OVERCOMING INFERTILITY IN AN AGE OF ASSISTED REPRODUCTIVE TECHNOLOGIES

by

Evanthia Spyropoulos

A Thesis
Submitted to the Faculty of Graduate Studies
in Partial Fulfilment of the Requirements
for the Degree of

MASTER OF ARTS

Department of Sociology
University of Manitoba
Winnipeg, Manitoba

THE UNIVERSITY OF MANITOBA

FACULTY OF GRADUATE STUDIES

COPYRIGHT PERMISSION

OVERCOMING INFERTILITY IN AN AGE OF ASSISTED REPRODUCTIVE TECHNOLOGIES

by

EVANTHIA SPYROPOULOS

A Thesis submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements of the degree of

MASTER OF ARTS

This thesis is dedicated to my mother,

Maria Spyropoulos

whose strength, love and support guide me in everything I do.

TABLE OF CONTENTS

ABSTRACT

This study explores women's experiences of infertility in an age of assisted reproductive technologies (ARTs). This study was directed at trying to understand the decision-making process surrounding motherhood, infertility and ARTs. This research uses in-depth, semi-structured interviews to elicit women's subjective experiences of the decision-making process surrounding infertility. This study also uses a structural analysis to understand how women's decisions are context dependent. More specifically, this study shows how the social, political and economic context of this society alienates women from their reproductive lives.

This research adds in-depth descriptive data on women's experiences of infertility to the current knowledge on this issue. I interviewed 15 women who were at various stages of their infertility experience and who had not all pursued medical intervention to achieve pregnancy. The interviews focussed on the various reasons why women want children and why they would , or would not seek ARTs to achieve this goal. This study is unique in that the women described all of the options available to them as alienating. This research shows that society has left many infertile women with little choice over the decisions surrounding their reproductive lives.

ACKNOWLEDGEMENTS

Many people contributed to this study and I would like to acknowledge them all.

To begin with, I would like to thank the 15 women who made this study possible. I thank you for sharing your knowledge, experiences and pain.

I would like to thank my advisor, Dr. Karen Grant, whose patience and wisdom have helped me throughout my academic career. I would especially like to thank Karen for being my mentor at a time when I really needed one. I would also like to thank my committee members, Dr. Susan Prentice and Dr. Annette Gupton, for their insight into this research.

My deepest gratitude goes to my mom, my sister Amalia Albanito and my friends Wendy Parker, Teresa Rogers, Heather Smith, Liz Standing, and Leslie Trafton. These 7 women have taught me the meaning of unconditional love and support. I would also like to thank Roz, Kelly and Anna who knew just what I was going through and were always ready to listen.

Chapter 1 - Introduction

Women in this society experience strong social pressures to give and nurture life. Right from the beginning of a young girl's life, she is taught to identify with motherhood. Social and cultural institutions in western society consistently emphasize the importance of motherhood to the female role (Miall, 1986). Several themes are reinforced: "[motherhood] as an expected part of marriage, children as an essential element of family formation, reproduction as part of the female role, [and] reproduction as natural or instinctive behaviour" (Bequaert Holmes, 1992: 271). Society values genetic motherhood. An inordinate amount of pressure is put on women to produce genetically related children (Overall, 1987). For women who internalize this culturally formed notion of biological motherhood, the inability to achieve this goal can be devastating.

In recent years, women's options for having children have changed. Before the advent of assisted reproductive technologies (ARTs), infertile women had two choices: they could either remain childless or adopt a child. Now, however, the availability of ARTs has had a significant impact on the infertility experience. The development and use of ARTs have introduced new dilemmas, choices and pressures for women (Achilles, 1990). For some women, the availability of these techniques, the negative view of childlessness, and the strong social pressures to procreate, are fundamental in the quest for a child of one's own. A woman facing infertility today may feel compelled to try everything available to overcome her problem (Bequaert Holmes, 1992). Unfortunately, these technologies are rarely successful and are often harmful to women physically, emotionally and financially (Corea, 1985).

Although the recent explosion of ARTs has brought more attention to the experience of infertility, information on the decision-making process surrounding ARTs is relatively unexplored. Research has not adequately addressed the reasons why some women persist in treatment at any cost. According to Alpern (1992: 147), "the desire to have children is believed to be the primary motivator behind the development of reproduction-aiding techniques and services." Until recently, few questioned the origins of this desire. As Richardson (1993:62) states, "to ask why women have children is to start a revolution in the way we think about women and motherhood." Motherhood has always been considered a natural part of the adult female role. This belief has strongly influenced the acceptance and use of reproductive technologies. The great length to which women go to fulfill their 'biological destiny' is often viewed as natural and reasonable (Alpern, 1992).

In recent years, many researchers have begun to question the source of women's motivation to have a child, and the role that reproductive technologies play in the decision-making process (Alpern, 1992, Corea, 1985; Spallone, 1989; Strother Ratcliff, 1989). These researchers have worked toward understanding the various reasons why women seek any possible solution to have a child. The main findings are that the desire to have children is a result of many interrelated forces. Investigations have uncovered the role society and the medical profession play in shaping the decision-making process around motherhood, infertility and ARTs.

If we are to help women overcome the desire to have a child at any price, then being better informed of this highly emotional and complex phenomenon is essential. What is more important, we need to acknowledge the painful reality for those who want to, but cannot, conceive. This information will help infertile women to understand how

the wider social context influences and constrains the decisions they make. With this information, women may begin to understand more clearly their experiences of infertility.

This is a study of women's experiences of infertility in an age of reproductive technologies. More specifically, this study addresses the decision-making process of fifteen women who were faced with fertility problems. This study attempts to unravel the reasons why women want children, and why they pursue the various options available to them for overcoming fertility problems. Further, this study addresses how the specific social, economic and political context in which women find themselves creates few options for nurturing relationships and therefore limits the choices available to women.

In chapter 2, I discuss the theoretical framework of this study. Chapter 3 consists of a literature review on motherhood, infertility and ARTs. Chapter 4, the methods chapter, presents the objectives of the study and outlines the research process. In chapter 5, I provide a demographic profile and brief biographies of the women who participated in my study. Chapter 6 provides a description of the women's narratives according to three central categories; motherhood, infertility and ARTs and links this information to similar research on these topics. Chapter 7 consists of the discussion and the conclusions. In particular, I discuss how the decision-making process surrounding infertility and the options available to women for overcoming infertility are alienating in several respects.

Chapter 2 - Theoretical Framework: Socialist Feminist Theory

The theoretical framework of the study is based on a feminist analysis. Feminism is a rich and varied body of knowledge. It reflects a variety of concerns and priorities including motherhood, infertility and reproductive technologies, among others. Furthermore, within feminism are various strategies for dealing with these issues and the desired outcomes. Although there is more than one feminist perspective, there are some basic premises that all currents of feminism share (Farganis, 1986; Tong, 1989; Lindsey, 1994). Feminists are dedicated to looking at social life from a woman's perspective, and start from the realization that women and men live different lives. The main goal of any feminist analysis is to improve the quality of women's lives.

To tap into the potential factors that motivate women to desire motherhood, this study uses a socialist feminist perspective. Socialist feminist theory situates women's experiences in the context of the political, social and economic structures in which they live. Furthermore, socialist feminist analysis provides a method that is historical (Eisenstein, 1979). This perspective deals with many issues that help to explain the situation of women in advanced capitalist societies. Jaggar (1983: 123) contends that, "socialist feminism...offers the most convincing promise of constructing an adequate theory and practice for women's liberation."

This theoretical perspective brings together Marxism and radical feminism. As Eisenstein (1979: 6) states, "the synthesis of radical feminism and Marxist analysis is a necessary step in formulating a cohesive socialist feminist political theory." Socialist feminists believe that women's lives are best understood both by their relation to the means of production and the relations of reproduction. Both radical feminism and Marxism, taken together, give socialist feminists important theoretical and

methodological tools for understanding the experiences of women. Hence, discussing how radical feminism and Marxism contribute to socialist feminism is important. It is also essential to highlight how socialist feminism departs from these two perspectives, and is thus a distinct theoretical framework.

The concept of patriarchy is central to socialist feminist analysis. Radical feminists use the concept of patriarchy "to refer to all systems of male dominance" (Jaggar, 1983: 106). "Patriarchy is a sexual system of power in which the male possesses superior power and economic privilege...it is rooted in biology rather than in economics or history" (Eisenstein, 1979: 17). For most radical feminists, patriarchy is the universal basis of female subordination and male domination. The oppression of women is manifested through sexual practices such as rape, prostitution, motherhood, heterosexuality and sexual intercourse (Jaggar, 1983). Radical feminists argue that women, by virtue of their sex, are oppressed by men. The differences that exist between the sexes are rooted in human biology, and are essentially a pre-social given.

