van den Akker, O.B.A., Payne, N., and Lewis, S. (2017) Catch 22? Disclosing Assisted Conception treatment at work. International Journal of Workplace Health Management

**Abstract**

*Purpose:* The purpose of this study was to explore factors influencing decision-making about disclosure of Assisted Reproductive Technology (ART) use in the workplace.

*Design:* A qualitative study design was used. Thirty-one women and six men who were using or had recently used ART were recruited from British fertility networks and interviewed. Data were transcribed verbatim and thematically analysed.

*Findings:* Two main strands were identified each encompassing two themes: i) 'Concerns about disclosure' covered the very personal nature of disclosing ART treatment and also career concerns and ii) 'Motives for disclosure' covered feeling it was necessary to disclose and also the influence of workplace relationships.

*Research limitations*: The relatively small, self-selected sample of participants was recruited from fertility support networks, and lacked some diversity.

*Practical implications:* Clarity about entitlements to workplace support and formal protection against discrimination, along with management training and awareness raising about ART treatment is needed to help normalise requests for support and to make decisions about disclosure within the workplace easier.

*Originality/ value***:** The study has highlighted an understudied area of research in ART populations. The data provide insight into the challenging experiences of individuals combining ART with employment and, in particular, the complexity of decisions about whether or not to disclose.

**Keywords: Fertility, involuntary childlessness, assisted conception, disclosure, stigma, employment, communication**

## Introduction

Recent data from the HFEA (2015) shows numbers of ART treatments in the United Kingdom (UK) have more than doubled between 1992 and 2007, and is continuing to increase. Treatment is sought by those who experience infertility or subfertility for medical reasons (NHS, 2017), including following the treatment of cancers (Vitale et al, 2017). Vitale et al (2017) reported that the experience of infertility due to cancer in women can be more devastating than the cancer itself and the possibility of having a child after cancer can have beneficial effects on the therapeutic process. However, both the treatment of disease and subsequent different types of ART's are known to have an effect on the emotional state of women and the failure of treatment may influence the quality of life of the woman and the relationship within the couple (Vitale et al, 2016). Treatment for infertility is also sought by those involuntarily sub fertile through lifestyle factors, such as delayed childbearing associated with a lack of partner (Salomon et al., 2015), health concerns (Holton et al., 2011), or educational and employment reasons (Birch Peterson et al., 2015). These delays have important consequences for fertility prospects, which are diminished and may require treatment. Single men and women, and same sex couples are also increasingly seeking treatment in the UK to overcome involuntary childlessness and build a family (van den Akker, 2017). Many involuntary childless people never seek treatment (Greil and Mcquillan, 2004) and some of these are too depressed to seek help (Crawford et al., 2017). However, especially for women who do seek treatment, assisted conception is time consuming, costly, physically uncomfortable, unpredictable and can lead to effects on mood and performance in work and non-work domains (van den Akker, 2012). The experience of infertility or involuntary childlessness (the preferred term used in this paper) is also influenced by the social context in which it takes place, including socioeconomic status, religion, culture, gender, gendered practices and direct and indirect messages women and men receive (Bell, 2016). While

women using assisted conception experience greater levels of distress than men (Greil, Slauson-Blevis, & McQullian, 2010), men too may need to cope with anxiety or depression (Fisher and Hammarberg, 2012). They may invest time and emotional efforts into diagnostic investigations and providing sperm samples, as well as supporting their partner through the numerous tests and invasive treatment processes. Therefore, men and women who are involuntarily childless for various reasons face devoting substantial amounts of time - including time from work - and emotional energy to a family building process which has an uncertain outcome.

Research to date has neglected the experiences of combining ART treatment with employment. This is an important gap in the research as ART users need to disclose this treatment process to supervisors and colleagues to obtain workplace support. However, disclosure of personal aspects of life at work, where most people spend much of their time, can be fraught with difficulties. Communication Privacy Management (CPM) theory (Petronio, 2002) suggests that individuals maintain and coordinate privacy boundaries with potential communication partners. These privacy boundaries draw divisions between private and public information. The boundaries may be permeable or rigid depending on the perceived benefits and costs of disclosure.

