**Beyond work-family conflict: The experience of combining work and fertility treatment**

(Work in progress. Full paper not to be made available on the conference website etc.)

Nicola Payne, Suzan Lewis and Olga van den Akker

Middlesex University

Nicola Payne is a Health Psychologist and Associate Professor in Psychology at Middlesex University. Her primary research interests within the field of occupational health psychology include work–life balance, occupational stress, the impact of work on health behaviours and behaviour change interventions, and issues related to combining work and health issues such as fertility treatment. With Suzan Lewis, she recently co-edited a book and co-led an ESRC seminar series on work-life balance in recession, austerity and beyond.

Suzan Lewis is Professor of Organisational Psychology at Middlesex University Business School. Her research focuses on work-personal life issues and workplace practice, culture and change in diverse national contexts, with a particular interest in gender and other forms of diversity. She has led many national and international research projects and published widely on these topics and has also worked with employers and policy makers on diversity and work-life issues and workplace change in Europe, Asia and North America. She was founding co-editor of the international journal Community, Work and Family.

Olga B.A. van den Akker is Professor of Health Psychology at Middlesex University. Her research interests include all aspects of Reproductive Health Psychology, with a focus on fertility issues. Her research into chronic diseases and aspects relating to sexual and reproductive health has been funded by the British Academy, Charitable organisations, regional health authorities and the NHS Research and Development. She has published 4 books and numerous journal articles on her research. In 2007 she became Head of Department of Psychology at Middlesex University. She was editor in Chief of the Journal of Reproductive and Infant Psychology and is on the editorial board of a number of other journals.

**Beyond work-family conflict: The experience of combining work and fertility treatment**

(Work in progress. Full paper not to be made available on the conference website etc.)

**Abstract**

**Purpose:** Over 40,000 people in the UK each year use Assisted Reproductive Technology such as IVF. Yet, there are no statutory entitlements to absence or flexible working, despite the long, physically and psychologically demanding ART process, and few work environments have policies in place to support ART users. Work-life balance research, theory and policy tend to focus on expectant and existing parents and carers and have been criticized for this narrow focus. For example, traditional theories focus on the concept of work-family conflict (WFC), whereby conflict is experienced when pressures arising in the work role are incompatible with pressures arising in the family role. In this paper we argue for the need to extend the definition of family in work-family conflict research by focusing on family building in ART users. We draw on theory and research on WFC, and also on the importance of personal meanings attached to different roles and the centrality of these in defining identity, to explore the ways in which experiences of work and ART treatment may conflict and the impact of meanings of employment and potential parenthood.

**Design/methodology**: A qualitative approach was used to generate rich and in depth accounts of the nature and complexity of experiences and dilemmas. Interviews of 60-90 minutes were conducted with 31 women and 6 men who were using or had previously used ART. Interviews were transcribed verbatim and thematic analysis was conducted.

**Findings**: Four major themes emerged: the emotional strains of the ART treatment journey and work, the demands of work time and “body time”, shifting identities and priorities across time, and the practicalities and meanings of line manager support. The findings reveal bi-directional strain-based and time-based conflict between work and ART treatment, gender differences and the protective effect of job flexibility and line manager support. However, conflicts experienced were also shaped by personal meanings attached to different roles and the centrality of these in defining identity in relation to career and becoming a parent.

**Limitations/implications**: Despite some limitations, such as a small self-selected sample, the findings have implications for policy and practice. In particular, specific policy, focusing on flexibility and line manager support, is crucial to support and protect ART users in the workplace, and this should be coupled with line manager guidance and education.

**Originality/value**: This paper contributes to the literature by responding to calls to extend research on WFC to incorporate a wider definition of family and a wider range of employees and by addressing the lack of knowledge about how the growing number of people using ART experience treatment and employment. It highlights the need for a dynamic conceptualization of WFC to take account of complex experiences of the precarity of the ART treatment journey over time and the transient but important shifts in the centrality of identity in relation to career and becoming a parent.

**Key words:** Work-family conflict; fertility; assisted reproductive technology; identity; supervisor support

**Beyond work-family conflict: The experience of combining work and fertility treatment**

**Introduction**

The majority of literature on the work and family interface (e.g. Allen, French, Dumani, & Shockley 2015; Michel, Kotrba, Mitchelson, Clark, & Baltes; 2011; Nohe, Meier, Sonntag, & Michel, 2015) focuses on conflicting demands. Conflict between work and family roles has been linked to increased stress and negative health outcomes (e.g. Cooklin et al., 2016; Emslie, Hunt, & Macintyre, 2004; Shockley & Allen, 2013), as well as to negative organizational outcomes, such as reduced organizational commitment and job performance (e.g. Li, Bagger, & Cropanzano, 2017; Muse, Harris, Giles, & Field, 2008). Thus managing the interface between work and personal life is important for both employees and employers.

However, work-family conflict research has been criticized for a narrow focus on employees with children (or other dependent care obligations) (e.g. Casper, Weltman, & Kwesiga, 2007). Ozbilgin, Beauregard, Tatli, and Bell (2011) and Kossek, Lewis, and Hammer (2010) call for organizations to identify and support the diversity of individuals’ needs for managing the interface between work and personal life. One group of workers neglected in work-family conflict research and policy developments is those using assisted reproductive technology (ART), that is, having fertility treatment such as in vitro fertilisation (IVF). For example, in the UK employees have a statutory right to absences for pre and post natal care (maternity, paternity or parental leave), but not for pre-conception care, so few work environments have formal policies in place to support ART users.

This paper aims to address this research gap by examining the experiences of combining employment and ART. It addresses calls to extend the definition of family in work-family conflict research (e.g. Beauregard, Ozbilgin, & Bell, 2009), by focusing on family building involving ART. Below we first discuss ART in more detail before drawing on theory and research on work-family conflict, and on the importance of personal meanings attached to different roles and the centrality of these in defining identity, to consider implications for the experiences of the interface between work and ART treatment.

***The experience of fertility treatment***

It is estimated that each year 45,000 people in the UK use ART and demand is growing (HFEA, 2013). While infertility may be classified as a disease or disability (Khetarpal & Singh, 2012), there is a growing demand on ART from people who planned a family later in life, who are single or in same sex relationships (da Motta & Serafini, 2002). The ART process is physically demanding and time consuming. The daily administration of intravenous hormones may have unpleasant physical and psychological effects and throughout this time most clinics require women to attend for scans and blood tests almost every day in order to check the effectiveness of the drugs in stimulating the ovaries. This is followed by egg collection and then once the collected eggs are fertilized in vitro, viable embryo/s are transferred to the womb. The timing of these procedures is somewhat unpredictable. After embryo transfer women are generally advised to rest and wait two weeks before a pregnancy test to determine the success of the treatment. Only a minority of cycles result in a successful pregnancy and not all of those result in a live birth (Pinborg, Hougaard, Nyboe Andersen, Molbo, & Schmidt, 2009). Therefore, users often go through months or years of treatment cycles, and may have several cycles treated each year.