The biologically determinist claims of some radical feminists portray patriarchy as inevitable and unchanging. Many radical feminists fail to acknowledge that women's lives have changed historically, and are often governed by the economic structure of a particular society. Unlike radical feminists, socialist feminists do not accept patriarchy as a universal phenomenon that shapes women's lives and coerces their behaviour (Gerson, 1985). Socialist feminists believe that in addition to patriarchy, any theory trying to explain women's experiences must also take into account the economic and social structure of a particular society. As Young (1990: 27) claims,

> a feminist theory must account for male domination as structured in a set of specific, though variable, social and economic relations, with specific material effects on the relations of men and women.

To understand the oppression of women, socialist feminists agree that considering the relationship between patriarchy and capitalism is important. As Eisenstein (1979: 5) claims, "capitalism and patriarchy are interdependent and are essential to socialist feminist analysis." The control of women's sexuality and reproduction are inseparably linked to capitalism. As Jaggar (1983: 136) states, "sexuality and procreation are a part of the economic foundation of society, partially determining 'the economy,' and partially determined by it." Women bear and rear the future labour force. Women provide capitalists with a cheap source of labour power and often function as a reserve army. The sexual division of labour also maintains the status quo. Therefore, any theory that neglects to address the economic and social structures cannot adequately deal with the complexities of women's lives.

The analysis of socially constructed gender characteristics provides a partial explanation for women's experiences and behavior (Gerson, 1985). The differences between the sexes are not innate, but are socially imposed. Moreover, gender character types vary historically, and are therefore alterable (Jagger, 1983).

Many socialist feminists look at child socialization within the nuclear family to further their understanding of the acquisition of gender characteristics. The different ways in which young girls and boys are socialized perpetuate and maintain masculine and feminine character types (Farganis, 1986). A variety of social practices operate to sustain existing relations of production and reproduction. The nuclear family is a fundamental system that preserves the sexual hierarchy of capitalist patriarchal society. Socialist feminists challenge the specific household arrangements and ideology of the nuclear family (Thorne and Yalom, 1982).

Socialist feminists move beyond the nuclear family and incorporate the wider social structure in their analysis. As Jaggar (1983: 130) contends,

> socialist feminism does not view contemporary masculinity and femininity as constructed entirely through the social organization of procreation; these constructs are elaborated and reinforced in nonprocreative labour as well.

Various institutions socially impose the differences between men and women throughout an individual's life. These include the ideology of the nuclear family, child-care arrangements, the education system, the sex-segregated structure of the paid labour force, the media, and the health care system. These systems organize, define, protect and maintain the dominant ideology of capitalist patriarchy (Eisenstein, 1979). It is within these specific social practices that the sexual division of labour is reinforced and maintained.

Socialist feminism departs extensively from radical feminism. Nevertheless, the ideas generated by radical feminists have played a part in socialist feminist theory. Radical feminists provide socialist feminists with the necessary tools to understand how patriarchy operates within various institutions to maintain male dominance and female subordination. This theoretical perspective shows how women's bodies are used against them to serve the interests of a male dominated society.

Along with some premises of radical feminism, socialist feminists have incorporated and moved beyond the tenets of Marxist theory. These feminists have adopted and transformed Marx's analysis, to a feminist theory (Jaggar, 1983; Eisenstein, 1979).

Marx demonstrated how human nature varies historically according to the relations of production within a society. Socialist feminists extend this to explain the nature of women's lives. They conceptualize the oppressive nature of reproduction and

production within a specific historical and economic context. There is nothing innately oppressive about motherhood, heterosexuality, child rearing and childbearing (Eisenstein, 1979; Gerson, 1985). However, socialist feminists contend that these activities have been historically developed by capitalist patriarchy in such a way that renders them oppressive.

Socialist feminists have also adopted Marx's class analysis to further their explanation of women's oppression. They extend Marx's class analysis to include an understanding of the significance of the patriarchal sexual hierarchy within capitalist society. This perspective refines Marx's class analysis to include sexual politics as a core attribute in its investigation of human life (Young, 1990).

Marx's theory on alienation strongly influences socialist feminist political theory. Although Marx's theory on alienation is clearly male-biased, it provides an important conceptual map for uncovering the alienated forms of social experiences for women. Therefore, socialist feminists have revised Marx's theory of alienation to define and understand the oppressive nature of women's experiences in capitalist patriarchal societies (Eisenstein, 1979; Jaggar, 1983). According to Young (1990: 168),

> alienation means the objectification or appropriation by one subject of another subject's body, action, or product of action, such that she or he does not recognize that objectification as having its origins in her or his experience.

In this society, a number of social, political and economic institutions operate to limit women's experiences. Socialist feminists contend that the institutionalization of sexuality, childbearing and child rearing have prevented women from fully developing their potentialities (Jagger, 1983). For socialist feminists, the liberation of women cannot come about unless we abolish alienated forms of activity (Jagger, 1983).

Another important theoretical tool that they have adopted is Marx's analysis of human consciousness. Socialist feminists have embraced Marx's theory on this phenomenon because it enables them to investigate the realities of human consciousness. According to socialist feminism, because a woman is defined by her sex, her consciousness is defined by her relations to the means of reproduction; i.e., her beliefs, attitudes and desires are grounded in the prevailing mode of reproduction (Jagger, 1983).

Understanding and explaining the 'internalization' of oppressive social realities is a fundamental tool in socialist feminist political theory. Women's experiences are inextricably linked to the social structure. As Gerson (1985: 193) states, "the forces that shape options and channel actions, motives and belief systems are often hidden from conscious awareness." Separating a woman's individual consciousness from that of a socially imposed reality is extremely difficult. This leads to the conclusion that any analysis of women's consciousness must take into account that women's lives do rest on social processes (Currie, 1988; Thorne and Yalom, 1983; Gerson, 1985).

Socialist feminists believe that it is essential to ground consciousness within specific historical contexts and modes of production. Jaggar (1983: 150) describes this perspective as follows:

> it must be historical, it should be nondeterministic, recognizing the ways in which certain historical circumstances allow specific groups of women to transcend at least partially the perceptions and theoretical constructs of male dominance and in which this feminist 'raised consciousness' can inspire and guide women in a struggle for change.

Socialist feminism is a distinctive approach that enables one to conceptualize how women's oppression has its roots in the material and social arrangements of society, particularly in the material and social organization of reproduction within

capitalist patriarchal society (Tong, 1989). Within the sexual division of labour, capitalism and patriarchy can shape a woman's life. As Eisenstein (1979:27) explains, "a sexual division of labour and society that define people's activity, purposes, goals, desires, and dreams according to their biological sex, is at the base of patriarchy and capitalism." Within capitalist patriarchal institutions, gender differences are socially constructed thereby ensuring male domination and female subordination, and the reproduction of an oppressive society.

Socialist Feminism in this Study

Socialist feminist theory is an important conceptual map for uncovering the reasons why women want children in an age of ARTs. Socialist feminists play a key role in uncovering the realities of motherhood within this society (Thorne and Yalom, 1982; Jagger, 1983). This theoretical perspective guides the researcher to consider a number of interrelated social processes that can potentially affect a woman's desire to have a child. Furthermore, socialist feminism gives me the necessary tools to consider the relations of power that shape motherhood, and the ideology that defines and protects it.

Socialist feminist theory allows me to conceptualize the role that patriarchy and capitalism play in defining women's lives. This is accomplished by conducting a structural analysis of women's lives. I address the separate structures that affect a woman's identity, values, and desires in this society. These separate structures include production, reproduction, sexuality and the socialization of children (Thorne and Yalom, 1982). Moreover, a structural analysis of women's lives uncovers the

institutions that reinforce and perpetuate capitalist patriarchal values and ideals, among them the ideology of the nuclear family, and modern medicine.

Challenging the ideology of the nuclear family is essential to any socialist feminist analysis. As for my research, an evaluation of the ideology and specific structural arrangements of the nuclear family, based on a socialist feminist political theory, is instructive. As many socialist feminists have revealed, it is within the nuclear family that capitalist patriarchal ideology comes to fruition (Thorne and Yalom, 1982; Jagger, 1983). It is through an analysis of the ideology of the nuclear family that we can set out the principle site for the perpetuation of male dominance and female subordination.

