblivious thing because they don't have the same issues that you have and that you're going through.

P4 stated

> You're different. So sometimes you feel like an outcast, if that makes sense. There's always the pressure of "Oh, you need to have a child. You need to have a child." [or] "You've been with your husband for 6 months; you're not pregnant." So, it wasn't easy to gain the support of others.

The participants in this study all shared their sentiments regarding the emotional impact of living with infertility. Issues related to loss, negative internalized feelings about self, and questioning oneself arose due to involuntary childlessness.

**Theme 2: Emotional Impact**

The study participants also shared their experiences with mental and emotional conditions related to their experiences. P1 explained, "Receiving the diagnosis definitely hurt. I never thought it would be me. I never thought that I could not be a mother, so I did experience a little bit of depression." P2 added,

> I also experienced some depression, definitely some anxiety, and a lot of medical anxiety as well. A lot of sleepless nights, a lot of crying at night, and a lot of negative self-talk. Just a lot of beating myself up about being unable to do what I never thought I couldn't do.

P3 stated

> "Yeah, it's just been very difficult and very hard. I watch my friends with their children and their grandchildren, and I know that won't ever happen to me, so it's just really sad, and sometimes I just fall back into depression. It's not a thing of not being happy for them, but just a thing of being in your own pain and suffering from infertility".

P4 explained, "I went into a bit of depression. I was always crying at work. I went into that for a short period."

P5 stated

> It was a little depressing because I always wanted children from when I was a little child. It was disheartening. It kind of breaks you down, or it broke me down in a sense because it made me feel unwanted. I was in a mental condition. I felt like my depression led to fluctuations in my weight depending on where my mood was. I felt like I had my own personal battle with depression in this day and age; even though I'm past the age of having children, it still affects me currently.

P6 stated, "More of my challenges are mental. You just feel like you're not enough or you're not woman enough. I had maybe like 2 years where I did suffer from my depression."

P7 explained

> It was kind of devastating to know that we couldn't know what it would be like to have a child of our own, of our own genes. It just breaks me down to question my own self as a woman. It was definitely disheartening because in our culture, it's the expectation to be fruitful, meaning that you have to have children, so it just

> makes you as a woman feel like incomplete if you're not able to do that. You know, it's a battle I have dealt with for a very long time, being in a dark space and frustrated.

***Subtheme 1: Sense of Loss***

Many of the participants of this study described experiencing a sense of loss related to involuntary infertility. One subtheme that arose while exploring the emotional impact of infertility was the subtheme of the sense of loss.

P2 added

> Before I really, truly educated myself, I blamed myself, and I felt incomplete. I felt kind of like a failure because why can't my body do what everybody, what every other woman's body can do?

P4 stated, "It's like a loss of cultural acceptance. We are not as accepting as some other cultures regarding certain things, and children are a deep topic." P6 explained, "Even though you've worked so hard to become the woman you have become, that's all you're ever looked at. It's like you lose your title as an individual."

***Subtheme 2: Internalized Beliefs About Self***

Another subtheme that manifested during the exploration of emotional impact was that of internalized beliefs about self. Many of the participants explained struggling with negative thoughts and beliefs about themselves due to their issues of infertility.

P1 explained

> "I got to the point of thinking, 'What was wrong with me?' 'Why isn't it taking?' 'Is there something I can do to push it along for it to work?' or, you know, 'What do I need to stop doing?' So, I had my mind in a lot of different."

P2 stated

> "Culturally, the woman is supposed to have the baby, so quite naturally, it was my fault; I did something wrong. I was broken in some type of way, like a broken doll on a shelf. I was no good."

P5 explained

> When I learned about my diagnosis, I felt like I was broken in a sense, umm or that something was wrong with me. I just believed that no one would want me. I was broken in a sense, and I knew something was wrong with me.

***Subtheme 3: Depression***

Several participants described experiencing episodes of depression related to infertility.

P3 added

> I was very depressed for a couple of years because I miscarried, and that's around the time that I found out that I had infertility issues. I watched my siblings and my family, and just a lot of people have babies, so I went into a really depressed time, about 2 years. I was very depressed, and it's still hard today, even though I'm of the age where I can't even have children anymore.