While women may experience fertility problems as having the greatest impact on their daily lives and self-identity, men tend to experience it more indirectly through their partners (Beutel et al., 1999). Both women and men having fertility treatment have been found to experience high levels of distress (Greil, Slauson-Blevis, & McQullian, 2010), although this is greater for women (Anderson, Sharp, Rattray, & Irvine, 2003; Slade, O’Neill, Simpson, & Lashen, 2007). Stress levels vary with stage and length of treatment (Greil et al., 2010). This is problematic as stress may negatively influence ART success rates, although this evidence is equivocal (Boivin & Schmidt, 2005; Stoleru et al., 1997).

Thus evidence suggests that the time needed for scans and procedures, the effects of taking intravenous hormones and the stress associated with using ART and its uncertain outcomes may conflict with the demands of work, particularly for women. Conversely, experiences at work may also impact on experiences and outcomes of treatment. In the absence of research examining experiences of combining employment and ART use, the remainder of this section draws on the substantial literature on work-family conflict.

***Approaches to understanding the work-family interface***

Much of the literature on the work-family interface is based on role conflict theory, which suggests that incompatibilities arising from engagement in multiple roles may create conflict and difficulty in carrying out roles effectively (Greenhaus & Beutell, 1985). Work-family conflict (WFC) is bi-directional and it may be strain-, time- or behaviour-based (Greenhaus & Beutell, 1985). The existence of time-based conflict (when the time demands associated with one role restrict the amount of time that can be devoted to the other role) and strain-based conflict (when stress arising in one role spills over to the other role resulting in strain), in particular, have generally been supported (e.g. Bruck, Allen, & Spector, 2002; Michel et al., 2011).

There is some evidence of gender differences in WFC, with women, particularly mothers reporting the highest levels of work interfering with family (e.g. Allen & Finkelstein, 2014; Hill, 2005). However evidence is inconsistent in this respect (Eby, Casper, Lockwood, Bordeaux, & Brinley, 2005) which, is has been argued, may be due to the fact that WFC is not static across the life course (Allen & Finkelstein, 2014). Gender roles and behaviours tend to become more divergent following the transition to parenthood, even in previously egalitarian dual career families (e.g. Katz-Wise, Priess, & Hyde, 2010; Lewis & Cooper, 1988). Moreover there is evidence that women have to make particular efforts to manage or conceal bodily changes, such as pregnancy at work while retaining their professional identity (Gatrell, 2012; 2013). In the context of gendered norms and expectations of motherhood and fatherhood, as well as bodily changes, women are more likely to struggle with experience of multiple roles, conflicts and identity dilemmas (Ladge Clare, & Greenberg, 2012; Ladge & Greenberg 2015). However research on the transition to parenthood usually considers a trajectory that begins with pregnancy, overlooking the earlier extended transition of those using ART.

There is also evidence that WFC is influenced by work and organizational factors including support and flexibility. For example, support from supervisors or line managers has been found to reduce WFC (e.g. Den Dulk & de Ruijter, 2008; Goh, Ilies, & Wilson, 2015; Paustian‐Underdahl & Halbesleben, 2014; Thompson & Prottas, 2006) and is associated with better health outcomes (Hao et al., 2016; Shockley & Allen, 2013). In particular, family-supportive supervisors, who empathize with an employee’s desire to effectively manage work and family responsibilities by providing emotional and practical support, promote greater employee control over work, thus reducing WFC and improving health (e.g. Hammer, Kossek, Anger, Bodner, & Zimmerman, 2011; Moen et al., 2015).

However, the largely quantitative research on WFC has been criticized for neglecting the subjective meanings assigned to time spent in multiple roles. Although quantitative research has examined variables such as role salience in relation to WFC (e.g. Noor, 2003), identity is not typically viewed as a fundamental part of the perceptual experience of time and thus of WFC and it is not usually explored in depth within this paradigm. Thompson and Bunderson argue that work and non-work conflict are a function of the phenomenology of time. This approach does not deny that there are objective time constraints, but complements the focus of much WFC research by arguing that personal meanings attached to different roles and the centrality of these in defining identity are crucial to understanding conflict. People typically have multiple identities, such as employee, spouse, parent, child, friend (Vignoles, Regalia, Manzi, Golledge, & Scabini, 2006). Within a potential hierarchy of salient identities an anchor identity emerges (Thompson & Bunderson) which can shift across the life course. For example, research on new mothers returning to work (Haynes, 2008; Ladge & Greenberg, 2015) or choosing to leave work (Kanji & Cahusac, 2015) illustrates some of the conflicts experienced in identity transitions. However, identity issues in employees experiencing a more protracted and uncertain transition to parenthood have not been addressed.

According to Thompson and Bunderson (2001), not only is the centrality of different roles to identity important, but also the extent to which one’s time in work and non work roles is spent in identity discrepant or identity affirming activities determines the perception of conflict between those roles. For example, identity affirmation in both work and non work roles leads to mutual enrichment, whereas identity discrepancy in both roles leads to mutual depletion, conflict and alienation. Discrepancy only in the anchor identity leads to spillover conflict, with frustration also tainting time in the non-anchor role, whereas discrepancy in the non-anchor identity leads to compensation conflict, where an individual resorts to the anchor identity to achieve affirmation. Indeed, Rothbard and Edwards (2003) propose that in order to manage conflicts or identity tensions individuals may *compensate* by decreasing involvement in a dissatisfying role and increasing involvement in or pursuing rewarding experiences in another role, or they may reduce the time or ego attachment devoted to one role to *accommodate* the demands of a role that is currently viewed as more central to identity.

In summary, role conflict theory, including related evidence on gender and family supportive supervisor effects, may help understand the experience of combining employment and ART use. However, a phenomenology of time approach further highlights the importance of also exploring the meanings of employment roles and the desire for parenthood, and the identity centrality of both, in understanding ART users’ experiences, as well as the processes used to manage conflicts or identity tensions. Therefore, the purpose of this study was to broaden the focus of WFC theory by focusing on workers using assisted reproductive technology (ART) and to explore ways in which experiences of work and ART treatment may conflict and the impact of meanings of employment and potential parenthood. These insights will be important for raising awareness of the issues facing the growing number of people using ART and to inform effective workplace policies and practices to support them.

**Method**

In order to begin to understand the experience of employed ART users and how they make sense of and manage their situations, a qualitative interview approach was used to capture rich and contextualized description of experiences (Breakwell, Smith, & Wright, 2012; Thompson & Bunderson, 2001). The use of qualitative research to explore the experiences of a population with very specific needs that are not addressed within the large body of mainstream, quantitative, WFC research permits a fuller and deeper understanding of the complexity and quality of experiences and dilemmas (Schonfeld & Mazzola, 2012). Furthermore, in a review of qualitative work-family research, Beigi and Shirmohammadi (2017) highlighted a need for more qualitative research.