The nuclear family is characterized by a particular sexual division of labour. This arrangement maintains the power of men over women. The family, as defined under capitalist patriarchy, also protects the sexual hierarchy of society. In other words, the sexual division of labour not only dictates roles based on sex, it also reinforces the ideological reality of capitalist patriarchy. Furthermore, it is within these practices that the social construction of feminine and masculine identities is most evident.

Along with a critical evaluation of the nuclear family, I address the oppressive nature of medical practices, specifically in terms of women. In this society, medicine is viewed as a 'neutral science.' We widely accept that physicians and medical scientists are fundamentally concerned with helping and improving the lives of all. Socialist feminists challenge the medical profession, and argue that it asserts and sustains-either overtly or covertly-the social, political and cultural values of society (Young, 1990). It is within reproductive medicine that the oppressive nature of medical

practices is most evident. Socialist feminists have pointed out that women have been increasingly alienated from their reproductive lives because of the medical profession's control over procreation and childbearing. Not only have women lost control over if and when to have children, they now have little control over the conditions of labour and reproduction. Women lack alternatives to childbirth because of a monopoly over reproductive practices by the medical profession. The medical profession dominates the lives of women who want to, but cannot, procreate. Various technological innovations, such as IVF, have been developed under the dictates of capitalist patriarchy. These techniques further the alienation of women from their bodies, and place the control of reproduction within the hands of medical scientists and physicians.

With a socialist feminist critique, I can conceptualize the progressive loss of control that women experience because of the medical profession and various technological developments. A socialist feminist political theory allows me to incorporate gender as an important variable in my analysis of the medical profession and recent technological developments. I consider the gender-specific nature of medical practices, treatments and technologies; all of which are geared toward controlling women's reproductive lives.

Methodologically, socialist feminist theory not only guides me in terms of the factors that I need to address to uncover women's motivation for seeking ARTs, it also influences my analysis of women's experiences. There are many problems in trying to develop a theory based simply on women's voiced explanations. Therefore, I consider the personal experiences of women, but I also incorporate a structural approach to my data analysis (Currie, 1988). Utilizing socialist feminist theory to make sense of how women's decisions and experiences are related to, and interact with, various social

processes, is fundamental to a structural analysis. Overall, this theoretical perspective enables me to situate women's experiences within the broader social context of capitalist patriarchy.

In sum, I move beyond an experientially-based analysis, and incorporated a more structural understanding of women's decision-making surrounding ARTs. As a number of socialist feminists have revealed, women's experiences and desires are grounded in specific historical, social, political and economic foundations, and are often hidden from conscious awareness (Jagger, 1983; Eisenstein, 1979).

Chapter 3 - Review of the Literature

The primary objective of this chapter is to review thoroughly what has been written about motherhood, infertility and IVF, to highlight the potential reasons why women want children. Although not all women with infertility problems seek IVF as a way of solving their dilemma, this review will focus on this technology because it is often the last option sought when others fail.

Motherhood

A common perception is that all women want and need to have children. Motherhood is typically viewed as the most natural and expected role for a woman to occupy. Throughout the history of modern society, a vast amount of literature has been devoted to proclaiming that "a truly feminine woman wants to give birth to and care for babies..." (Oakley, 1980: 39). Women who choose not to have a child are often asked to explain their nonconformity to their presumed biological destiny (Phoenix et al., 1991).

A number of questions need to be addressed to further our knowledge of motherhood in contemporary society. These questions must focus on what is it that truly makes women want children, and why this is such a significant aspect of their lives. These are questions that need to be answered to understand the realities of motherhood. More importantly, this information may help to explain infertile women's quest for children of their own.

A vast amount of information has been devoted to the issue of motherhood by writers in various disciplines and professions (e.g., medical scientists, psychologists, sociologists and feminists). Each of these orientations differ dramatically in their response to why women have children. In what follows, I look at each perspective, highlighting the diversities that exist and criticisms of the theoretical perspectives.

Medical/Scientific Perspectives on Motherhood

The medical/scientific analysis of reproduction dominates the literature. According to this perspective, a woman's desire to mother is a result of her biology. This theory of a maternal instinct began in the 18th century when it was used to describe a female animal's behaviour with her young (Antonis, 1981). In the 19th century, medical scientists began to use this theory to explain women's reproductive behaviour. According to this perspective, reproduction is an innate, universal and inevitable phenomenon.

This framework continues to dominate the medical and scientific literature in the 20th century. It is still widely accepted that motherhood is based on biological programming, and therefore, it is natural for women to mother and to want to be mothers. Advocates of this theoretical perspective contend that there is a hormonal/physiological basis for women's mothering. Oakley (1980: 57) states "whichever way you look at it, women are at the mercy of their bodies....women's biological abilities have created their ultimate destiny."

Sociobiology is another area that has addressed this issue by focusing on anatomy and physiology as a clue to reproductive behaviour (Farganis, 1986). According to Lindsey (1994: 41),

> the fundamental assertion of sociobiology is that we are structured by nature with a desire to ensure that our individual genes pass to future generations and that this is the motivating factor in almost all human behaviour.

This perspective explains human behaviour in terms of genetic history, and links it to human survival. According to this theory, "people are constrained by certain behavioral predispositions which are influenced by genes" (Farganis, 1986: 114). The fact that women desire motherhood is attributed to a genetic determination, which is a part of their evolutionary heritage (Lindsey, 1994).

The belief that women are born with a biological drive and need to reproduce has been heavily criticized (Alpern, 1992; Farganis, 1986; Richardson, 1993). Feminist critics believe that these theories confine women to their biological destiny (Phoenix et al., 1991; Oakley, 1980; Jagger, 1986; Rich, 1986). No substantial evidence exists to support such biological claims. The attempt of medical scientists and sociobiologists to place mothering in the domain of nature oversimplifies a very complex phenomenon. Assuming that the desire to mother is simply the result of biological programming is unrealistic (Mackie, 1987). In other words, biological explanations cannot adequately deal with the changing nature of women's lives, primarily in relation to motherhood. A number of feminists stress the need for a more historical and structural understanding of motherhood (Thorne and Yalom, 1982). These feminists believe that we should try to understand the desire to mother in relation to a society's particular social, political and economic system, and not to attribute it to a biological, pre-social phenomenon.

Psychological Theories on Motherhood

Psychological theories on mothering tend to concur with the basic premises of the medical scientific approach. This theoretical perspective generally assumes that motherhood is essentially a psychological state, which is accompanied and caused by a physiological condition (Oakley, 1980). Psychologists agree with medical scientists that women have a mothering instinct: motherhood is a psychological state, but the stimulus is biological.

The main difference between psychological theories and medical theories is that the former focuses on inherent aspects of the female personality, whereas the latter focuses simply on biological drives. The most influential approach in the psychological literature on motherhood is the psychoanalytic perspective. According to this tradition, motherhood is an inherent characteristic of the female psyche (Phoenix et al., 1991). Proponents of psychoanalysis argue that the desire to mother is slowly built into the feminine personality during early experiences in the family (Phoenix et al., 1991). Therefore, the desire to mother is part of the unconscious inner dynamics of the psyche, and a normal characteristic of a woman's identity and personality. According to Antonis (1981: 62), "psychoanalytic writers place motherhood at the centre of women's psycho-emotional development." Thus, they see a woman who fails to internalize this aspect of her personality as poorly adjusted to her adult female identity.

Psychological theories on mothering are criticized in much the same way as medical explanations. Little evidence exits to support the belief in an unconscious psyche controlling the behaviour of women (Oakley, 1980; Phoenix et al., 1991). To assume that the desire to mother is an inherent aspect of the female sex is to create a

rigid, oppressive and mythologised view of women. These theories tend to over psychologize human behaviour.

The most compelling criticisms against both psychological and medical theories on mothering are that they are asocial and ahistorical. Medical and psychological perspectives almost totally disregard the vast amounts of social influences affecting human behaviour. The world in which individuals exist is dynamic, diverse and ever-changing. All women are exposed to a variety of societal and cultural expectations that play a fundamental role in their behaviour. To assume that every aspect of reproductive behaviour is a result of biological programming or an inherent personality characteristic is misleading and flawed.

Functionalists on Motherhood

Functionalist sociologists have developed a socio-cultural analysis of motherhood. These theorists situate motherhood within sociological concepts such as roles and identities. The purpose of these investigations is to show the normative quality of motherhood for women and the overall functioning of society in general. Functionalist sociologists believe that the desire to mother is a response to the reproductive norms of society. Conformity to reproductive norms is considered essential to the proper functioning of society.

The main tenet of this perspective is that motherhood is normal and the most important aspect of the adult female social role. Motherhood is viewed as a means by which women achieve full adult status, and in this respect, is central to their sense of

themselves as normal, functioning adults. This normative behaviour is not a part of women's natural biological inheritance, but is learned through socialization (Phoenix et al., 1991).