Thus despite the need to disclose to obtain workplace support, there are a number of potential costs or reasons why workers may feel ambivalent or fearful about disclosing ART use. Firstly, not everyone feels comfortable with disclosures that blur private and professional boundaries. For example, there may be concerns about stigma (Whiteford and Gonzalez, 1995). In particular, reasons why men do not disclose using ART to those outside of their immediate personal relationships tend to centre on shame (Lee and Chu, 2001) and fear of

thoughtless comments (Throsby and Gill, 2004). This is problematic because research has shown that social support is associated with less stress (Martins et al., 2013) and less depression, and anxiety and greater positive adjustment to involuntary childlessness (Bute, 2013; Mahajan et al., 2009).

Secondly, gendered assumptions about ideal workers, who do not allow personal life (Holt and Lewis, 2011) or problematic and unpredictable (female) bodies to interfere with work (Swan, 2005), may inhibit some women using ART from disclosing. Due to the paucity of research on disclosure of ART treatment in the workplace, work on pregnancy in the workplace may serve as an example. Pregnant women applying for jobs have been treated with hostility (Hebl et al., 2007) and research on bodily issues at work (e.g. Gatrell, 2011) shows that pregnant employees (at least among professional and managerial women) report feeling side-lined or discriminated against due to assumptions that they are no longer committed to their work (King and Botsford, 2009). Pregnant women respond by "supra-performing" (Gatrell, 2011) to minimize the impact of pregnancy at work (Costello, 2009) and show that they can conform to the male ideal worker. Disclosure is left to later in the pregnancy when the signs are obvious and the risks of miscarriage reduced. Women who are pregnant via non-normative routes, such as single or older women or those who used ART may be doubly reluctant to disclose (King and Botsford, 2009), as they will be revealing more than just the pregnancy. Thus disclosure of ART treatment is likely to be especially difficult in the workplace.

Thirdly, there is evidence from other health related fields that disclosure of personal information at work can be perceived as risky. For example, in a study of workplace disclosure in breast cancer survivors, Robinson et al. (2015) found that women felt they had

to disclose that they had breast cancer because they feared colleagues might guess they had a major health problem. They also disclosed in the workplace because they wanted to be open, although they had concerns about confidentiality and the distress of telling people. Reasons for not disclosing chronic illnesses (Munir et al., 2005) and mental health issues (Brohan et al., 2012) in the workplace include privacy; fear of gossip, discrimination, and rejection; and fear of loss of social support and loss of employment.

Fourthly, this previous research on disclosure of pregnancy and of chronic and mental illness raises questions about how comfortable ART users feel about requesting time off work. In the UK there are no statutory rights to conception care, such as absence from work for assessments of fertility status and for ART appointments and procedures. Workplace policies to support workers using ART are also not commonplace. This is despite evidence verifying a need for such support in other countries (e.g. the U.S. Family Building Act of 2001). The lack of policy for conception care may result in ART users feeling anxious about whether disclosure in the workplace will result in the provision of support, such as enabling time off work. For example, parents with childcare demands are often reluctant to request flexible working arrangements because of non-supportive workplace cultures (Friedman, 2001). These concerns have not been examined in ART users.

Non-disclosure of stigmatized conditions can lead to living with different identities which are presented and maintained in different social situations. Ragins (2008) refers to 'disclosure disconnects' whereby varying degrees of disclosure in different settings result in individuals attempting to manage an identity that is concealed in certain settings. For example, a person has the dilemma to, on the one hand, show authenticity as an employee and colleague in order to maintain the identity of an honest person and verify the sense of self as one who has

meaningful (workplace) relationships (Creed and Scully, 2000), and on the other hand to keep private matters away from the workplace and protect themselves from experiencing discriminations or stigma (King and Botsford, 2009). Martins et al. (2013) suggest that if disclosure is perceived to be safe, and potentially leads to social support, it may be beneficial to disclose. Non-disclosure may be a safer strategy where confiding personal information may not lead to support.

Issues relating to the disclosure of ART treatment in the workplace have been neglected in research. One exception is a study by Finamore et al. (2007). They failed to find an association between women's disclosure of ART in the workplace and reduced stress but found that women disclosed to explain frequent absences for medical appointments. Reasons for non-disclosure focused on privacy. However, this study was based on questionnaires which precluded in depth exploration of experiences and decision-making about disclosure.

The present paper is part of a larger study of work and involuntary childlessness. It explores ART users' accounts of decision-making about whether to disclose to supervisors and colleagues in the workplace and factors influencing their decisions.