P7 stated

> "Finding out that you're not able to have children on your own is like a feeling; it's like going through a walk of shame, almost like you get that low self-esteem, which I experienced, and I did fall into a depression, to be like, well if I'm not able to do these things, not to be a mom, the natural way, you know, something that comes from me, it's a feeling of incompleteness."

### *Subtheme 4: Anxiety*

Several participants described experiencing anxiety related to infertility. P4 explained

> Like, when I was always anxious, is what they would call it. I was anxious a lot. I would always be crying and emotional. But now it's more so episodic. It comes and it goes. Some days I would be okay. P5 added, "I had anxiety and just up and down mood swings, but not any, like, conditional physical diagnosis outside of my infertility, but I did experience mental.

## Theme 3: Barriers

Another theme from the data was the barriers each participant encountered related to their infertility diagnosis. Participants struggled with barriers related to a lack of support and understanding from others and barriers presented due to cultural expectations and beliefs. Five out of the seven participants described feeling unsupported and stated they lacked understanding from those close to them. P1 and P7 reported feeling supported or understood by family members and their spouses. All seven participants highlighted the cultural expectation and importance of childbearing in Nigerian culture. Each

participant detailed how cultural expectations and beliefs contributed to their experiences with infertility.

P1 explained, “As for my culture and being Nigerian, that’s one of our biggest things to become a mother, so when I couldn’t, it was hurtful. Luckily, I had support from my husband.” P2 stated, “I didn't have anybody; I don’t think I had any support, and I didn’t have any women in my family who understood what I was going through.” P4 explained, “There are some girls, like my schoolmates, who we don't really speak as much anymore because they don’t understand.” P5 stated, “In culture, infertility is not a real thing. My family didn’t understand me.”

***Subtheme 1: Lack of Support or Understanding from Others***

Several of the participants acknowledged the lack of understanding and support received from others due to their issues of infertility.

P2 stated

> My family couldn’t understand, and my cousins had children, so they didn’t really understand. I didn’t meet anybody else in my culture who had gone through this experience, so it was just like I would be, you know, the oddball in the family.

P4 explained

> My family and friends have a lack of understanding regarding infertility, so it was very difficult for the family to accept, especially the husband's family, and they still don't accept it. I had no support from family or in-laws.

### *Subtheme 2: Cultural Beliefs*

Research participants highlighted the influence of cultural beliefs on their experiences with infertility.

P4 explained

> In our culture, your children are your blessing; they help you when you're old. That's what the woman is supposed to do because if you don't have children, then what are you doing? That's how we look at it. It's something that you have to do.

P6 added

> Culturally, not having children influences the belief that something is wrong with you if you cannot or do not have children. P7 stated, “There is a cultural expectation to be fruitful and have children.

## Theme 4: Treatment Experiences

The participants in this study also discussed their lived experiences related to treatment practices in the United States. Each participant examined their unique experiences related to the psychosocial consequences of infertility. Issues related to finding the right representation in counseling and using psychotropic medications to address presenting symptoms of anxiety and depression were identified.

P1 explained

> I decided to go to the doctor to see what was going on, and that’s when she diagnosed me. When I first got diagnosed, I was around age 32 when I started to look at fertility treatments. I found someone who wasn’t exactly what I was looking for, but luckily, she could help towards the end of the process, so it was

really good. I felt like I could really open up to her, so we had something in common to a certain extent, which helped me.

P2 stated

I did seek treatment, which definitely caused more talk within the family because, again, culturally, you don't talk about your business. You just don't. I did find a therapist, an African American woman who didn't perse have fertility issues. Still, she could sympathize and empathize with me, and she provided many coping mechanisms. I would have preferred someone from my own culture, but it's okay.

P3 stated

The challenge was figuring out the best therapist for me, and my culture played a big role in my decision, so I had to go through a few therapists until I found a therapist that was great for me.

P5 stated

I went through quite a few therapists before I found one that I felt was right for me, and that was an additional layer of the challenge because it's like I'm seeking help. Still, I must go through this, another form of trial and error, to find the person that I'm most comfortable with.

P6 said

I did go to therapy, and I had a good therapist. However, in our culture, therapy is a big stigma, getting any kind of treatment for any kind of like depression or mental health. It's just looked down upon, and you're looked at like you're crazy and unstable. So that's just the experience, but I feel like being in America helped

> me be more open-minded and seek the help I needed. I wish I had a Nigerian therapist, but my therapist was good.