***Participants***

Ethical approval for the research was received from the authors’ university. Participants were recruited through posting a message on the websites of several fertility support networks in the UK. Potential participants contacted the research team by email and were then sent an information sheet and consent form. If they still wished to participate they were asked to arrange a time for the interview and to return the consent form by email prior to the interview. This process generated a convenience sample of 37 ART users working in a range of occupations including education, health, finance, marketing, media, technology and retail. Half were currently using ART while the rest were recent past users with a successful outcome and all were employed full-time when treatment commenced. Duration of treatment was between 3 months and 5 years. The mean age of participants was 36 (SD = 5.58). The sample included 27 married or co-habiting women, 4 single women and 6 married or co-habiting men. The relatively few accounts from men were complemented from a different perspective by the women’s perceptions of their partners’ experiences. Recruitment relied on volunteers and it was particularly difficult to recruit men, who were less willing to speak about this issue.

***Interviews***

Semi structured interviews were conducted by telephone in 33 cases, with the remaining four in participants’ homes. Interviews lasted between 60 and 120 minutes. They were digitally recorded and transcribed verbatim. The interview schedule was developed taking into account previous research, WFC theories and input from two UK charities dealing with fertility and working family issues respectively. Interview topics included: participants’ job role and the importance of their career and of becoming a parent; reasons for using ART, the treatments received, and experience of treatment; experiences of combining work and treatment, work factors that have affected and been affected by treatment; and how they managed taking time off work, including policies and practices used to help combine work and treatment.

***Data analysis***

Since there appears to be no previous research on the experiences of employed ART users or on combining work and treatment, the aim of the analysis was to give a broad overview of the data, guided by the research questions and using a WFC and identity lens. Therefore, verbatim transcripts from the interviews were analysed using thematic analysis (TA) with the assistance of NVivo software. 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. Braun and Clarke’s six-stage process was broadly used to conduct the TA. This involved two of the authors initially reading and re-reading three quarters of the transcripts in detail (step 1) and coding participants’ responses into groups of codes that summarized the content of the data, guided by the aims of the study (step 2). These groups were then collated into initial themes (step 3) and were checked in relation to the same three quarters of the interviews (to ensure they were all represented) (step 4) and were discussed among all authors. The remaining transcripts were coded by a further two authors and again the themes were discussed among all authors. Data saturation was reached towards the end of the coding process. Themes were reviewed through an iterative process throughout and were finally refined and named (step 5). All authors reviewed the analysis and checked that quotations within each theme were relatively similar and consistent with each other and that the themes were conceptually distinct. Internal consistency and conceptual distinctiveness are comparable to convergent and discriminant validity respectively. Finally quotes from participants (who were given pseudonyms) were selected to illus­trate the themes (step 6).

**Findings**

Four main, interrelated themes emerged from the analysis: the emotional strains of the treatment journey and work creating strain-based conflict, which underpins and colours all the other themes; the demands of work time and “body time” creating time-based conflict, shifting identities and priorities across time, and the practicalities and meanings of line manager support.

***An “emotional roller-coaster”: the strains of treatment and work***

The desire for parenthood, the emotional highs and lows of different stages of treatment, and the effects of fertility drugs commonly created significant stress for women and took over their lives. This increased over time, particularly for women who had received more than one round of treatment or who had experienced complications or a miscarriage. A few women ended up experiencing significant levels of depression. Harriet described this “emotional roller-coaster”:

*…very, very exhausting, it was a roller-coaster of emotions and a lot of heartache because I had obviously three miscarriages along the way and an enormous amount of despair but coupled with hope … it was kind of all-consuming actually… it dominated my life ... (Harriet, Teacher, single)*

The men also invested hopes in the process and experienced similar emotions, although they were not directly affected by the fertility drugs and acknowledged that the impact of the treatment process was more intense for their partners. They felt the need to try to stay strong in order to support their partners and also to offer practical support, even though they too suffered anxiety and disappointments. Ian described feeling anxiety about what his partner was going through and feeling like a “spare wheel”:

*…as the man, you do feel slightly spare. … I tried to make myself useful just by things like mixing up the drugs …just doing that and kind of being involved. … I was very worried about her; I was worried about any complications; and at the same time I was worried about our future: if it didn’t work could we go through it again. I’m not going to lie, it’s a very stressful time to go through because I know that [my wife] felt like in a way she’d failed at something. (Ian, Assistant Manager, retail)*

For the women, the emotional stress of treatment and the interface with work created a form of bi-directional strain-based conflict. A common concern was that the stress of work may affect treatment outcomes. Some participants reported they had been advised by their fertility clinic to relax and avoid stress or even feared that if they continued to work it would ruin their chances of treatment success. Jackie (an Account Manager) expresses this as a battle which the job rather than the treatment could “win”: “*…the job will get done and the effect will be that maybe my treatment won’t work because I am so stressed, so ultimately the job is going to end up winning”.* In addition, the effects of fertility drugs and the constant worry about whether treatment would be successful, spilled over to work, creating strain from treatment to work. This made it difficult to concentrate and perform at work and to keep emotions away from the workplace. In this respect women often talked about the need to remain ‘professional’, understood in terms of keeping personal concerns and emotions away from the workplace or simply being able to cope with the usual demands and stresses of work. These strains intensified along the treatment journey and became increasingly acute after cycles were unsuccessful or if a pregnancy resulted in a miscarriage. Sarah highlights these difficulties of treatment interfering with work and in particular how returning to work after experiences of failure or loss is particularly difficult:

*I don’t think you come across as professionally as you would normally because you’re tired and listless…You’re really distracted worrying about what the results are going to be like and just generally, you’re not focused on what you ought to be doing… it’s really, stressful, and really, really emotional and particularly when …you’ve thrown yourself into it and you’ve had some treatment and you find out it doesn’t work, you have to go back to work, you just have to carry on as normal (Sarah, Civil Servant)*

The men interviewed found it easier to continue to be an effective employee and remain ‘professional’. While men also talked about some emotional stress of treatment interfering with work, they were more able to segment work and treatment. For example, Oliver (a Collections Advisor) said: “*I’m very good at segregating things, and if I don’t want to think about something, I don’t think about it”.* However, Edward, like a few of the women, especially those in more senior positions, who deliberately attempted to segment work and treatment reported that the stress of both had an additive effect, which was very hard to escape from or manage:

*…you are stressed at work, and it is fine; you can leave, and you can leave the stress there. But then you come home …. you are stressed. So you are basically stressed for 18 hours of the day and you only sleep the other six. (Edward, Change Manager)*

However, participants commonly reported that work also provided a distraction from the emotional stress of treatment and even in some cases, the trauma of miscarriage. It provided a focus and some degree of normality, so, as described by Grace, the effect of work was not entirely negative:

*I didn’t feel like my normal self really, but I think the job, if anything, just distracted me from sitting around and worrying about it so much. So I think that was probably quite positive really, that I was working. (Grace, Teacher)*

This theme highlights a unique form of bi-directional strain-based conflict which differs in nature from the work-family conflicts associated with, for example, working and caring. Complex strain-based conflicts for women undergoing treatment related to the significant emotional and physical demands of treatment interfering with the demands of work, anxieties about treatment affecting performance and coping at work, and fears that work stress would undermine treatment outcomes. On the “roller-coaster” treatment journey these strains intensified with more rounds of treatment and miscarriages. Nevertheless work also provided a distraction. The men interviewed also talked about strong emotions but did not talk about treatment taking over their lives and reported greater segmentation of their work and personal lives.