## Method

*Materials*

A semi-structured interview schedule was developed based on previous research and input from the organizations Fertility Network UK (FNUK; a UK charity supporting people who have ever experienced fertility problems) and Working Families (a UK charity supporting working parents and carers and their employers find a better balance between responsibilities at home and work). The interview schedule, which was part of a larger study, comprised open

ended questions and prompts to explore participants' job role, aspects of their career and family, combining work and treatment, how they managed taking time off work, and decisions about and experiences of disclosure in the workplace.

*Participants*

A convenience sample of 37 participants was recruited. Most were members of FNUK or Fertility Friends (both leading online infertility and fertility support communities in the UK), and some were recruited through snowballing techniques. Half were in treatment and half were previous ART users. Twenty-six were married or co-habiting (partnered), 5 were single women, and 6 were married or co-habiting men. The mean age of participants was 36 (SD = 5.58). All were white and heterosexual and were in professional or white collar jobs.

*Procedure*

Ethical approval was obtained for the study from the University Ethics committee. Participants were recruited through messages on the websites of six fertility support networks or organisations. Potential participants contacted the research team by email and were then sent an information sheet and consent form and were asked to arrange a time for the interview. Due to issues relating to time and location, thirty-three participants preferred to be interviewed by telephone while four agreed to be interviewed in their home. Interviews were conducted by a Research Assistant except for four early interviews which were conducted by two of the authors. Interviews lasted between 45 and 120 minutes, were digitally recorded and transcribed verbatim.

*Data analysis*

Transcripts from the interviews were analysed using thematic analysis (TA) with the

assistance of NVivo 10 software to help organise themes and subthemes and associated quotes. Braun and Clarke (2006) argue that as TA is not theoretically bounded, it is a flexible technique for identifying, analysing and reporting patterns (themes) in the data. TA was conducted within a realist/essentialist paradigm, such that experience and meaning were theorised in a relatively straight-forward way because they were considered to be reflected via language (Braun & Clarke, 2006). Data analysis began while data were still being collected and Braun and Clarke's six-phase process was broadly used. Initially one of the authors and a research assistant read and re-read 25 of the transcripts in detail (step 1: familiarising yourself with the data). Participants' responses were coded into groups of codes that summarised the content of the data, guided by the aims of the study (step 2: generating initial codes). These were collated into initial themes and subthemes (step 3: searching for themes), which were checked against the same 25 interviews (to ensure that they were all represented). These themes were discussed among all authors to further ensure reliability (step 4: reviewing themes). A further 12 transcripts were coded by the remaining two authors and again the themes were discussed among all authors. At this point it was decided that data saturation had been reached and so no further interviews took place. Themes and subthemes were reviewed through an iterative process throughout and were finally refined and grouped under four major named themes (step 5: defining and naming themes). Themes were then linked, enabling theorising about the disclosure process, including barriers to and facilitators of disclosure of ART use in the workplace. Finally quotes from participants, who were given pseudonyms, were selected to illustrate each theme and the findings were drafted (step 6: producing the report).

## Findings

Thirty participants (81%) eventually disclosed their use of assisted conception to their line

manager because they wished to or felt it was necessary. However, all participants expressed concerns about disclosure and for seven (19%), these concerns deterred them from disclosing to their line manager. Thirty-one participants (78%) disclosed to colleagues. However, all participants were concerned to limit the number of colleagues who were aware they were having treatment.

Four main themes emerged from the data and these are grouped under two key strands: 1) concerns about disclosure ("it's very personal" and career concerns) and 2) motives for disclosure ("I felt I had to" and workplace relationships). Career concerns applied only to decisions about disclosing to line managers in the workplace. The other themes applied equally whether in relation to disclosure to line managers or colleagues. These themes and illustrative interview data are set out in the following sections.

**Strand 1: Concerns about disclosure**

The main concerns that made it difficult to disclose ART treatment in the workplace are related to i) the very personal nature of such disclosures and ii) career concerns.

***"It's very personal"***

A major theme permeating all the accounts was concern about disclosing something that was considered intensely personal and private in the workplace context. As highlighted by Grace (partnered), participants felt *"awkward and embarrassed about confiding in somebody at work that very personal stuff*". There was some variation in the extent to which participants felt uncomfortable in blurring the boundaries between work and personal life in this way. The men in particular and also men and women in more senior roles were most concerned to keep work and their personal life separate in order to remain "professional". For those like

Jenny, who were reluctant to disclose treatment even outside of work, the decision making about disclosure at work was very difficult.