***Subtheme 1: Securement of the Right Representation in Counseling***

While exploring the importance of seeking treatment following issues of infertility, one reoccurring subtheme presented itself, and many participants found it equally as important to find the right representation while seeking counseling and mental health services. P1 explained

> It was a challenge finding the right counselor. I wanted someone who was not quite going through what I was going through, perse, but I didn't want a therapist who had five kids because, in a certain way, she could give me advice, but she would never understand. I also wanted an older person, up in age. I wasn't sure if they had those issues, so that's how I picked them.

P5 added

> I sought therapy and a psychiatrist because I was afraid to share with my family. The treatment process also took a toll mentally. It was definitely hard to find someone that I felt like I could personally identify with culturally. They tend to have different life experiences in general, so that was a concern of mine and a challenge.

P7 stated

> I was recommended to seek professional help for my mental health, but I didn't. In my culture, we do not seek help; we seek guidance from our higher spiritual ground. If I had the opportunity to seek help, I would have wanted to speak with

> someone who could relate to my experiences and understand my culture. These people do not fully understand Nigerians and what we go through.

***Subtheme 2: Psychotropics***

The final subtheme that arose while exploring treatment experiences was that of psychotropic medications. Many of the participants described experiencing intense emotional disturbances following their issues of infertility. Several of the participants reported receiving psychotropic medication to assist with better-managing symptoms of depression and anxiety. The accounts are as follows:

P2 stated

> At one point, I was taking a course of antidepressants to give me an extra boost with the different techniques she gave me to help me, so therapy did help a lot, and the medication did as well.

P3 explained, “Also, because of my sadness and mood, I was put on antidepressants and mood stabilizers.” P4 added, “I spoke to a psychiatrist for maybe 2 months. They gave me some medication and a low dose for 2 months. I only took it the first. I didn't take it the 2nd month.”

## Summary

This transcendental phenomenological study aimed to examine the experiences of Nigerian women living in the United States with primary infertility. This chapter reviewed the settings in which each qualitative interview took place, participants' demographics, an explanation of the data collection and data analysis methods, offered evidence of the study’s trustworthiness, and concluded with the results inclusive of the

responses of seven research participants. The results highlighted four core themes. The four core themes that emerged following the exploration of the lived experiences of Nigerian Women living in the United States with infertility were (a) relational issues with others, (b) emotional impact, (c) barriers, and (d) treatment experiences. Additional subthemes emerged from the core themes described. In Chapter 5, I will further explore the existing literature and provide an interpretation of the findings, study limitations, implications, conclusion, and direction of future research.

# Chapter 5: Discussion, Conclusions, and Recommendations

## Introduction

The purpose of this transcendental phenomenological qualitative study was to explore the unique lived experiences of Nigerian women living in the United States with a diagnosis of primary infertility. This chapter includes results from Chapter 4 and an overview of the interpretations of the study findings. I also describe the limitations of this study and the implications for future research on Nigerian women living with infertility issues in the United States.

Issues of infertility can greatly impact the psychosocial experiences of women plagued with involuntary childlessness. Specifically, cultural and social factors greatly influence Nigerian women in the United States. Infertility has been described as one of the most important reproductive health concerns of Nigerian women (Esan et al., 2022). Based on the high importance placed on a woman's ability to procreate in Nigerian culture, women experiencing involuntary childlessness are more prone to high levels of psychological and emotional distress, social isolation among family and friends, marital conflict, and various forms of abuse (Esan et al., 2022).

The purpose of this qualitative study was to investigate the lived experiences of Nigerian women aged 50 years and older living in the United States and diagnosed with primary infertility. A developed understanding of the psychosocial consequences and lived experiences provide insight into the cultural context of infertility for many Nigerian women. The supports and challenges infertile women experienced and how those experiences affected their reproductive journey were also explored. In this transcendental

phenomenological study, I used purposive sampling to show the influence of sociocultural constructs based on participants' accounts of infertility. I used the following research question to explore the lived experiences of infertile Nigerian women living in the United States with primary infertility and their psychosocial experiences: What are the lived experiences of Nigerian women living in the United States who received infertility treatment?