***The demands of work time and body time***

The emotional stress of treatment was clearly problematic but the time demands of treatment and work were also experienced as conflicting creating bi-directional time-based conflict. Although women generally tried to prioritize treatment, the time demands of work still interfered with treatment. Time was experienced in different ways. While some interviewees talked about the problems of being in two places at once as mainly practical issues, most accounts of work interfering with treatment tended to be highly emotionally laden, especially if women felt that they had made compromises to their treatment process (for example, delaying aspects of treatment) in order to meet work demands. This narrative below from Nikki’s interview illustrates how conflicting time pressures can affect the experience of ART treatment, in this case because her preoccupation with work schedules prevented her from paying full attention to important information:

*I remember sitting with the nurse and she was talking to me about something and I was looking at my watch and thinking I really haven’t got time for this. That is awful because you are going through something that means so much to you and on the other hand you are sitting there thinking, oh my God, I’m going to be late. … I was constantly torn and divided between what I wanted to do and therefore maybe didn’t take on board all the information or the support networks that were available to me. (Nikki, Lecturer)*

The time demands of treatment getting in the way of work was also widely discussed, in terms of both the amount of time needed for treatment (and therefore away from work) and also the unpredictability of time and timing of treatment. Some women reported requiring extended periods of absence due to feeling particularly unwell during treatment or after procedures, due to complications such as ovarian hyperstimulation syndrome, after a miscarriage or occasionally where the emotional stress of treatment resulted in depression. However, most women found time required for appointments was difficult to combine with work, especially the unpredictable timing of egg collection and embryo transfer procedures which often meant time off work had to be arranged at the last minute. This also created stress and anxiety. An important issue here is the conflict between different meanings of what can be constructed as work time and body time. Work time generally requires predictability and the avoidance of unplanned absences, especially for those in professional occupations within which ideal workers are widely expected to prioritize work and often work long hours to demonstrate commitment. In contrast time for treatment is more at the mercy of the human body which can be unpredictable and difficult to control. Below Sarah illustrates how body time can make it very difficult to meet job demands and expectations while undergoing ART:

*You have to fit in with the clinic timing as far as you can, but also, to a certain extent you fit, well, to a great extent you fit with your body timing. And when your body is ready for this or for that, that’s when you have to be at the clinic… That can mean missing important meetings or regardless of what deadline there is in my work, there can often be quite pressured deadlines that absolutely have to be met, but regardless of deadlines I have to be off and that’s that. And that’s-, I find that quite stressful. (Sarah, Civil Servant)*

Time-based conflict was again expressed as less intense by the men, who had a degree of choice. They can miss appointments if work requires it although the men we interviewed attended as many as possible because they felt this was something they and their partner were going through together. The women we interviewed commonly said the same about their partners. However, men and women also talked about specific difficulties for men in requesting leave from work because they felt that treatment is seen as an issue affecting women or that men may be more concerned about the stigma of infertility. Ian illustrates what he sees as a lack of sympathy for men in relation to ART:

*It’s seen very much as something a woman goes through – and by and large it is. But the effect on the man isn’t really considered in my experience. If anything it’s an inconvenience. Whereas with a woman it’s obvious that they’re going to have to go through a lot of processes and changes; there’s a lot more sympathy switched on…* Ian (Assistant Manager, retail)

Thus bi-directional time-based conflict was experienced, with women struggling to attend clinic appointments and also struggling to attend work meetings and meet deadlines; feeling torn between the two. There was a particular conflict between the expectations of work or professional time and the demands of the body. Time-based conflict was less problematic for men, although there can be specific difficulties in taking time off for appointments, because fertility treatment tends to be considered a woman’s issue.

***Shifting identities, shifting priorities across time***

Investment in and commitment to career prior to treatment varied among participants. Some women and men had viewed their career as crucial to their identity. Others took a more instrumental perspective, describing work as a way to earn money and to support their life outside of work. However, career salience was not static. Thus, a third major theme relates to shifts in anchor identity. Becoming a parent assumed greater significance during treatment and for some women it ‘took over’ their lives. This influenced the personal meanings of work and ART treatment and experiences of conflict between them. As highlighted by Nikki, even women (and men) who said they initially felt that career was central to their identity experienced a shift to their anchor identity being becoming a parent:

*I think I realized what my priorities were; so although I’d always been very career focused, when you are then told that actually you may never have children it kind of made me appreciate that I couldn’t visualize my life without children even though I am quite ambitious and career orientated it had always featured in my life. (Nikki, Lecturer)*

Nikki’s narrative shows how this identity shift involved reconsidering priorities and putting work on the ‘back-burner’ or seeing it as something that could become the focus again at a later date. This was generally achieved by reducing involvement in the non-anchor work role to accommodate the demands associated with the anchor identity of becoming a parent. In some cases women made decisions that could affect their career in order to do this, such as Lisa (a Bank Manager) who said: “*I want to progress with the organization,* but *at this stage I would put any promotional aspects or driving forward for that in second place to becoming a parent”.*

Nevertheless, despite a shift in priorities, conflict between work and treatment was still experienced; frustrations with experiencing discrepancy in the current anchor identity (due to the difficulties of trying to become a parent) spilled over to and tainted time in the non-anchor role of work. For example, Angela (a TV producer) said: *“It just made me resent work in a way that I’d never done before … and I stopped loving my job and started hating my job”*. Furthermore, with more rounds of treatment or complications and miscarriages, the conflict between work and treatment and resentment increased and at the extreme, work ceased to meet any needs, so identity discrepancy was also experienced in relation to the non-anchor work role. In these cases women talked about experiencing depression and expressed intentions to quit their jobs or, in a few cases, such as Jenny, who had a more instrumental attitude to work, decided to sacrifice their careers to focus on their anchor identity of becoming a parent:

*I thought, ‘I can’t do this, I’m heading for a fall, something has to give, and it’s a case of what are the priorities here, what are the most important things?’ And I thought, ‘Well, my job has to go,’ which is quite a drastic thing, and I need to work and I need to earn money, but it was definitely the right decision (Jenny, Casual Assessor, recruitment)*

Although career was less salient to identity it remained important to some participants, where it was discussed as a means to financially support the anchor identity of becoming a parent and to support a future child. This was especially the case for the single women such as Harriet (a teacher) who said “*of course being a single person I have to have a good career behind me*” and men such as Edward (a *Change Manager*) who said “*work pays for the mortgage, it puts food on our table…. I work so that [my wife] can have this time off*”.