According to functionalism, a woman's motivation to mother is based on a need to fulfill her role in society. This is often called the motherhood mandate. Lindsey (1994: 183) describes the motherhood mandate as "the belief that a woman's greatest fulfilment and ultimate achievement will be in her role as mother." Without this, a woman has not reached her mature adult status, nor has she fulfilled her true destiny and role in life (Richardson, 1993).

It is important to point out that medical, psychological and functionalist theories are differentially applied to women, based on their marital status and sexual orientation. According to MacIntyre (1976: 159), "the equation of marriage with motherhood, and non-marriage with non-motherhood, is extremely pervasive." Motherhood is an integral part of the adult role, but only within the confines of marriage. The desire to mother outside of a marriage is viewed as dysfunctional and abnormal. Richardson (1993: 77) states that "there are contradictory theories of motherhood for single and married women...single women (and lesbians) desire children for selfish/bad reasons."

Functionalist sociologists continue to promulgate the notion that motherhood is a normal, if not expected, part of the adult female role. This approach reinforces fundamentally the mandatory quality of motherhood, but within a particular socio-cultural context. Functionalists view motherhood as a taken-for-granted difference between men and women, one that is essential to the overall functioning of the family (Farganis, 1986). Although functionalist explanations of motherhood differ from medical

and psychological ones, the outcome is essentially the same. As Phoenix et al. (1991: 40) state, "common to all these, is a view of motherhood as an essential stage of development and as an ultimate fulfilment for all women."

Feminist Theories on Motherhood

The criticisms of the medical, psychoanalytic and functionalist theories have been articulated by feminist theorists who are dissatisfied with the state of knowledge on this issue. These theorists challenge ideas of a maternal instinct and the normative quality of motherhood (Oakley, 1980; Antonis, 1981; Rowland, 1989; Lindsey, 1994). Feminist researchers are deeply concerned with prevailing ideologies that mandate motherhood for all women. Unlike functionalist sociologists, feminists view the motherhood mandate as problematic and oppressive to women.

According to some feminist theorists, the sources of women's motivation for having children are highly complex, and cannot be merely attributed to biological or psychological programming, or to normative behaviour (Farganis, 1986; Oakley, 1980; Alpern, 1992). They reject these theories because they fail to consider the number of social processes that play a part in the desire to have children. Moreover, the social organization of motherhood and reproduction, and the relations that emerge from these activities in capitalist patriarchal society are ignored.

It is not motherhood in and of itself that has alarmed some feminists. The main concerns of feminists arises out of the belief that motherhood, as defined and restricted under capitalist patriarchy, exploits and oppresses women (Jagger, 1983; Rich; 1986; Young,1990). Some feminists focus on how, in our society, procreative

activities are organized so that women have lost control over these experiences (Jagger, 1983). A number of feminists believe that women are conditioned to want to have children. As Rowland (1987: 68) states,

> women have children because they are socialized or conditioned to do so; or because they are convinced of the rewards of mothering; or in order to gain a self-identity in a world that continually denies them of this; or to prove their self-worth and attain the status of a 'mature adult.'

These realities suggest that women's choices are suspect when it comes to having children in this society (Jaggar, 1983). Therefore, some feminist theorists want to understand how women's motivations for motherhood are shaped socially.

To that end, feminists believe that it is essential to examine motherhood "in specific social and historical contexts and in terms of ideological functions" (Phoenix et al., 1991: 66). Feminist theorists believe the sources of women's motivation to mother are not determined by biological factors, but are instead socially constructed by capitalist patriarchal institutions, among them the dominant ideology and the socialization processes of contemporary society (Farganis, 1986; Thorne and Yalome, 1982). Most feminists believe that by addressing these structures, we can understand the choices women make (Stanworth, 1987). These institutions exert strong social pressures on women to regard motherhood as the most significant aspect of their lives (Katz Rothman, 1989).

Many feminists have looked at the social construction of gender characteristics and the significance of gender identities to understand why women desire motherhood. Identities are commonly considered parts of the total person (Mackie, 1987). Gender identities are culturally formed role expectations and actions that differ for men and women (Lindsey, 1994). Gender-role identities involve the acceptance of oneself as

feminine or masculine. In other words, one has internalized the culturally assigned behaviours of these ascriptions. Individuals use these aspects of the self to evaluate themselves, to understand who they are, and to know what is expected of them.

Feminist theorists argue that societal structures construct the contents of gender identities to maintain appropriate sex-determined behaviour (Rowland, 1989). Men and women are often taught to identify with different forms of behaviour based on biological differences. For women, motherhood is constructed as the most salient gender-role identity. Phoenix et al. (1991: 13) state that "motherhood is central to the ways in which women are defined by others and to their perceptions of themselves." It is through the role of mother that women are highly valued and rewarded for their achievements in this society.

Feminists believe that the importance society accords to the motherhood role partially explains why most women desire children. Pronatalist attitudes and beliefs force some women to believe that without motherhood, they are not real women. This is because women are repeatedly told that their identity, social maturity and self-respect rests on having children. These combine to place motherhood at the centre of women's lives. Furthermore, a number of feminists have pointed out that the present organization of motherhood restricts women from developing their capacities in other areas of life (Jagger, 1983).

Gender-role identities aid in shaping women's motivation to have children. Therefore, looking at how individuals acquire their identities is important. According to some feminist theorists, individuals acquire identities in the course of gender socialization (Mackie, 1987). Lindsey (1994: 48) defines socialization as "the lifelong process through which individuals learn their culture, develop their human potential,

and become functioning members of society." This process teaches males and females that they are expected to behave differently because of their biological sex. The process of socialization defines which attitudes, values and behavioral patterns are considered appropriate for men and women (Lindsey, 1994).

The patriarchal family is the most significant agent of socialization for gender roles. Through socialization in early childhood, young boys and girls learn what is expected of them, and ultimately what they should desire and value in life. Through their interactions with parents and siblings, young children learn what is required of them to fulfill their gender roles. Socialization ensures that children will identify with, and conform to, the norms of society (Alpern, 1992). This process maintains the sexual division of labour that is essential to the continuation of capitalist patriarchy.

It is within the confines of the nuclear family that girls are taught to accept motherhood as the greatest achievement and ultimate fulfilment for women (Lindsey, 1994). This socialization process begins at birth and continues throughout adult life. As Antonis (1981: 61) states, "motherhood is the chief occupation for which females are reared." Women are taught to be mothers, and are told they ought to be mothers. Young boys are also socialized to view family life in a particular way. Children are consistently taught that a man's role in life is to provide for his family, whereas a woman's job is to stay home and bear and rear children. The ways in which young boys are socialized helps to reinforce the prevailing view of women as mothers. The patriarchal nuclear family not only conditions women to want to mother, it also informs them that children must be reared by women (Farganis, 1986). Within a patriarchal family, the mother should be firmly dedicated to having and raising her children. Young

boys and girls are socialized in ways that influence and reinforce traditional sex-role orientations.

Pronatalist and promaternal stereotypes are encouraged well beyond the stage of early childhood socialization. Women are consistently exposed to experiences and pressures that inform them of the importance of motherhood for the adult female role. Women are often bombarded with "do's" and "don'ts" from their families, friends, the media and the education system (Richardson, 1993).

Another expectation that is consistently reinforced in women is that of wifehood. For the majority of women in this society, adulthood involves finding a husband and getting married. The normative expectations of adulthood reinforce the imperatives of wifehood for a woman's identity and social maturity. These inform women that motherhood and marriage are central to the feminine gender role (Antonis, 1981). Women learn that marriage and motherhood are inextricably linked. As Antonis (1981: 59) states, "marriage and reproduction are linked together in a way implying that each explains and necessitates the other." It is common for women to be told that children are essential to a marriage because they make a marriage happier and more complete. Children are often viewed as the most important sign of a couple's commitment to each other, and to society.

We cannot disregard the fact that women are so strongly socialized to believe that marriage and motherhood are central to their lives. It is unrealistic to assume that women are not affected by the beliefs and attitudes that inform them of the importance of motherhood in their lives. Capitalist patriarchal institutions tie women to a role that limits the choices and options available to them for achieving a meaningful life

(Richardson, 1993, Jaggar, 1983). These institutions form an environment in which women believe that motherhood is essential for, and desired by, all women.