Themes that emerged during the participant interviews include (a) relational issues with others, (b) emotional impact, (c) barriers, and (d) treatment experiences. Several subthemes emerged under each of the identified main themes. Three subthemes emerged under relational issues with others: (a) discrimination, (b) marital conflict, and (c) social pressure. Four subthemes emerged under emotional impact: (a) sense of loss, (b) internalized beliefs about self/questioning self, (c) depression, and (d) anxiety. Two subthemes emerged under barriers: (a) lack of support or understanding from others and (b) cultural beliefs and expectations. Also, two subthemes emerged under treatment experiences: (a) finding the right representation in counseling and (b) psychotropic medications.

## Interpretation of the Findings

In this section of the research study, I highlight findings that answered the research question. The data emerged from all data sources, including a demographic questionnaire, reflective journaling, and semistructured, one-on-one phone interviews. Themes and subthemes were identified in responses to the information provided by research participants' statements. The accounts from the research participants showed

both commonalities and minor differences in their experiences with primary infertility. I found that most participants experienced relational issues, including marital conflict, discrimination, and social pressure from others due to infertility. However, some research participants divulged experiencing little disruption to their relationships with family and friends and expressed having a loving and supportive spouse.

Further study results indicated that all participants experienced significant emotional impact. The participants of this study detailed their treatment experiences. All the participants identified experiencing a sense of personal loss, internalized negative beliefs about self, and psychological symptoms of depression; less than half of the participants reported experiencing symptoms of anxiety. The results indicated barriers for participants related to a lack of support and understanding from others and barriers presented by cultural beliefs and expectations.

Many participants echoed the experience of having little to no support from family and friends. The participants further confirmed that cultural beliefs and expectations played a major role in the support received from those close to them. Many research participants found difficulty in finding the right representation in counseling and expressed their views on the use of psychotropic medications. These findings align with Esan et al. (2022), who argue that infertility is a condition that attracts stigma in Nigerian society and causes relational strain for infertile women.

Relational issues among family, friends, and spouses are a major concern for many Nigerian women facing involuntary childlessness. Fehintola et al. (2017) described infertility as a socially unacceptable condition, as childbearing is considered the hallmark

of womanhood, and an inability to bear children makes society see women as incomplete, leading most women to social isolation and abandonment. Mohammad and Ardalan (2009) further confirmed that infertility has been recognized as a potentially serious, costly, and burdensome issue for families. Most of the participants in the study reported experiencing discriminatory behaviors from others. They described being socially isolated by their peer groups and viewed as "less than" by people in their community and family members for not entering the stage of womanhood. The experience of primary infertility magnified the sense of social isolation and abandonment, leaving many of the women feeling overlooked, ostracized, or reduced in their womanhood due to unfair treatment despite their accomplishments of success, education level, or life achievements. Mahboubeh al. (2021) revealed the negative attitudes of community members toward infertility and reported that, regardless of age, educational level, or employment status, many Nigerian women still experienced various forms of social stigma, leaving them open to psychosocial pressures.

In Nigerian culture, African marriages are based on children; infertility could lead to separation, polygamy, and, finally, divorce (Anokye et al., 2017). Sharing their marital experiences proved more difficult for some participants due to the lack of support they received from their spouses and in-laws. Most of the participants reported experiencing marital conflict, including constant fighting and arguing with their spouse, feeling unsupported by their spouse and in-laws, and experiencing a huge strain on the sexual aspect of their marriage. Most of the participants described feeling undesirable to their spouses and reported feeling an immense amount of pressure placed on sexual intimacy

and the need for procreation in their marriages. Some participants reported questioning their worthiness as married women because of their inability to fulfill the obligation of childbearing. All but one participant reported that their marriages ended in divorce due to their issues of infertility. For many women experiencing involuntary childlessness, infertility can bring about profound psychological and emotional distress. It can also produce a great deal of stress as couples undergo extensive and often expensive fertility treatments. These factors can strain a marital relationship immensely, leading to its dismantlement. Furthermore, societal pressures and cultural expectations for couples to procreate further ignite the social pressure and stigma related to childbearing as a part of marriage. This endured stress can further contribute to damaging the relationship.