Especially where career had once been an important part of a woman’s identity and was envisaged as potentially an important part of her future identity as a working parent, women remained concerned about work and wanted to continue to be an effective employee. Some of these women acknowledged that if treatment was not successful they may need to refocus on their career. While this view was common among single women, married women such as Nikki also acknowledged this:

*I suppose it wasn’t necessarily that work had an expectation that I’d still just get on and do everything but I definitely put that on myself and I think that is because of my career ambition and I think because we were given such low percentages [i.e. likelihood of successful treatment] – and this sounds awful – but I didn’t want to commit myself wholly to treatment at the risk of losing my career knowing that actually it probably wasn’t going to work anyway and then I’d be left with a slow career progression and no child... (Nikki, Lecturer)*

Despite identity discrepancy between participants’ views of themselves as future parents and the frustrations experienced during the treatment journey, there was little evidence that work was currently helping to compensate for this discrepancy. However, there were some exceptions. For example, Neil (a Programme Manager) talked of compensating for feelings of lack of control over the ART process: *“I think actually my career has probably got more important to me during the treatment… having something that feels like you have some level of control and something where you feel you can achieve things… has been useful to me”.*

Thus shifts in participants’ anchor identities led to prioritizing treatment over work. Although recognized as time limited, this created considerable conflicts and tension. This was complex and manifested in diverse ways, relating to previous career ambitions; the need for income; the value of work and associated with fear of treatment failure linked to a bleak future if careers were forfeited.

***The practicalities and meanings of line manager support***

A major theme throughout the data concerns the impact of line manager support. For some participants autonomy to make small adjustments to their working hours to accommodate treatment, was intrinsic to their job. Job flexibility, for example, the ability to come in to work late, to make up time later or to work remotely or take time off for treatment or recovery was experienced as especially helpful for managing the unpredictable timing of procedures and/or unpredictable working hours and travelling demands and thus reduced time-based conflict between work and treatment. For example, Charlotte (a Human Resource Manager) said: *“because what I did was either work late or brought the work home.…I was able to be flexible... Otherwise…the time taken to attend appointments and things that would have been more of a problem”.*

Other participants were not as lucky as Charlotte; they lacked this flexibility and thus line manager support was crucial to enable flexibility and time off work. However, beyond the vital time management issues, support or lack of it, also took on other meanings. Asking for and receiving support tended to evoke strong emotional meanings and identity issues, especially related to shifting priorities and discrepancy in the current anchor identity of becoming a parent. Support from line managers tended to be experienced as affirmation of participants’ aspiring parent (as well as career) identities and was viewed as enabling them to have the best chance of becoming parents. Line manager trust and faith also affirmed identity, values and multiple roles. Thus the most supportive experiences seemed to involve trust and informal job flexibility and concern without being intrusive. Line manager support enabled the prioritization of treatment (supporting the anchor identity), helped manage the time demands of work and treatment and could also help reduce anxieties about stress undermining the treatment process. Grace’s line manager was very supportive and she talked about the impact of this:

*I just knew that I didn’t have to worry about work… So it didn’t really stress me out at the time …. if I’d been expected to come into school and carry on as normal, I think that would’ve been a lot more stressful. (Grace, Teacher)*

While such supports help ART users to feel valued, by contrast, the worst case scenario was a lack of job flexibility coupled with a line manager lack of trust and refusing to provide any support for time off or very reluctantly providing a minimum of support but making it difficult. The lack of support Jackie received added to the emotional strains of treatment and lead her to fear that stress would undermine the treatment process:

*…he called me up and he said “I don’t agree that you won’t travel” and he says “I’ve spoken to a specialist and I understand you can book your treatments around your job so I re-, I decline to allow you not to travel”…..so I have this problem on my hands that I’m stressed, because he’s making me stressed and that’s no good for what I’m trying to do, because I can’t go into that treatment feeling as stressed as I am. So it’s, the whole work thing is almost counterproductive against the treatment (Jackie, Account Manager)*

Gaining support for a shift in anchor identity from career to becoming a parent was particularly difficult for those in occupations where the expectation is to prioritize work to demonstrate commitment. Often line managers expressed support and offered flexibility, but, as highlighted by Jenny, participants felt that the expectations of them at work were not adjusted which could conflict with their treatment aims:

*trying to have a family, that’s the priority, and work is second to that, for me, but when you’re in a job where it feels like your job has to be everything, because that’s what your employers want, I found that quite difficult. I think my employers and my bosses have always been very understanding… but the workload doesn’t stop and what’s expected of you continues, and that’s fine, but sometimes it’s just not really doable. It’s not always felt conducive to helping the treatments happen successfully*. (Jenny, *Casual Assessor, recruitment*)

There were mixed views about whether practical support was sufficient or whether emotional support was also needed. Some felt that support for the time demands of treatment and work was enough while others wanted more acknowledgement of the importance of their non work identity. For example, Ian was pleased to have practical support but felt that his commitment to treatment was not taken seriously enough by his line manager:

*She never asked me about it. It was just kind of something that I had going on, like a hobby almost…. it felt very practical the way I was being dealt with; very kind of managed. But there wasn’t much in the way of: do you want to talk about it or anything like that.* Ian (Assistant Manager, retail)

Line manager understanding or experience was crucial here and participants expressed concerns about how a lack of understanding could undermine the provision of support. For example, Nikki (a Lectuer) said: “*if they don’t know what IVF is or have ever been through anything like that I think it’s quite difficult for them to say yes or no”*. This acknowledges the fact that ‘blame’ for failing to provide support should not necessarily be placed on line managers as lack of understanding may result from a lack of sufficient information and guidance from the organization.

Overall this theme attests to the importance of job flexibility and, especially where this is limited, line manager support, both in enabling the management of work and non work boundaries and reducing conflict between work and treatment, but also as affirmation of the value of workers who shift their anchor identities and priorities during treatment.

**Discussion**

This paper contributes to the literature by responding to calls to extend research on WFC to incorporate a wider definition of family and a wider range of employees (Casper et al., 2007; Kossek et al., 2010; Ozbilgin et al., 2011) and by addressing the lack of knowledge about how the growing number of people using ART experience treatment and employment. The findings demonstrate that the emotional and time demands of treatment (Greil et al., 2010) can generate considerable conflicts and tensions in the workplace. They reveal bi-directional strain-based and time-based conflict, gender differences and the protective or buffering effect of job flexibility and line manager support, all of which are discussed in mainstream WFC research (Allen et al., 2015; Greenhaus & Beutell, 1985; Michel et al., 2011). However, the nature of the conflicts reported by ART users are rooted in their specific experiences which are not simply a result of the amount of time or strain related to treatment and work but also to personal meanings of these and the centrality of identity in relation to career and becoming a parent (Thompson & Bunderson, 2001). Although conflict permeates participants’ accounts, the data reveal the complexity of the interplay of experiences of treatment with the demands of and feelings about work. In building on Thompson and Bunderson’s phenomenology of time approach, this analysis of the complex and diverse experiences of ART users thus also contributes to and develops WFC theory by suggesting that identity is not just an antecedent of WFC, as conceptalised by quantitative research, but it is a fundamental part of the experience of conflict. Furthermore, identity and subsequent priorities shift across time, so the experience of WFC is not static.