Empirical Research on Motherhood/Parenthood

In recent years, researchers have conducted studies to uncover why women and men desire parenthood (Newton et al., 1992; Greil, 1991; Williams, 1990b). The purpose of these investigations is to determine individuals' attitudes and intentions toward parenthood, and how these factors influence their decisions to have children (Gormly et al., 1987). Some of these studies address the meaning of motherhood for women and the significance attached to this role. It is important to point out that studies dedicated to understanding why individuals desire parenthood rarely consider the social context in which decisions are made.

Although there is substantial variability in the reasons given for wanting to have children, consistent responses emerge. The most commonly identified reasons for having children include the following: gratifying the need for gender-role fulfilment; achieving adult-status or a social identity; seeking sources of marital completion and biological continuity; and alleviating social pressures (Newton et al., 1992; Greil, 1991; Gormly et al., 1987; Achilles, 1990). Most individuals feel that parenthood is a natural and normal part of being an adult. One study found that most individuals (women and men alike) believe that motherhood is the most appropriate role for women, and that all women should want to be mothers (Scott and Morgan, 1983).

Researchers have found that the reasons identified for wanting children are generally more significant for women than men (Newton et al., 1992). In other words, both men and women desire children, but in differing magnitudes and sometimes for different reasons. Throughout studies, women proclaim motherhood as their ultimate achievement in life (Newton et al., 1992 and Williams, 1990b). In addition, as Scott and Morgan (1983) found, women in their study derived their major role definitions from being a mother. According to Greil (1991: 31), "the reasons for this are because the parent role is more central to the transition to adulthood for women, ...and parenthood is more central to women's identity than men's." A study conducted by Williams (1990: 550) found that most women "believe biological motherhood is an inherent and essential part of femininity." These findings show that the beliefs and attitudes of this pronatalist society affect women. The social construction of a woman's identity plays a fundamental part in her desire to have a child. As Bequaert (1992: 263) states,

> the few studies that have been conducted have found that women tend to adhere to the dominant ideology of the importance of motherhood and had experienced strong external social pressures.

The motherhood mandate is still widely accepted and pervasive in our society. Although more and more women are finding different means for achieving personal fulfilment, motherhood is still accepted as the most important source of a woman's identity (Lindsey, 1994). Achilles (1987: 287) reveals that "motherhood has remained central to a woman's sense of identity and self-esteem." The fact that women are socialized to value themselves primarily through motherhood is evident throughout these studies.

Although variation does exist, the majority of women in this society internalize the importance of motherhood for the adult female role. Women and men widely accept the prevalent cultural stereotyping that equates motherhood with femininity. Most of the women interviewed in the studies reviewed feel a strong need to experience motherhood to express their womanhood. Motherhood serves also as a means to establishing their gender-worth (Williams, 1990b; Newton et al., 1992). The internalization of these beliefs and attitudes plays a role in women's desire to have children.

Infertility and the New Reproductive Technologies

To understand more clearly women's desire for a child, we need to look closely at the issues surrounding infertility and ARTs. The propaganda that women are nothing unless they bear children is especially problematic for those who want to, but cannot, conceive. This is especially the case when ARTs are available.

An Historical Context

Throughout history, women have been the targets of infertility treatment and diagnosis. The Bible tells us that God punished women with infertility because of their sins. As well, men punished women for being infertile (Rehner, 1989). In the western world, between the 14th and the 17th centuries, when a couple was unable to have a child, the woman was accused of making the man impotent. As Rehner (1989: 26)

reveals, "infertile women have been burned at the stake as witches" because they were considered evil. According to Shattuck and Schwartz (1989: 332), in the 19th century, "even after the discovery that male sperm was a contributing factor to infertility, medicine continued to regard women as the more responsible agent for infertility."

Even in modern times, infertility is considered an exclusively female flaw (Rehner, 1989). Modern medicine has redefined the meaning of infertility and the appropriate techniques to cure this disease. The source of the problem and the proposed solutions still revolve around women's bodies and their behavioural characteristics. As Shattuck and Schwartz (1991: 334) reveal, "to avoid medical responsibility for infertility, societal attention is instead directed at blaming women for their liberalized sexual freedom and at holding women accountable for choosing education and careers over motherhood." Women are told that the longer they wait to have a family, the less chance they will have at conceiving. Women are often bombarded with negative comments about pursuing a career or education, rather than having a family. The cause of infertility becomes a matter of women having made poor choices. In reality, women's economic and educational gains have not led to an increase in infertility. According to Faludi (1991: 30), "women's quest for economic and educational equality has only improved reproductive health and fertility." Blaming infertility on women's choices is indicative of male power that oppresses and controls women.

The Medicalization of Infertility and Women's Lives

Within contemporary society, medical and scientific experts hold an incredible amount of authority over a wide array of issues. This authority is generally accepted because of a strong belief in the legitimacy of the objective knowledge produced by these experts (Franklin, 1990). The medical profession has exclusive power over the production and deployment of knowledge related to the human body. As Spallone (1989: 76) states, "they have the power to define the problems, the therapies, the technology, and its social meaning."

Popular representations by the medical profession construct the image that infertility is exclusively a biological problem found within the individual (Franklin, 1990). Their response to infertility is through medical intervention, with the end goal being pregnancy (Strickler, 1992). Keeping in mind that the accepted meaning of any disease or disability plays a part in defining the appropriate treatment strategy is important. This applies to the problem of infertility. Therefore, it is critical to analyze how infertility has been defined and represented by the medical profession; that is, how it has been medicalized.

Infertility has been defined as a medical disease. According to the medical model, the inability to procreate is distinctly abnormal. As Becker and Nachtigall reveal (1992: 459), the medical model makes it clear that "infertility falls outside the model of normalization to represent, instead, the abnormal, aberrant, or atypical body that must be cured." This definition places infertility in the hands of medical scientists, and encourages invasive technological solutions to the problem of infertility (Strother Ratcliff, 1989).

The medical establishment, which includes physicians, medical scientists and proceduralists, is a profit-oriented industry. They have routinely sought to redefine women's experiences as medical diseases. Historically, we can see this in childbirth and menopause, among other female experiences. According to Corea (1985: 303), "ever since the late 1800s the medical profession has fought to control childbirth." And as Strother Ratcliff (1989: 184) demonstrates, "instead of menopause being seen as a natural aging process...it has come to be seen as a 'deficiency disease' that merits technology-based medical intervention." The treatment strategies initially proposed by medical scientists to cure these medical disabilities have now become routine medical procedures. These innovations include caesarean sections, ultrasonography, episiotomies, hysterectomies, and estrogen replacement therapy (Strother Ratcliff, 1989; Corea, 1985).

Defining infertility as a medical condition is very strategic. Diagnosing infertility as a physiological inability is the chief means by which the medical profession can justify control over its treatment. Reproductive technologies are closely tied to this medical definition. According to Steinberg (1990: 90), "the meaning of infertility has a necessary relationship to the structure and implementation of assisted reproductive technologies." These innovations reinforce a medical definition of infertility and a technologically-based treatment strategy. As Spallone (1989: 66) reveals, "infertility was the first medical disability for which in-vitro fertilization was put to use as a clinical treatment."

Infertility: Its Prevalence and Distribution

Infertility is "the inability or failure to conceive after one year of regular, unprotected intercourse" (Sandelowski, 1990: 48). This definition is not universally accepted, but researchers and the medical profession commonly use it (Royal Commission on New Reproductive Technologies [RCNRT], 1993). Various organizations now use a two-year time period because "a significantly smaller proportion of couples has a pregnancy after two years than during the first two years" (RCNRT, 1993: 183). According to the Royal Commission Report (1993: 189), "based on the two-year estimate of the prevalence of infertility (7 percent), approximately half a million Canadians (250,000 couples) in their reproductive years are currently affected by infertility."

In recent years, medical experts, scientists and the media have presented infertility as a growing health problem (Sandelowski, 1990). The numbers used to describe the magnitude of the problem are very important. As Bryant (1990: 2) explains, "numbers chosen to define infertility affect both the perceived magnitude of the problem, and the apparent cure rate." It is common to come across articles in the professional literature and popular press that address an infertility epidemic. According to Grant (1994), when factors such as the postponement of childbearing to later years are taken into account, rates of infertility are similar to those thirty years ago. In fact, some researchers have discovered that rates of infertility have decreased in recent years (Faludi, 1991). As Faludi (1991: 29) reveals, "the percentage of women unable to have babies had actually fallen - from 11.2% in 1965 to 8.5% in 1982." Reports of infertility reaching epidemic proportions may merely reflect the medical profession's attempt to create a market for their services and a changing social milieu.