However, the strain of infertility does not end with discriminative behavior or marital conflict for Nigerian women faced with infertility. Esan et al. (2022) further report the Nigerian societal construct is not supportive of couples and individuals facing fertility problems. Many of the participants recorded experiencing severe social pressure within the Nigerian community. This included receiving constant questioning about their decision to have children, being forced to answer questions related to the time frame of having children, and questions regarding the state of their marriage. One participant reported her mother-in-law took on another wife for her husband due to her issues with infertility. She described feeling the pressure to procreate to save her marriage. Many women reported family and friends displayed a lack of understanding toward their inability to have children and reported many people view infertility as a choice rather than a reproductive issue.

Because of sociocultural beliefs that reproduction is the woman´s primary responsibility and a failure is her failing, many women are severely emotionally impacted by their experience of infertility (Bello et al., 2021). The cultural expectations, societal structures, and belief systems reinforce the burden of dealing with primary infertility as an emotionally distressing event. According to participants' accounts, many experienced a sense of loss related to the loss of individuality, cultural acceptance, and self-esteem. Most of the participants described feeling incomplete, experiencing hopelessness, and feeling the loss of motherhood. Along with experiencing a sense of loss and struggling with negative internalized beliefs about themselves, including feeling broken, worthless, or being punished by their higher power. Some participants even described engaging in repetitive self-blame, questioning their purpose in life, and asking themselves, "What is wrong with me?" Mahboubeh al. (2021) further suggest that the individual sometimes initiates a process of self-stigmatization, which refers to negative attitudes created in individuals due to the conditions they have been put through. Consequently, women might internalize the stigma and see themselves as lower than other women, resulting in a loss in their self-esteem, feelings of shame and inferiority, worthlessness, constant questioning of self, a loss of control, and social isolation (Hasanpoor-Azghady et al., 2019).

The data analysis is used to highlight the high emotional impact of depression and anxiety on the participants of this study. Bello et al. (2021) confirmed infertile women also have more anxiety and depression symptoms than fertile women, which predicts the actual psychopathology leading to severe psychological distress. All the participants

admitted to experiencing high levels of depression related to loss, grief, anger, sadness, shame, self-blame, and lack of femininity. Some of the participants explained experiencing episodes of insomnia, intense crying spells, engaging in negative self-talk, and experiencing changes to their weight due to mood instability. More than half of the participants reported experiencing episodes of anxiety and excessive worrying about their inability to procreate.

Perceived barriers related to the experiences of primary infertility have ongoing effects on the mental and emotional wellness of many of the participants. Whitehouse and Hollos (2014) established that women in sub-Saharan Africa bear the primary social consequences of infertility and are often misunderstood and unsupported by family and friends. The lack of support and understanding from others within the Nigerian community left many of the participants feeling alone and silenced in their reproductive journey. Many participants identified a lack of knowledge centered around reproductive health as a major issue contributing to the lack of support received from family and friends. Many participants explained that family and friends do not understand issues of infertility and hold the belief that all women of good faith are "supposed to be able to have children." Some participants spoke about the significance of religious beliefs regarding a woman's ability to procreate and the cultural beliefs that many hold regarding prayer as a solution to infertility.

Cultural beliefs and expectations also serve as a deterrent for many participants seeking support. Soroye et al. (2021) confirmed that many people who experience mental illness in Nigerian culture are reluctant to seek help because of the stigma associated with

it. Many participants highlighted the importance of a woman's cultural responsibility to procreate, "be fruitful," and have many children. Participants discussed overcoming these barriers following the completion of their reproductive journey and reported learning to accept their experiences as a part of God's plan for them.

One common concern that arose for participants of this study was the importance of having access to culturally diverse and culturally competent care for Nigerian women diagnosed with infertility in the United States. Previous researchers recognized the importance of culturally sensitive counseling for individuals of Nigerian descent. Idoko (2023) reported that acknowledging cultural differences builds trust between counselors and clients, while understanding local norms enhances communication, aiding accurate diagnosis and treatment, and tailored counseling diminishes stigma around seeking help. Similar to Idoko's (2023) findings, participants in this study expressed the importance of finding the right clinical representation during the treatment experience. Several of the participants reported the difficulty of sharing their experiences with a clinical provider due to fear of being judged and being viewed as mentally unstable. Some participants explained that Nigerian culture strongly believes that issues should be handled by spiritual advisors and older adults in the community rather than by health care professionals. In addition, participants stated that though they could find adequate counseling support for their presenting issues, they desired to receive professional help from a provider they could culturally identify with. In addition to all the participants being able to find clinical support that they were satisfied with, more than half of the

participants reported being prescribed psychotropic medications to further assist with managing psychological and emotional distress related to infertility.