Experiences of ART and work were framed within personal meanings of time and temporality. ART was experienced as a journey, but an uneven or bumpy one, encapsulated by many as an emotional roller-coaster. Participants were at different phases of this journey, ranging from those who had recently embarked on treatment to others who had successfully completed treatment and become parents but all accounts of treatment and work were highly emotionally charged. For those whose treatment was short and uncomplicated, strain- and time-based conflicts tended to be intense but relatively short lived, while for others the emotional and physical demands were exacerbated with more rounds of treatment, disappointments, complications and miscarriages. As WFC is not static but fluctuates (Goh et al., 2015; Matthews, Wayne, & Ford, 2014) there is thus diversity among employed ART users in their experience of this trajectory and of WFC at any one particular time.

The temporal framing of many of the accounts positions this conflict as a time limited phase, particularly exemplified by a temporary shift in participants’ anchor identities towards prioritizing treatment over work. This shift to becoming a parent as the anchor identity and subsequent shift in priorities to focus on treatment influenced ways of coping with conflicts and tensions. Theories of the role of anchor and non-anchor identity in WFC suggest that conflicts may be managed by processes of accommodation or compensation (Rothbard & Edwards, 2003; Thompson & Bunderson, 2001). There was limited evidence of compensation in terms of prioiritising work to achieve affirmation in the face of lack of success in becoming a parent, although there was an acknowledgment among a few participants, especially single women, that if treatment was not successful there would be a need for a shift in priorities to focus on career in future. However, there was much evidence of accommodation. This involved prioritizing treatment and attempting not to allow work to interfere with it even among those who were once highly career oriented. There was also much evidence that experiencing discrepancy in the anchor identity, through struggling to become a parent, creates frustration which taints time in the non-anchor work role (as proposed by Thompson & Bunderson). Moreover with increasing unsuccessful rounds of treatment or miscarriages, or where parenthood had always been the anchor identity (and career had never been particularly important), resentment towards work grew. In such cases discrepancy was likely to be experienced in relation to both becoming a parent and in relation to work. Thompson and Bunderson propose that identity discrepancy in both roles leads to mutual depletion, conflict and alienation. Where this appeared to occur, women seemed to experience significant levels of depression and were prepared to sacrifice their careers. At the same time, despite experiencing conflict and trying to prioritize treatment, most participants were concerned about continuing to be an effective employee and many even found work a good distraction, indicating benefits to combining work and treatment.

While women and men having ART treatment have been found to experience high levels of distress (Greil et al., 2010), men experience less distress (Anderson et al., 2003; Beutel et al., 1999; Slade et al., 2007), so it is not surprising that time- and stain-based conflict between work and treatment also appeared to be less of a problem for men. It was clear from the interviews with the six men, as well as women’s account of their own and their male partners’ perspectives, that experiences of ART and work and associated conflicts are highly gendered. While gender is a social construct, ART is also physical, so this differs from sex differences reported in mainstream WFC literature (Allen & Finkelstein, 2014; Hill, 2005). It is not physically essential for men to attend every clinic appointment nor to undergo treatment. Hence there was some evidence that the men interviewed were better able to combine work and treatment through the process of segmenting work and non work domains, such that thoughts, feelings and behaviours in one role were actively suppressed from affecting performance in the other role (Edwards & Rothbard, 2000). Due to the physical as well as emotional and time demands of treatment, sustaining these boundaries was especially difficult for women.

An interesting distinction emerged between ‘body time’ and work or professional time. It is women who have to manage body time, that is, time when the body is ready for treatment and the bodily and associated emotional symptoms in the workplace. The unpredictability of body time can make it very difficult to conform to (male gendered) ideal worker norms of prioritizing work over personal life at all times and not bringing emotions to work (Bailyn, 2006; 2011) while undergoing ART. Gatrell (2011; 2013) introduced the term maternal bodywork to discuss processes whereby pregnant women or new mothers negotiate the borders between workplace and reproduction by concealing signs of bodily change, and this can also apply to women undergoing ART, who must manage their body at work. Many of the women participants worried about the conflict between treatment and remaining “professional” suggesting assumptions that ART treatment and all it involves should be kept out of the workplace.

Managing the body at work was not the issue for the men. Rather, for the men interviewed and from the women’s accounts of their partners’ experiences, gendered expectations that ART is a woman’s issue rendered their needs largely invisible. However, men do experience some time- and strain-based conflict and both men and women in acknowledged some potential difficulties for men in requesting support. Gendered assumptions about ideal workers who do not allow personal life to interfere with work (Gregory & Milner, 2009; Holt & Lewis, 2010) may also make it appear more likely that requests from fathers will be turned down (Brescoll, Glass, & Sedlovskaya, 2013; Walsh, 2008). Insofar as fertility treatment is seen as a woman’s issue, it may be especially difficult for men to take time off to support their partner and the emotional demands they experience may also be underestimated.

The importance of flexibility and line manager support for reducing WFC has been well documented (Den Dulk & de Ruijter, 2008; Goh et al., 2015; Paustian‐Underdahl & Halbesleben, 2014; Thompson & Prottas, 2006). In this study they were especially vital for those in jobs with the highest levels of job demands and/or the lowest levels of flexibility. Management support in terms of flexibility to attend treatment was of practical benefit in reducing time-based conflict between treatment and work. However, support also appeared to perform another function of demonstrating that employees are valued and trusted and thus affirming their shifting identities and priorities at this point. In this respect line manager support helped reduce anxieties about work and stress potentially undermining the success of treatment; so also reduced strain-based conflict.

***Implications for theory, future research, policy and practice***

This research highlights the need for WFC research and theory to look beyond expectant and existing parents by extending the definition of family to include family building (when this is not straightforward). It highlights the need for a dynamic conceptualization of WFC to take account of complex experiences of the precarity of the ART treatment journey over time and the transient but important shifts in the centrality of identity in relation to career and becoming a parent (Thompson & Bunderson, 2001). As experiences of WFC are not static, diary studies would be useful in future research for capturing this journey and the outcomes of initiatives to support these employees. Research on the work-family interface also increasingly recognizes that multiple roles can be enriching as well as conflicting (Carlson, Hunter, Ferguson, & Whitten, 2014; Wayne, Casper, Matthews, & Allen, 2013), and there is some evidence in the current analysis of the positive role that work can play during treatment, especially when line managers are supportive. Thus, although the data from this study overwhelming speak to conflict between work and ART treatment, future research should also examine the possibilities and conditons for enrichment.

The findings of this study must be interpreted within its limitations. The use of qualitative methods and a small sample means the findings are not generalizable. However, the goal of qualitative research is to develop in depth understanding, which at this stage, in this under-researched area, is most appropriate. A questionnaire would not have captured the strong and fluctuating emotions evoked by treatment trajectories. Quantitative research may be useful to build on this study to assess the extent to which experiences influence WFC and enrichment, occupational health and even ART treatment outcomes, and particularly the protective effects of workplace support.