> *I was so private and I wasn't even telling my friends, I definitely didn't want to tell anyone at work at all, and I really agonised over that. I wanted to keep it to myself, I didn't want people to know… it helps me keep it away from work* (Jenny, partnered)

Reluctance to disclose this very personal information was also attributed to fear of being judged and included explicit references to stigma related to having treatment, especially among men such as Matthew and single women such as Harriet. There were also concerns about gossip and that people would fail to maintain confidentiality.

> *...ultimately for fear of judgement. I was in a big school and I was unmarried, an unmarried mother seeking IVF treatment … so I kept my privacy*. (Harriet, single)

> *I think there is an element of slight anxiety I suppose in how-, what people are going to-, in their views of IVF and that sort of thing* (Matthew, partnered)

Fears about continued intrusion into this very personal issue by well-meaning colleagues who might enquire about treatment progress also made decisions to disclose difficult. In particular, there were concerns about having to disclose whether treatment had been successful immediately after embryo transfer, which, if not successful, would also be highly distressing. However, experiences of those who had disclosed varied; some found questions about treatment progress from colleagues with whom they had a good relationship quite supportive, while others felt that their anxieties about intrusion were justified.

> *They were all asking at each stage, "How is it going? What stage are you at now?" When you are going through something like this it almost gives people permission to*

*ask questions … just very personal questions … you wouldn't ever ask a normal couple who are trying to conceive, those questions. That was difficult*. (Nikki, partnered)

Nikki's comments above illustrate an underlying frustration that people using assisted conception are treated differently to those trying to conceive naturally, who would not have to disclose so early nor be asked personal questions about their attempts to conceive.

*I certainly can't imagine telling a colleague that you're trying to have a baby [if you are not having ART treatment]. It's too kind of – I don't know. You don't tell people you're having sex, do you?* (Verity, partnered)

This frustration about differential treatment also emerged in relation to the second theme relating to career concerns.

***Career concerns***

Concerns about the possible negative career consequences of disclosing ART treatment to line managers emerged as a theme, especially among the women in this sample of professional and white collar workers. These concerns influenced their thinking about whether and when to disclose and ask for support from line managers. This was a particular concern for single women who relied on employment and a single salary to support treatment and any future child if treatment was successful. The women were also concerned about requesting support for time off or flexibility to manage treatment and then ultimately having to ask for support again for maternity leave. While maternity leave is a statutory right, they still felt uncomfortable about what they perceived as implying "*I need some time off in order that hopefully I can have a whole load more time off"* (Sarah, partnered). They feared

possible career implications, including loss of career opportunities and questioning of their career commitment.

Participants once again drew contrasts with people trying to conceive naturally. The perception among those who discussed possible career disadvantages was that disclosure would be providing advance notification, which, it was suggested, might impact on opportunities for promotion. For example, Nikki expanded on her earlier comments:

> *I didn't want to make it so public that it would jeopardise my roles within the team. At the time we were going through IVF there were quite a lot of role changes so I was competing for different roles within my team and therefore didn't want to be seen as, okay, she's going to have a baby so there's no point in giving her a more senior role. I think that was what was most difficult because a lot of people who were trying naturally, they wouldn't have to disclose any of that* (Nikki, partnered)

Relatedly, the decision about whether to disclose was also influenced by perceptions that line managers or colleagues may question their focus on and commitment to work. This perception that their priorities lie elsewhere could again have negative career consequences. Most of the men were less concerned about this. For example, Oliver (partnered) remarked *"In terms of like if my wife does get pregnant, it will be her that's having the time off, and so it doesn't really affect me as much"*. However, like most women participants, Ian, who worked in a job with high ideal worker expectations also feared that to disclose to his manager would result in his commitment to his job being questioned.

> *Having worked with my boss' boss for about six years now, his opinion would have been, well Ian's doing this, he's not interested in his career, who's next. I absolutely know that they weren't interested in promoting or pushing anyone who wasn't giving*

*the cause 200% really. To have something massive like this revealed is a bit like shooting yourself in the foot really.* (Ian, partnered)

Participants also felt that unexplained absences due to ART treatment if they did not disclose could equally be interpreted in terms of lack of commitment. This was highlighted by Kerry (partnered) who said "*I got the sense that people thought I was ducking and diving out of work and being unreliable*". Thus women may end up in a catch 22 situation whereby whether or not they disclose and whether or not treatment is successful they could be seen as less committed.