## Limitations of the Study

There were two main limitations to the study. The first limitation of this study was the data collection method. The data used for this study was collected via telephone interviews. There was difficulty assessing the authenticity of the information collected because the interviews were conducted via phone; therefore, significant indicators, such as participant body language and nonverbal cues, could not be recorded during the interview process. Though these components were not fully captured, participants appeared forthcoming with their responses and provided detailed accounts of their experiences.

The next limitation of this study was the use of semistructured interviews. The questions detailed during the interview process were all newly developed and formatted to extract the lived experiences of Nigerian women diagnosed with primary infertility who are now residing in the United States. The semistructured interview questions had not been used previously and, therefore, could have included more streamlined questions to extract more details regarding the lived experiences of this population.

## Recommendations

The first recommendation is to change the geographical location of future studies. The current study was conducted on Nigerian women residing in the United States. Future studies can benefit from being conducted using this population located in Nigeria

for a more representative sample. The second recommendation is to increase the sample size of the study. This study interviewed eight women living in the United States.

The third recommendation is to use the quantitative method. Using a quantitative research method could mean recruiting thousands of participants in the study, and increasing the sample size could lead to a more representative sample. As a result, a quantitative study could produce numerical results that might help produce highlighted results that can assist participants seeking treatment. The fourth recommendation is to use an alternate data collection method. The current study uses one-on-one qualitative interviews. Using a different data collection method could bring similar or different results and ensure the study's trustworthiness. The fifth recommendation is to include Nigerian men in future studies. Including Nigerian men in the study could provide a more comprehensive viewpoint on the psychosocial experiences of infertility in both men and women and further extend knowledge regarding this topic. It would be interesting to explore the similarities and differences in the experiences that both Nigerian men and women have regarding infertility.

## Implications

The results from this study could be used to produce positive social change by illuminating the experiences of Nigerian women who experience infertility. Reducing the stigma and psychosocial consequences experienced by Nigerian women related to infertility. The findings of this study provided irrefutable evidence of the experiences and emotional distress of Nigerian women plagued with infertility. The outcome of the study can promote a sense of universality and acceptance for all Nigerian women who read this

study and encourage this population of women to speak about their experiences to evoke positive change openly. The potential benefits of openly discussing the experiences of infertility has been reflected during the process of member checking as all of the participants displayed a level of eagerness to further contribute to the outcome of the study by providing additional information about their journey of infertility. This further confirmed the need for a safe therapeutic space for women of this demographic to be able to openly share their experiences in a culturally sensitive environment. Outcomes from this study could also be used to provide insight for other individuals and help others develop an understanding of the impact of infertility on a woman's life. Additionally, information from this study could also help reduce the stigma associated with infertility in the Nigerian community.

The results from this study can be used to empower the study participants and the Nigerian community. The positive social change implications of the study include obtaining knowledge useful for mental health professionals working with Nigerian women struggling with involuntary childlessness as well as other researchers who are seeking to improve reproductive health within the Nigerian community. Key findings could also inform the development of culturally competent and diverse counseling services and further improve treatment experiences for Nigerian women.

## Conclusion

The purpose of this qualitative phenomenological research study was to explore the lived experiences of Nigerian women living in the United States with a diagnosis of primary infertility. I utilized one-on-one, semistructured qualitative interviews to extract

data needed to assess individual experiences and responses related to the psychosocial issues of infertility. As revealed from the themes identified from the collected data, the participants of this study endured social, emotional, and psychological distress, specifically related to infertility. The completed qualitative interviews provided a framework to understand how Nigerian women living in the United States experience their journey with infertility.

A review of the historical literature confirmed that Nigerian women experience a great deal of psychological, social, and emotional turmoil due to infertility. It was found that even though infertility occurs for both men and women, Nigerian women receive the bulk of the blame for the cause of childlessness (Whitehouse & Hollos, 2014). Infertility remains controversial in the Nigerian community (Mahboubeh et al., 2021).