The self-selected sample is a limitation as participants may have had especially good or bad experiences they wanted to share. Additionally, our participants were all white and heterosexual, most worked in more professional occupations, and there were few men and single women. Thus findings from men and single women must be interpreted with some caution, although many of the women in our sample reported that their partners had similar experiences to those reported by the male participants themselves, which adds weight to the men’s accounts. Related to this, although half the sample were currently ART users, half were those who had recently completed treatment with a successful outcome, so no one had given up on treatment. This may have influenced their perception of their experiences. However, retrospective accounts were just as emotionally laden as current reports and the inclusion of those who had given up on treatment would most likely have led to even more emotionally laden accounts. Nevertheless, future research should specifically aim to examine the experiences of a diverse range of ART users.

Despite some limitations, the findings of this study have implications for policy and practice. Workplace (and ideally statutory) policy is crucial to help support and protect employees having fertility treatment and, due to gendered expectations that this is a woman’s issue, it is important not to exclude men from such policy. Our findings suggest that such policy should focus on the provision of job flexibility and line manager support, especially since line managers are central to how policy is implemented in practice and due to the importance of the practicalities and meanings of line manager support for employees have ART treatment. While there may be difficulties for employers and line managers in providing support, not doing so may be counterproductive, exacerbating risks of employee depression and turnover. In contrast, by reducing conflict between work and treatment, support may help employees remain productive members of the workforce and increase retention. However, guidance and education for line managers about the needs and experiences of employees having ART treatment is vital. The diversity of their needs, especially in relation to length of treatment and complications during the process must be considered. It would be inappropriate to expect line managers to provide support if they themselves receive insufficient guidance and support from the organization. Our findings suggest that the shift in ART users’ identities and priorities away from work is temporary, and they also wish to remain effective employees while having treatment. Providing support, especially flexibility, will help them do this and thus is of mutual benefit to employees and employers.

**References**

Allen, T. D. & Finkelstein, L. M. (2014). Work-family conflict among members of full-time dual-earner couples: an examination of family life stage, gender, and age. Journal of Occupational Health Psychology, 19(3), 376-384.

Allen, T. D., French, K. A., Dumani, S., & Shockley, K. M. (2015). Meta-analysis of work–family conflict mean differences: Does national context matter? *Journal of Vocational Behavior, 90*, 90-100.

Anderson, K.M., Sharp, M., Rattray, A., & Irvine, D.S. (2003). Distress and concerns in couples referred to a specialist infertility clinic. *Journal of Psychosomatic Research, 54*(4), 353–5.

Bailyn, L. (2006). *Breaking the mold: Redesigning work for productive and satisfying lives.* New York: Cornell University Press.

Bailyn, L. (2011). Redesigning work for gender equity and work–personal life integration. *Community, Work and Family, 14,* 97-112.

Beauregard, T.A., Ozbilgin, M., & Bell, M.P. (2009). [Revisiting the social construction of family in the context of work](http://eprints.lse.ac.uk/25220/). *Journal of Managerial Psychology, 24*(1), 46-65.

Beutel, M., Kupfer, J., Kirchmeyer, P., Kehde, S., Kohn, F.M., Schroeder-Printzen, I. ... Weidner, W. (1999). Treatment-related stresses and depression in couples undergoing assisted reproductive treatment by IVF or ICSI. *Andrologia, 31*(1), 27–35.

Boivin, J. & Schmidt, L. (2005). Infertility-related stress in men and women predicts treatment outcome 1 year later. *Fertility and Sterility, 83*(6), 1745–52.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77-101.

Breakwell, G. M., Smith, J. A., & Wright, D. B. (2012). *Research Methods in Psychology*. London: Sage.

Brescoll, V.L., Glass, J., & Sedlovskaya, A. (2013). Ask and Ye Shall Receive? The Dynamics of Employer-Provided Flexible Work Options and the Need for Public Policy. *Journal of Social Issues 69*(2), 367-388.

Bruck, C. S., Allen, T. D., & Spector, P. E. (2002). The relation between work-family conflict and job satisfaction: A finer-grained analysis. *Journal of Vocational Behavior, 60*, 336–35

Carlson, D. S., Hunter, E. M., Ferguson, M., & Whitten, D. (2014). Work–family enrichment and satisfaction mediating processes and relative impact of originating and receiving domains. *Journal of Management, 40*(3), 845-865

Casper, W., Weltman, D., & Kwesiga, E. (2007). Beyond family-friendly: The construct and measurement of singles-friendly work culture. *Journal of Vocational Behavior, 70*(3), 478-501

Cooklin, A. R., Dinh, H., Strazdins, L., Westrupp, E., Leach, L. S., & Nicholson, J. M. (2016). Change and stability in work–family conflict and mothers' and fathers' mental health: Longitudinal evidence from an Australian cohort. *Social Science & Medicine, 155*, 24-34.

Den Dulk, L. & de Ruijter, J. (2008). Managing work-life policies: disruption versus dependency arguments. Explaining managerial attitudes towards employee utilization of work-life policies. *International Journal of Human Resource Management, 19*(7), 1222-1236.

Eby L. T., Casper W. J., Lockwood A., Bordeaux, C., & Brinley, A. (2005). Work and family research in IO/OB: content analysis and review of the literature (1980–2002). *Journal of Vocational Behavior, 66*, 124-197.

Edwards, J.R. & Rothbard, N.P. (2000) Mechanisms Linking Work and Family: Clarifying the Relationship between Work and Family Constructs. *The Academy of Management Review, 25*(1), 178-199.

Emslie, C., Hunt, K., & Macintyre, S. (2004). Gender, work-home conflict and morbidity amongst white-collar bank employees in the UK. *International Journal of Behavioral Medicine, 11*(3), 127-134.

Gatrell, C. (2011). Policy and the pregnant body at work: Strategies of secrecy, silence and supra-performance. *Gender, Work and Organization, 18*, 158-181.

Gatrell, C. (2013). Maternal body work: How women managers and professionals negotiate pregnancy and new motherhood at work. *Human Relations, 66*, 621-644.

Goh, Z., Ilies, R., & Wilson, K. S. (2015). Supportive supervisors improve employees' daily lives: The role supervisors play in the impact of daily workload on life satisfaction via work–family conflict. *Journal of Vocational Behavior, 89*, 65-73.

Greenhaus, J. H. & Beutell, N. J. (1985). Sources of conflict between work and family roles. *Academy of Management Review, 10*, 76-88.

Gregory, A. & Milner, S. (2009). Work-life balance: a matter of choice? *Gender, Work and Organization, 16*(1), 1-13.

Greil, A.L., Slauson-Blevis, K., & McQullian, J. (2010). The experience of infertility: A review of recent Literature. *Sociology of Health and Illness 32*(1), 140–162.

Hammer, L. B., Kossek, E. E., Anger, W. K. Bodner, T., & Zimmerman, K. L. (2011). Clarifying work-family intervention processes: The roles of work-family conflict and family supportive supervisor behaviors. *Journal of Applied Psychology, 96*(1), 134-150.

Hao, J., Wang, J., Liu, L., Wu, W., & Wu, H. (2016). Perceived organizational support impacts on the associations of work-family conflict or family-work conflict with depressive symptoms among Chinese doctors. *International Journal of Environmental Research and Public Health, 13*(3), 326.