Medical scientists have studied the etiology of infertility extensively. According to Shattuck and Schwartz (1991), the etiology of infertility is due to male factors in 40% of cases, female factors in 40% of cases, and idiopathic (unknown) factors in 20% of cases. However, in its recent report, the Royal Commission on New Reproductive Technologies (RCNRT) noted that "it is difficult to attach exact figures to the proportion of infertility that is attributable to either male or female member of a couple" (RCNRT, 1993: 167).

Researchers have identified potential causes of infertility for both males and females. The factors that contribute to female infertility include ovulation and endocrine disorders, obstructions in the reproductive tract due to inflammatory disease, endometriosis, sexually transmitted diseases, and structural or functional problems of the uterus and cervix (RCNRT, 1993). For males, the factors that contribute to infertility include sperm production and maturational problems, hormonal dysfunctions, sperm motility, obstructions and blockages, ejaculation and anatomical abnormalities (RCNRT, 1993).

None of these immediate causes arise spontaneously, but are a result of other factors (Bryant, 1990). It is uncommon to come across information in the popular press or scientific journals that address medically induced (iatrogenic) infertility. Fortunately, some researchers have addressed this devastating, but recurring, phenomenon (Corea, 1985; Overall, 1987; Spallone, 1989). According to these researchers, various techniques developed by the medical profession have contributed to the problem of infertility. Corea (1985: 117) states that "these iatrogenic causes include IUDs, caesarean-sections, the pill or Depo-Provera, and DES." The medical profession implemented these techniques without proper evaluation as to the potential

harmful effects they had on women. The medical profession hailed these innovations as serving the interests of women - the key to women's liberation and freedom from reproduction. In reality, they were experimental procedures - practised on women's bodies.

Infertility has been linked to untreated sexually transmitted diseases (STDs). Physicians and government officials failed to respond appropriately to the growing problem of STDs and the connection between STDs and infertility (Faludi, 1991; Corea, 1985). These diseases are largely responsible for the vast proportion of infertility during the '80s and '90s. According to Bryant (1990: 20), "STDs are well known to be related to pelvic inflammatory disease, and inflammation of the fallopian tubes which can lead to permanent damage." Nevertheless, physicians and government officials seemed uninterested in these health problems that could be cured and prevented. According to Bryant (1990: 24), "in the same year that the Canadian Government funding agencies spent $3.5 million on basic NRT research, only slightly over $400,000 was spent on public health and health services research activities related to reproductive disorders." Faludi (1991) notes that chlamydia is the fastest growing STD in North America, yet it was poorly publicized, diagnosed and treated.

In western countries, infertility is perceived as a problem only within the confines of marriage (Overall, 1987). Physicians treat this as a medical problem when it affects married, middle-and upper-class, heterosexual couples. The medical profession plays a powerful role in perpetuating the status quo; that children should only be raised within the nuclear family. According to Overall (1987: 173), "this reinforces the connection of standard heterosexuality with reproduction and disengages other forms of sexual life expression from procreation."

Several researchers have shown that the medical profession is actively participating as an agent of social control by defining whose infertility problems are worthy of attention (Woliver,1989; Rowland, 1987). This gatekeeper function reinforces, and is consistent with, the more general belief system regarding the link between marriage and acceptable motherhood which was discussed earlier. The medical profession has the authority to make moral and social judgements about who should be allowed to reproduce in our society. Through their practice, doctors are essentially saying, biology is destiny, but for only a select group of women. This reality poses serious implications for women who do not fall within the norms of acceptable motherhood.

The emotional turmoil experienced by infertile women is compounded when they are single, poor, or in a lesbian relationship. Medical researchers and physicians reinforce the oppression of silence experienced by these infertile women. Information aimed at understanding the experience of infertility for single or lesbian women is virtually nonexistent. Most studies focus on middle- and upper-class, well-educated, married couples. Whether the experience of infertility differs between classes, or in non-traditional versus traditional families is unknown. Medical authority over the problem of infertility allows medical researchers to limit information according to their values and beliefs. As Franklin (1990: 207) states, "these explanations are used selectively, to produce explanations of the experience of infertility which reinforces social norms." More importantly, the gatekeeper function of the medical profession ultimately prevents some women from receiving assistance for fertility problems.

The Experience of Infertility

A small number of researchers have investigated the infertility experience in societal terms, to try and understand it better (Sandelowski, 1990; Stanton et al., 1991; Klein, 1989; Miall, 1986; Connoly et al., 1992). These studies focus on the impact of infertility on psychological and emotional well-being, interpersonal relationships, sex role identity and the marital relationship. Essentially, these investigations attempt to show that individuals experience the effects of infertility in all aspects of their lives.

Infertility is a multidimensional experience. Infertile women are not a homogeneous group. Each woman goes through a different series of stages and resolutions, and is affected by the experience in varying ways and degrees. Many factors affect the experience of infertility, including the options available for becoming a mother; the diagnosis and treatment at the present time; the time involved in the infertility experience; the motivation for wanting motherhood; the value placed on conceiving; and the mechanisms a woman uses to handle life experiences (Kraft et al., 1980; Woods et al., 1991; Stanton et al., 1991; Miall, 1986).

Although this is a complex event, researchers have found some common reactions to the initial awareness that a problem exists. The initial response to the diagnosis of infertility is often one of surprise. Some emotional reactions to the problem of infertility include grief, sorrow, anger, frustration, distress, anxiety, feelings of guilt and a loss of self-worth (Williams, 1990; Stanton et al., 1991; Woods et al., 1991). A study conducted by Miall (1986) found that most women categorized infertility as something negative, as a type of failure. In this study, nearly half the women interviewed admitted finding it hard to disclose the problem to their families and friends, because they felt inadequate and ashamed.

The majority of studies conducted suffer methodological problems, and the findings are generally inconsistent (Downey and McKinney, 1992). During investigations, most women are at different stages of their infertility work up, but the researcher often groups them together (Connoly et al., 1992; Downey and McKinney, 1992). Future research efforts should account for time involved in the infertility work up, the specific treatment that participants are presently involved in, and a variety of other psychosocial factors that are significant to the experience. Although these studies are inconsistent, they have generated some useful information. The findings demonstrate that the realization that one is unable to conceive is the beginning stage of a long and often painful experience.

After failing to conceive, infertile women face many decisions, such as whether to remain child-free, adopt, or seek medical assistance. The reasons behind the decision a woman makes are still relatively unclear. The choice to remain child-free is often considered a non-issue for those women who desire a child, or for those who have a partner who wants a child. This is not surprising considering how much pressure is placed on women to have children and to become biological mothers (Woliver, 1989). We live in a society that regards the childless woman (or couple) as a failure. Therefore, for some, remaining child-free is not an option. Adoption is often difficult in North America because of the steady decline of adoptees, and the long waiting lists for infants (Grant, 1994). This is especially problematic for women (couples) who want more than one child. Another potential problem with adoption is that the majority of women (couples) want a genetically-related child, and therefore view adoption as a second-best option (Williams, 1990). Remaining child-free, or trying to adopt does not always satisfy the needs of the infertile woman or her partner.

Therefore, women may seek a medical solution for their problems. Although not all women seek medical solutions to infertility, a majority will find themselves on the medical treadmill (Klein, 1989).

In western countries, the medical path is often unavoidable (Rehner, 1989). Women are encouraged to seek assistance from a reproductive specialist. Medical scientists tell these women (couples) that medical treatment such as ARTs can produce desired results. The first visit to the physician begins the often long journey through various diagnoses, treatments and surgical procedures. According to Woods et al. (1991: 182), "the progression is usually from low-risk to high-risk diagnostic tests and from low-risk to high-risk treatment options." Because 10-20% of women (couples) never learn why they cannot conceive, they will continue to try anything to achieve their goal (Rehner, 1989). This uncertainty also complicates the treatment strategy, and extends the length of treatment time (Rehner, 1989).

The medical options available to infertile women (couples) include drug therapy, surgical procedures, inseminations by husband/donor, intra-uterine insemination, in vitro fertilization (IVF), and gamete intra-fallopian transfer (RCNRT, 1993). Quite often, the medical option chosen depends on the severity of the problem. Often, doctors combine a range of techniques to achieve successful results. Ultimately, the medical practitioner decides which treatment strategies they will prescribe according to the diagnosis.

The infertility work up can last anywhere from 2-12 years (Hallebone, 1991; Klein, 1989). According to Becker and Nachtigall (1992), most women enter treatment unaware of the lengthy and often complex procedures involved. Nevertheless, most women continue until they have exhausted all medical options. Throughout the

infertility work-up, women (couples) experience an emotional roller coaster. According to Woods et al. (1991: 187), "women experience feelings of excitement and joy to sadness and uncertainty. Feelings of surprise, fear, hope...betrayal." During the infertility work-up, a woman's life is greatly affected in all spheres. The rigorous treatment makes it difficult to continue working and therefore women may thwart life plans and careers (Rehner, 1989). It is common for social and marital relationships to be damaged during the infertility work-up (Rehner, 1989; Stanton et al., 1991). Not being able to procreate can consume the lives of the people involved, sometimes with no resolution in sight.