Nevertheless, not all the women participants talked about career concerns. A counter view expressed by a minority of women from the outset was that having a child was so much more important than their job or career.

*To be quite honest, I didn't care. If they'd turned round and said, 'Well, asking for this means that you'll never be promoted," I would have said, "Right, I don't give a stuff" quite frankly*. (Angela, partnered)

In summary, all participants expressed some degree of concern about disclosing what was considered to be the intensely personal and private experience of ART treatment in the public sphere of the workplace. This was compounded by fears of judgemental or stigmatising responses from others, as well as anxiety about further intrusive personal question about treatment progress. The women in particular also talked about the potential impact of disclosure on their careers. It was feared that having to reveal in advance that they may have a baby would prolong any potential negative perceptions of mothers at work by reducing promotional opportunities or calling into question their career commitment. The nature and

extent of these concerns varied according to gender, whether participants were partnered or single and expectations relating to their job role. However, cutting across both personal and career concerns about disclosure, the point was repeatedly made that people using assisted conception are treated differently from those trying to conceive naturally, which was regarded as frustrating and unfair.

**Strand 2: Motives for disclosure**

The main motives for disclosing ART treatment in the workplace are related to i) feeling it was necessary to disclose and ii) the influence of workplace relationships.

***"I felt I had to"***

Despite concerns about disclosure, a key motive for disclosing in the workplace was feeling there was little choice and it was necessary. Where participants made an early decision to disclose it was because they needed to request support for time off work to attend appointments. This was especially the case among participants who lacked any intrinsic flexibility in their working hours and locations. However, there were also concerns, even among those with more autonomy at work, that their line manager or colleagues would notice that they were taking time off, that their productivity had reduced or that they were being more emotional at work.

> *I didn't want people to think I'd just lost the plot for no reason; and I wanted people at work to understand why my work ethic had changed, and why I needed time off without trying to think up reasons*. (Brenda, partnered)

The need to disclose was also discussed in terms of wanting to be honest and transparent, so they felt they had a "responsibility" to disclose. This was particularly prevalent where there

was considerable interdependence within work teams or where they may need colleagues to cover work.

> *I just again felt that I couldn't be absent and coming and going in the way I would be and also expecting him to pick up work for me in my absence without being honest about why I wasn't going to be there.* (Sarah, partnered)

Indeed, where participants did not disclose, their concerns about secrecy and not being 'honest' created anxiety and conflict in combining work and treatment, leading to the realization that disclosure might be the better option.

> *So when I had to go to like appointments or getting blood tests or whatever, you know, I just had to lie and sort of sneak around. Which I actually found more stressful than doing IVF. So it was really tricky* (Ruth, single)

Those who did not initially disclose felt that it became necessary to do so with more rounds of treatment or if treatment became challenging.

> *I felt that I needed to tell him because I knew that potentially I was going to need time off again and it was going to be disruptive and it may end up in having a miscarriage again.* (Charlotte, partnered)

***Workplace Relationships: shared values, experiences and friendships***

In all cases, workplace relationships were key to whether participants felt comfortable about disclosing ART treatment. For example, disclosure to a line manager or colleagues was more likely if participants felt they would understand because they had shared values in relation to work-life balance or childcare. In some cases managers or colleagues themselves had also disclosed personal experiences of ART treatment which created a context where the decision

to disclose was much easier

> *I knew that he's been through IVF three times himself, so it's something I felt very comfortable talking to him about.* (Yasmin, partnered)

If line managers, in particular, were perceived as workaholics, lacking 'work-life balance' or did not have a family, participants were more reluctant to disclose.

> *My boss is nearly 50, he's single, and he's divorced about three times. He has no intention of having children and he's a workaholic. So, how can he ever, ever, really possibly understand what I'm going through*? (Jackie, partnered)

The most positive experiences were described as embedded in workplace friendships. That is relationships with line managers or colleagues often extended beyond just being work colleagues. This was associated with talk of telling friends at work about having ART treatment, legitimising the blurring of the boundaries between work and non-work spheres of life.