Haynes, K. (2008). Transforming Identities: Accounting Professionals and the Transition to Motherhood. *Critical Perspectives on Accounting,* *19*(5), 620-642.

Hill, E. J. (2005). Work-family facilitation and conflict, working fathers and mothers, work-family stressors and support. *Journal of Family issues, 26*(6), 793-819.

Holt, H. & Lewis, S. (2010). You can stand on your head but you still end up with lower pay. Gendered Work Practices in two Danish Workplaces. *Gender, Work and Organization, 18*(3), 202-221.

Human Fertilisation and Embryology Authority (HFEA) (2013). <http://www.hfea.gov.uk/>

Kanji, S. & Cahusac, E. (2015). Who am I? Mothers’ shifting identities, loss and sensemaking after workplace. *Human Relations, 68*(9), 1415-1436.

Khetarpal, A. & Singh, S. (2012). Infertility: Why can’t we classify this inability as a diability? *Australasian Medical Journal, 5*(6), 334-339.

Katz-Wise, S. L., Priess, H. A., & Hyde, J. S. (2010). Gender-role attitudes and behavior across the transition to parenthood. *Developmental Psychology, 46*(1), 18-28.

Kossek, E.E., Lewis, S., & Hammer, L.B. (2010). Work–life initiatives and organizational change: overcoming mixed messages to move from the margin to the mainstream. *Human Relations, 63*, 3-19.

Ladge, J. J., Clair, J. A., & Greenberg, D. (2012). Cross-domain identity transition during liminal periods: Constructing multiple selves as professional and mother during pregnancy. *Academy of Management Journal, 55*, 1449-1471.

Ladge, J. J. & Greenberg, D. N. (2015). Becoming a working mother: Managing identity and efficacy uncertainties during resocialization. *Human Resource Management, 54*, 977-998.

Lewis, S. & Cooper, C. L. (1988). The transition to parenthood in dual-earner couples. *Psychological Medicine,* *18*(2), 477-486.

Lewis, S. Gambles, R., & Rapoport, R. (2007). The constraints of a ‘Work-Life Balance’ approach: An international perspective. *International Journal of Human Resource Management, 18*(3), 360-373.

Li, A., Bagger, J., & Cropanzano, R. (2017). The impact of stereotypes and supervisor perceptions of employee work–family conflict on job performance ratings. *Human Relations, 70*(1), 119-145.

Matthews, R. A., Wayne, J. H., & Ford, M. T. (2014). A work-family conflict/subjective well-being process model: a test of competing theories of longitudinal effects. *Journal of Applied Psychology, 99*(6), 1173-1187.

Michel, J. S., Kotrba, L. M., Mitchelson, J. K., Clark, M. A., & Baltes, B. B. (2011). Antecedents of work–family conflict: A meta‐analytic review. *Journal of Organizational Behavior, 32*(5), 689-725.

da Motta, E. & Serafini, P. (2002). The treatment of infertility and its historical context. *Reproductive Biomedicine Online, 5*(1), 65-77.

Moen, P., Kaduk, A., Kossek, E. E., Hammer, L., Buxton, O. M., O’Donnell, E., ... Casper, L. (2015). Is work-family conflict a multi-level stressor linking job conditions to mental health? Evidence from the work, family and health network. *Research in the Sociology of Work, 26*, 177-217.

Muse, L., Harris, S.G., Giles, W.F. & Field, H.S. (2008). Work-life benefits and positive organizational behavior: Is there a connection? *Journal of Organizational Behavior, 29*, 171-192.

Nohe, C., Meier, L. L., Sonntag, K., & Michel, A. (2015). The chicken or the egg? A meta-analysis of panel studies of the relationship between work–family conflict and strain. *Journal of Applied Psychology, 100*(2), 522-536.

Noor, N. M. (2004). Work-family conflict, work- and family-role salience, and women’s well-being. *Journal of Social Psychology, 144*, 389–405.

Özbilgin, M. F., Beauregard, T. A., Tatli, A. and Bell, M. P. (2011). [Work-life, diversity and intersectionality: a critical review and research agenda](http://eprints.lse.ac.uk/36557/). *International Journal of Management Reviews*, *13*(2), 177-198.

Paustian‐Underdahl, S. C. & Halbesleben, J. R. (2014). Examining the influence of climate, supervisor guidance, and behavioral integrity on work–family conflict: A demands and resources approach. *Journal of Organizational Behavior, 35*(4), 447-463.

Pinborg, A., Hougaard, C.O., Nyboe Andersen, A., Molbo, D., & Schmidt, L. (2009). Prospective longitudinal cohort study on cumulative 5-year delivery and adoption rates among 1338 couples initiating infertility treatment. *Human Reproduction, 24*(4), 991-990.

Rothbard, N.P & Edwards, J.R. (2003). Investment in work and family roles: A test of identity and utilitarian motives. *Personnel Psychology, 56*, 699-730.

Schonfeld, I. S. & Mazzola, J. J. (2012). Strengths and limitations of qualitative approaches to research in occupational health psychology. In R. R. Sinclair, M. Wang, L. E. Tetrick (Eds.), *Research methods in occupational health psychology: State of the art in measurement, design, and data analysis (pp. 268-289).* London: Routledge.

Slade, P., O'Neil, C., Simpson, A.J., & Lashen, H. (2007), The relationship between perceived stigma, disclosure patterns, support and distress in new attendees at an infertility clinic. *Human Reproduction, 22*(8), 2309-2317.

Shockley, K M., & Allen, T. D. (2013). Episodic work-family conflict, cardiovascular indicators, and social support: An experience sampling approach. *Journal of Occupational Health Psychology, 18*(3), 262-275.

Stoleru, S., Cornet, D., Vaugeois, P., Fermanian, J., Mungnin, F., Zerah, S., & Spria A. (1997). The influence of psychological factors on the outcome of the fertilization step of in vitro fertilization.*Journal of Psychosomatic Obstetrics and Gynaecology, 18*(3),189-202.

Thompson, J. & Bunderson, J. (2001). Work-nonwork conflict and the phenomenology of time. *Work and Occupations, 28*(1), 17-39.

Thompson, C. A. & Prottas, D. J. (2006). Relationships among organizational family support, job autonomy, perceived control, and employee well-being. *Journal of Occupational Health Psychology, 11*(1), 100-118.

Vignoles, V.L., Regalia, C., Manzi, C., Golledge, J., & ScabiniE. (2006). Beyond self-esteem: influence of multiple motives on identity construction. *Journal of Personality and Social Psychology, 90*(2), 308-33.

Walsh, I. (2008). The Right to Request Flexible Working. London: BERR (URN8/08).

Wayne, J. H., Casper, W. J., Matthews, R. A., & Allen, T. D. (2013). Family-supportive organization perceptions and organizational commitment: The mediating role of work–family conflict and enrichment and partner attitudes. *Journal of Applied Psychology, 98*(4), 606.