The reasons why some women continue infertility treatment is not well understood. As Newton et al. (1992: 24) state, "the attitudes and behaviours of those who persist in treatment have not been adequately addressed." The endless array of medical treatments available to some infertile women has prolonged this often painful and unattainable desire.

The very existence and availability of reproductive technologies further complicate the experiences of women who want a child. According to Shattuck and Schwartz (1991: 335), "the endless array of reproductive options has created a new burden for the infertile - the burden of not trying hard enough." As Lauritzen (1990:41) reveals, "once an individual is presented with a treatment option, not to pursue it is, in effect, to choose childlessness."

IVF: Its History and Career as a Medical Innovation

IVF is a recent technological development that has increased the options available to infertile women (couples). IVF practitioners promote this technology as the final hope in relation to the problem of infertility. As Hallebone (1991: 130) claims, "to get to the stage of IVF, many other medical and surgical procedures have taken place for each individual." According to Becker and Nachtigall (1992:466), "by the time couples reach IVF, they have reached the end of their treatment options." Women undergoing IVF treatment are exposed to even more emotional difficulties because this is considered their last chance for a biological child (Litt et al., 1992).

Medical scientists have been experimenting on women since the 1940s, though their attempts continued to fail. (The first major success came in Britain in 1978 with the birth of Louise Brown.) It is questionable if they informed women in IVF programs of the odds of becoming pregnant, and if in fact, they had consented to these experimental procedures. According to Corea (1985: 166), "women in IVF programs did not know the full nature of the program or that these programs were experimental versus actual therapy."

Throughout the developmental process, promising reports of this scientific endeavour filled the medical journals and popular press. As with any newly developed technological innovation, only positive reports were found in articles and media stories (McKinlay, 1982). IVF was and still is hailed as a safe and effective means of overcoming infertility. The main emphasis is on the successes that have occurred, although the number of successes is relatively small (Overall, 1989). Rarely is there any discussion of the actual success rates, the complicated procedures involved or the

devastating effects that IVF has on women (couples) who were unable to reproduce even after several attempts.

It is not a coincidence that billions of dollars are spent on researching techniques that focus exclusively on women's bodies (Strother Ratcliff, 1989). As Wajcman reveals (1991: 22), "political choices are embedded in the very design and selection of technology." A male-centred view of reproduction and parenthood drives these innovations (Rowland, 1987). In Western society, a child is what grows out of a man's seed, and women's bodies are reduced to baby-making machines (Katz Rothman, 1989). This powerful message plays a part in defining which of the technologies will be pursued and accepted.

The medical community strategically portrays IVF as a humanitarian response to a biological inability (Williams, 1990a;1990b). This powerful message enables the medical profession to place the treatment of infertility within the domain of medicine, and to justify the further development of various scientific innovations (Franklin, 1990). This also serves to reinforce the idea that this technology is good, and in the best interest of women (couples) who want a child of their own (Katz Rothman, 1989).

According to the RCNRT (1993), in Canada, as of 1991, fewer than 400 infants were born using IVF. When IVF was first developed, physicians generally performed it on women who had blocked fallopian tubes (Grant, 1994). The indications for IVF use have recently multiplied. According to the Royal Commission Report (1993: 498),

> in the mid- to late 1980s, IVF was being used for indications ranging from unexplained infertility, ovulation defects, and endometriosis, in addition to tubal blockages...IVF is also used as a diagnostic test of male infertility after assisted insemination has been unsuccessful, to ensure there is no chance the male partner's sperm can fertilize the egg, before the couple stops treatment or turns to donor insemination.

These technologies have expanded from being used on infertile women to the fertile population. As Corea (1985: 123) states, "IVF is being used on healthy women who have partners that are infertile." In other words, they promote IVF as the ideal means by which a fertile woman can give her infertile partner a child.

In Canada, "one cycle of IVF costs between $5,400 and $7,500 per patient" (RCNRT, 1993: 525). (Note: these costs are based on 1993 figures and may not represent present day costs). These figures reflect direct medical and patient costs; "they do not include the costs associated with premature and multiple births and chronic care for long-term disabilities" (RCNRT, 1993: 523). According to the Royal Commission Report (1993: 527), "30% of IVF deliveries are multiple, compared to a rate in the general population of about 1 percent." The costs of caring for triplets, quadruplets and quintuplets are much higher than for a single baby. The birth of multiple babies can cost a couple anywhere from $8,000 to $16,000 higher per year, as compared to giving birth to a single baby (RCNRT, 1993).

Researchers, medical practitioners and policy-makers have investigated the effectiveness of IVF. The documented success rates of IVF tend to vary in terms of who is reporting the figures. Those with a vested interest in this procedure (i.e., IVF proceduralists and researchers) report the highest success rates. According to these expert sources, percentages of successful IVF range anywhere from 15-25%. More critical evaluators of IVF dispute these figures (Corea, 1985; Grant 1994; Overall, 1989). These critics point out that clinicians often manipulate the figures presented in medical journals and the popular press, and are generally misleading. According to these critics, the actual number of successful births is between 0 to 5% (NACSW, 1991; Overall, 1989). Clinicians involved in IVF rarely provide information on the

number of women who have actually participated in these experiments. These professionals also fail to highlight that multiple births are common to IVF because doctors generally implant more than one egg. The meaning of success also varies from one clinic to the next. Some clinicians measure success as successful implantations, as opposed to live births (Grant, 1994). These omissions inevitably alter the statistical reports on IVF.

The effectiveness of IVF is, therefore, questionable. As the Royal Commission Report concludes (1993: 521),

> a substantial proportion of women undergoing IVF at fertility programs across the country are doing so when there is no evidence that, given their diagnosis or that of their partner, IVF will help them conceive. In other words, unproven and quite possible ineffective procedures are being offered as medical treatment, and women are undertaking the risks of these procedures without knowing whether they are more likely to have a child than if they received no treatment.

IVF clinics and practitioners are misleading women by promoting a false promise of success (Rowland, 1987). Medical experts continually exploit a woman's desire to have a child. According to Klein (1991: 395), "women find themselves compelled to undergo IVF, but few women end up taking a baby home." This reality has devastating implications for women who want to nurture life. The fact that medical experts directly link the desire to have a child with the hope for a medical cure merely serves to conceal alternative options (Franklin, 1990). As Woliver (1989: 38) states, "social solutions for infertility, rather than medical, are de-emphasized by reproductive technology." Medical scientists manipulate many women into believing that this is their last hope of conceiving a child. Unfortunately, the sense of failure and loss is multiplied when their last hope has been ineffective. Nevertheless, medical scientists are quick to point out that something is better than nothing.

Several researchers have addressed the technical procedures associated with IVF, and how they affect the health and well-being of women (Grant, 1994; Corea, 1985; Bequaert, 1992; Steinberg, 1990). In a routine IVF procedure, women who are unable to conceive are exposed to a rigorous treatment program. In the first stage, women take a hormone cocktail to stimulate ovulation, releasing up to twenty-two eggs, as opposed to one (Crowe, 1990). Women usually take these drugs for five days. During these days the patient must have blood tests every day to measure estrogen levels, and ultrasound is performed to monitor the releasing of her eggs (Crowe, 1990). In the next stage, the physician does a procedure called a laparoscopy. The purpose of this procedure is to harvest ripe eggs from the woman's ovaries. Once the doctor has harvested these eggs, he/she then inspects the eggs, and places them in a petri dish. At this time, the sperm is washed and prepared for the fertilization process. The most suitable sperm is placed in the petri dish with the harvested eggs, and the technician waits for fertilization to occur. When fertilization has occurred, the physician transfers the embryo into the woman's uterus. If the implantation has been successful, the patient must then wait to see if the IVF procedure was effective.

The term IVF strategically obscures the many procedures that are necessary in order for this process to be possible (Steinberg, 1990). Fertilization does not occur by simply uniting an egg and sperm in a petri dish. The procedures involved in IVF pose serious risks to the health and well-being of women. Not only are women harmed physically, this procedure is an economic burden and a serious risk to the psychological well-being of the participant.

The Social and Psychological Impact of IVF

According to Hynes et al. (1992: 269), "IVF is described by women as an emotionally demanding and stressful treatment, and, depending on the outcome, a source of great despair." Women who want to have a child are often eager to elect IVF because of the belief in the effectiveness of this procedure. Rarely are women informed of the true odds of becoming pregnant through this procedure (Corea, 1985).