> *It wasn't even so relevant that they [colleagues] needed to know as such. My other colleagues are more friends, so I was feeling like I was telling something to a friend* (Una, partnered)

Workplace relationships associated with shared values, experiences or friendships created the most supportive experiences in the workplace, which involved both practical support for time off work for treatment and some emotional support.

> *Obviously it made me feel better because he [line manager] did understand the pressures that you have to go through and the stress that it does bring on a person, but also the time off and things like that that I'd require. So, actually you couldn't ask*

*for more understanding*… (Polly, partnered)

In summary, accounts of why participants disclosed ART use at work focused on two, partially overlapping themes: perceived lack of choice and relationships at work. Perceived lack of choice was largely attributed to lack of job flexibility which necessitated line manager support but also the need to be honest and transparent, especially because of interdependence of work teams. Workplace relationships were thus implicit in this theme but were more explicit in the second theme. The second theme pointed to the importance of shared values and experiences associated with empathy and even friendship, which made it easier to disclose. In contrast, lack of shared values and management capacity to understand the ART process created barriers to disclosure.

## Discussion

This is the first in depth qualitative study to explore the experiences of individuals having ART treatment and to focus on disclosure of this treatment in the workplace. The confusion and ambivalence experienced by the participants in this study reflect the challenging nature of ART treatment, and this is rarely described in the literature (van den Akker, 2012). We found two main strands which reflected participants' decisions to disclose: Concerns about disclosure and Motives for disclosure. Similar themes have emerged in research on cancer (Robinson et al., 2015) and mental health disclosure in the workplace (Brohan et al., 2012). However, concerns about and motives for disclosure in this study were related to participants' unique experiences of ART treatment and concerns about blurring boundaries between the personal world of ART treatment and the public domain of work.

All participants expressed concerns about disclosing ART treatment, although the majority ultimately disclosed. However, privacy and intrusion concerns in the present study were not just about maintaining boundaries between the personal world of ART and work, but also about not wanting to be subjected to enquiries for updates about the success or failure of treatment. In particular, assisted conception was compared with natural family building where sex is seen as a private matter and people rarely disclose until at least 12 weeks into a pregnancy. Involuntary childlessness and the need to use ART were also felt to be stigmatizing. Stigma of involuntary childlessness (Throsby and Gill, 2004) and fears of judgement of using ART (Lee and Chu, 2001) are world-wide recognised problems, and are difficult to eradicate (van den Akker, 2012).

Privacy and stigma were particularly pressing reasons not to disclose for men, who are known to feel stigmatised by involuntary childlessness, and single women, who are undergoing ART alone, as these are perceived as non-normative contexts for masculinity and family building respectively (Fisher and Hammarberg, 2012; van den Akker, 2016). In these cases, they will be disclosing more than just a possible future pregnancy at work, but their virility for men or relationship status for single women (King and Botsford, 2009). However, their choice not to disclose was sometimes limited. Some women thought they had no choice but to explain what they were doing to defend a change in behaviour or emotions at work. This choice was further limited where multiple unsuccessful treatments or miscarriages were experienced. Others felt they had to disclose to maintain their identity as a truthful person; to maintain their work image as a reliable employee; and because the burden of non-disclosure became too much. The benefits of the social support they may receive via disclosure at work (Mahajan et al, 2009) were therefore weighed up against the negative consequences of disclosure, as was found in other research on disclosure in the workplace (Robinson et al,

2015; Costello, 2009; Swan, 2005). However, where blurring of boundaries occurred due to colleagues being friends (or where there was shared values and experiences), especially positive consequences of disclosure were reported.

Revealing and concealing involuntary childlessness can have identity implications (Bute, 2013) and 'disclosure disconnects' may be experienced (Ragins, 2008). For example, in the workplace ART users discussed the problems associated with their identity as an employee versus as a prospective parent. Disclosure, for them meant potentially being discriminated against at work, as reported by King and Botsford (2009) in relation to pregnancy. Non-disclosure, on the other hand, left them feeling a fraud to their colleagues (as reported by Creed and Scully, 2000). This suggests competing identities are fighting for recognition, and that more often than not, one needs to be sacrificed to save the other. Either way their commitment to their job could be questioned; if they disclosed they would be seen to be focused on family building and if they did not disclose they would appear to be an unreliable employee. Thus women ended up in a catch 22 situation whereby whether or not they disclosed and whether or not treatment was successful they could be seen as less committed.