The results of the study uncovered the first major finding, which showed that Nigerian women experience a great deal of relational issues, including discrimination and social isolation from others, marital conflict, and social pressure related to motherhood. The second major finding was that Nigerian women experienced intense emotional impacts related to infertility, including a sense of loss, negative internalized feelings about themselves, depression, and anxiety. The third major finding was that Nigerian women struggled with cultural barriers, such as having limited to no support from others and difficulty with navigating cultural beliefs and expectations related to infertility. The fourth and final major finding was that Nigerian women have psychological and emotional needs that can benefit from receiving culturally competent and culturally diverse treatment experiences.

This research showed that sociocultural beliefs and expectations strongly impact the perspectives and experiences of infertility and how Nigerian women perceive themselves and their experiences within the Nigerian community. Developing social change through ongoing knowledge and research can help Nigerian women and the community understand issues related to reproductive health problems and the concerns of women plagued with involuntary childlessness. The information from this study may help counseling professionals, Nigerian women, and the Nigerian community better understand the experiences of Nigerian women diagnosed with primary infertility. This study could help to improve understanding of psychosocial issues of infertility and reduce the stigma and discriminative behavior toward women with infertility. Finally, this study could better assist counseling professionals in further developing their skills and training for individuals planning to work with minority groups.

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# Appendix A: Research Flyer

Research Study
Exploring the Lived Experiences of Nigerian Women in the U.S. WITH Primary Infertility

## Overview

- The purpose of this research study is to gain insight and understanding of the unique lived experiences of Nigerian women living in the United States with Primary Infertility and who have completed infertility treatment.
- This study may help to inform counselors, counselor educators, and the counseling field on how Nigerian women experience resources and challenges during their infertility journey.
- Participants are asked to provide 60-90 minutes for in-depth individual interviews

This research is part of a dissertation study to complete the Ph.D. in Counselor Education and Supervision program at Walden University. Participants' anonymity will be protected upon selection.

Dates and times for participation are flexible.

## Eligibility

- Adults (50 years or older)
- Nigerian women born or descended from the country of Nigeria
- Must speak in one of the many Nigerian dialects, including Yoruba, Igbo, or Hausa language.
- Women who do not have biological children due to primary infertility.
- Women who have undergone and completed infertility treatment

**$25 Gift Card Compensation**

## Contact Us

**To learn more about this research study or to sign up to participate, please contact**

- Study's Primary Researcher: -Kafilat Oseni, MA, LPC, CPCS, C-PD
- Phone: [Redacted]
- Email: [Redacted]

# Appendix B: Demographic Questionnaire

1. Please state your current age.
2. How long have you been living in the United States?
3. Are you a first-generation immigrant to the United States?
4. How old were you when you moved to the United States?
5. How did you learn about your diagnosis of infertility?
6. Have you pursued fertility treatment in the United States?
7. During what age range did you undergo fertility treatment?
8. Did you pursue alternative options to infertility, such as adoption?

# Appendix C: Interview Protocol

The researcher of this study will administer interview questions to selected participants using English as the primary language. All participants will be provided with the same research questions and will be asked the same subsequent clarifying questions. Research participants will not be provided a written copy of the research questions; rather, the researcher will administer all research questions.

**Questions Related to Infertility and Cultural Experiences**

1. Tell me a summary of your infertility journey.
2. What beliefs do you have regarding infertility?
3. How has your cultural background influenced your experiences and beliefs about infertility?

    -Share your social experiences related to your infertility with family and friends.
4. Have you ever been discriminated against or stigmatized due to your diagnosis?
5. What are some of the challenges you have experienced due to your diagnosis?
6. Who or what have you considered sources of support (such as a church, support groups, family/friends)?

**Questions Related to Treatment**

1. Did you experience any mental or physical health conditions after receiving your infertility diagnosis? If so, please describe.
2. Did you seek any forms of mental health treatment due to infertility?

3. Please share any support or challenges you experienced during your treatment-seeking process.
4. Has your cultural background influenced your treatment-seeking behavior? If so, how?
5. What else can you share with me related to your infertility journey?