In the present study, a key reason for disclosure was 'necessity', but disclosure was also more likely where values and experiences were shared with the recipient, such as where the recipient had a family; had also experienced ART treatment; or was a friend. According to CPM theory (Petronio, 2002), disclosure is more likely to recipients (or communication partners) in these circumstances because the benefits of disclosure, such as obtaining workplace or social support, are more likely. Thus the boundaries between public and private information are rendered permeable and depend upon the individual situation. Similarly, theories of how people manage work and personal life, such as Border theory (Clarke, 2000)

and Boundary theory (Ashforth, Kreiner & Fugate, 2000) suggest that boundaries exist between work and personal life to keep the domains separate. However, borders or boundaries may also be blurred to help integrate domains where desired. In general, participants in the present study wished to keep the public domain of work and the personal world of ART separate, but where workplace friendships existed there tended to be a blurring of the boundaries. In contrast, the likelihood of non-disclosure increased if there was a lack of shared values or experiences, such as where line managers appeared to lack 'work-life balance' or did not have a family. Thus, as suggested by CPM theory, participants acted upon a number of competing needs and values which were dynamic and seemed to be adapted as the need to reveal more or less arose. However, reasons for disclosure based on recipients' individual differences, rather than workplace policy or practices, can put employees in unfavourable positions with regards to disclosure.

With the exception of concerns about privacy and stigma, the themes in the present study were less relevant to men, who, despite supporting their partners as much as possible, did not have to undergo the physical and emotional turmoil of the treatment to the same extent as the women. Bell (2016) refers to ART as "feminized", as it excludes men from the same intense treatment experience, even where the diagnosis is male factor infertility. ART treatment by its very nature and in medical terms is therefore a gender specific issue, with a shared outcome but with the route to the outcome largely burdening the female partner. In the workplace, this is compounded by gendered assumptions about ideal workers, who do not allow personal life (Holt and Lewis, 2011) or problematic and unpredictable (female) bodies to interfere with work (Gatrell, 2011). Consequently, maintaining an existing identity as employee and co-worker was especially challenging for women participants in this study, and a new identity as prospective parent was difficult to disclose and difficult to adapt to.

Apprehensions about career consequences were reported by many of the women in this study, including fears that their career commitment would be questioned or that their career opportunities and progression would be undermined. These anticipated negative effects reflect, and add, to those experienced by other women requesting maternity leave and flexible working to accommodate childcare (King and Botsford, 2009; Hebl et al., 2007; Friedman, 2001). Requesting additional time, over and above what naturally conceiving couples request might simply be considered too much by an employer; a concern raised by some of our participants. Interestingly, for other participants, having a child became such a priority that they were not concerned about their current or future careers, and wanted to focus on fulfilling this elusive aspiration. However, especially for single women, financial security is crucial to achieve this aspiration, because they are reliant on a single salary, and so concerns about career for more functional reasons may be a particular issue.

These findings should be considered within some limitations to the present study, including it being based on a small and self-selected sample, which may have captured those with the best or worst experiences. There was also a lack of diversity in the sample as all participants were white and heterosexual, there were few men and single people, and there was no one who had given up on having a child. Given the sensitivity of the topic and difficulties recruiting volunteer participants it was beyond the scope of this study to recruit a more diverse sample. It is important for future research to take active steps to target more hard to reach groups, such as same sex couples, and also to extend the findings to a larger sample using survey methodology. Nevertheless, the findings have some potential practical implications. With the future need for assisted conception not likely to see a decline (HFEA, 2015), it is important that policies and practices address difficulties concerning disclosure that men and particularly women undergoing ART treatment experience in order to help them obtain support.

This study has shown that reasons for disclosure are work related and personal. Similarly, feeling they had no choice, concerns about their identity and the effects of disclosure upon their careers posed additional burdens on employees already compromised by difficulties conceiving. Clarity about entitlements to support and formal protection against discrimination, along with management training and awareness raising about ART treatment may help to normalise requests for support and make decisions about disclosure easier. However, the complexity of ART users experiences and conflicts concerning disclosure suggest that fundamental changes in negative assumptions about both involuntary childlessness and family building and ideal workers are needed.

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