Limited empirical research addresses the psychological impact of failed IVF attempts (Hynes et al., 1992). There are some preliminary investigations aimed at addressing this emotionally turbulent experience (Newton et al., 1992; Hynes et al., 1992; Litt et al., 1992). Researchers discovered that continued IVF failure causes feelings of anxiety, anger, depression, lower self-esteem and especially a 'loss of control.' Studies reveal that women, more than their partners, are affected by IVF failure. This is sometimes attributed to the fact that women are exposed to the IVF procedure. Another possible reason for greater levels of distress among women is that women may identify more strongly with fulfilling a reproductive role. A study conducted by Newton et al. (1992) found evidence of this. According to this study (1992: 30), "women who emphasized role fulfilment not only had poorer adjustment before IVF, but also exhibited higher levels of anxiety, depression, and negative life appraisal when the cycle failed."

The IVF procedure intrudes into every sphere of a woman's life. According to Strickler (1992), the lives of women undergoing IVF revolve around basal thermometers, hormone injections and monthly cycles of anxiety. Women entering the IVF program have already been exposed to many disappointments and hardships. The emotional and physical stress associated with IVF merely exacerbates existing

problems. Throughout the IVF procedures, women (couples) wait impatiently, hoping that the technique is successful. According to a study conducted by Williams (1989), women's accounts of their experience with IVF showed that it was extremely stressful both physically and emotionally. These women found the waiting period the most stressful of all. "These women experienced intense psychological conflict between being optimistic or being realistic" (Williams, 1990: 134)

Besides the potentially serious psychological implications, IVF carries with it many social implications for women. Reproductive technologies negate and devalue the role that women play in procreation and motherhood (Young, 1990). IVF takes reproductive control away from women, and places it in the hands of mostly male physicians (Corea, 1985; Overall, 1987; Wajman, 1991; and Strickler, 1992). A process that was once unique to women is increasingly being taken over by a male-dominated profession. Although medical experts would have us believe that IVF increases women's choices, this is not necessarily the case. Some feminists are skeptical about the notions of choice and rights in a society which is structured and controlled by men. As Klein (1991: 404) declares, "reproductive technologies do not offer choice...they bring with them a loss of control for women, but a gain of control for international techno patriarchy."

Motherhood, Infertility, and Assisted Reproduction

Various belief systems and institutions play a part in a woman's desire to have a child. Pronatalist attitudes and capitalist patriarchal institutions construct an identity for women that equates femininity with motherhood. The gender socialization process

and the medical establishment aid in establishing the importance of biological motherhood in women's lives. Many pressures are placed on women to have children and to become biological mothers. Few women can escape these pressures.

The ideology that forces women to believe they are not real women without children is extremely problematic for those who want to, but cannot, conceive. Pronatalist and promaternal stereotypes directly affect the lives of women who are unable to procreate. These women have to cope with hardships, pressures and decisions. Women find themselves in a world where motherhood is consistently constructed as the most important aspect of their identity, and where being a childless woman is a sign of failure. Coming to terms with the absence of control over one's body, childbearing and parenting becomes a major crisis for the infertile woman.

Women who are unable to conceive are often encouraged to seek medical assistance to overcome fertility problems. These women are bombarded with an endless array of medical options to fulfil their biological destiny. In essence, medical practitioners and IVF proceduralists step in, proclaiming they can fulfill a woman's desire.

IVF is problematic for women who cannot conceive. Not only do these technologies offer false hopes to women, they reinforce methods of treatment that do not cure the infertility problem. What is more, IVF has introduced new pressures and dilemmas for women who want a child. IVF reinforces a woman's feelings of guilt, and loss of self-worth for not being able to reproduce. The very existence and availability of this technique may push some women to continue seeking a technological solution to their infertility problem. These pressures are fundamental to the decision-making process for some women.

Although the existing literature provides some important clues why most women want motherhood, the voices of women themselves are relatively absent. We must better understand the pain and emotional turmoil experienced by women who want a child. These women need to be informed of the issues surrounding the medical options offered to them by the medical profession. Women need to find support and reassurance for the difficulties they experience because of their infertility problems.

This study is a step toward documenting women's experiences according to the women themselves. By using the narratives of the women in this study as the foundation of my research, I hope to create a better understanding of women's experiences of infertility in an age of ARTs.

In the following chapter, I present the objectives of this study and the research process. As well, I discuss some problems I had with the data collection and analysis.

Chapter 4 - The Methods Chapter

Objectives of the Study

This exploratory study examines the many reasons why women seek medical assistance to overcome their infertility. I explore similarities and differences in women's experience of infertility. More specifically, I address the decisions women make when confronted with fertility problems and how they come to these decisions.

The objectives of this study are to understand the decision-making process surrounding ARTs. I want to understand why some women seek ARTs as a means to having and a child, and why others do not. The second objective of this study is to understand how the social context in which women find themselves influence these decisions. I also want to know if differences exist in the decision-making process if the cause of infertility was either female factor, male factor or unexplained infertility. As well, I want a study that combines the 'subjective' and 'objective' world of women's lives. To obtain what I believe is a comprehensive understanding of this reality, I begin with women's lived experiences, but I also conduct a structural analysis of these narratives. This study also aims at uncovering information that can contribute to the current knowledge on this topic. Newton et al. (1992) note that although the recent proliferation of ARTs has brought more attention to the experience of infertility, the reason(s) why women (couples) seek reproductive technologies as a solution to their problem is limited. Furthermore, studies have failed to address the social context in which women make these decisions (Alpern, 1992; Whiteford and Gonzalez, 1995).

The Research Process

Qualitative research methods of gathering and analyzing data are considered most appropriate for the goals of this study. Qualitative methods are more beneficial when the researcher is trying to tap into the subjective level of human experiences and when little is known about a particular phenomenon (Tesch, 1990). This is the case concerning the decisions women make when confronted with fertility problems.

To overcome the limitations of past research, this study uses methods capable of providing me with the necessary data to analyze the relationship between the personal worlds of women and the social contexts in which they find themselves. Understanding social phenomena at this level is an effective way of uncovering the realities of individual and social life (Ellis and Flaherty, 1992).

I conducted semi-structured interviews with each participant. I chose this method of data collection because of its relevance to this study. This method of data collection is considered most suited to gathering information that is experiential. I needed to gather narrative data. I designed an interview guide that consisted of semi-structured, open-ended questions (See Appendix A). This interview elicited information on the participants' experiences and perceptions, based on self-reported information.

I selected this method of research because of its suitability to the goals of feminist research. Although the ideas put forth by feminist researchers regarding qualitative methods are similar to those of other social scientists who advocate this method, some unique differences exist (Hammersley, 1992). As Fonow and Cook (1991:6) discuss:

> the intention and method of feminist research should be consistent with the political goals of the women's movement, and that research should be fully integrated into social and political action for the emancipation of women.

This study is dedicated to understanding the decision-making process of women who want to, but cannot, conceive.

Acknowledging and validating women's experiences is an essential aspect of feminist research. As Klein (1983: 91) states, "the claim that research on women is conducted with a feminist perspective can be made only when the methods applied take women's experiences into account."

I conducted my research according to various feminist principles of doing research. Specifically, I followed Oakley's (1980) suggestions for interviewing women. According to Oakley (1980: 41),

> the goal of finding out about people through interviewing is best achieved when the relationship of interviewer and interviewee is non-hierarchical and when the interviewer is prepared to invest his or her own personal identity in the relationship.

Throughout the interviews, I promoted a non-hierarchical relationship between myself and the informants. I accomplished this by reiterating the significance of the informants' participation throughout the interview process. In fact, I told the informants that their perceptions and experiences were the most important aspects of this research, and that they were the experts on these issues. I also encouraged an interactive process between myself and the women. There were several occasions when the informants and I engaged in extended conversations on several different topics. These discussions helped the informants and I get to know each other better, and to build a closer relationship.

Because of the sensitivity of the topic, there were a few factors that I needed to consider before conducting my research. According to Cowles (1988), one issue that needs to be taken into consideration when conducting research on sensitive topics is

how the researcher will deal with the subjects' responses to sensitive topics. The second consideration is timing. Cowles (1988) suggests that researchers should be flexible throughout the interview process, allowing time for crying and sharing of emotions. Further, they should arrange for potential follow-up intervention. During highly emotional times, I decided that I would turn off the tape recorder and suggest stopping the data collection temporarily. As for follow-up intervention, I was prepared to tell the informants that they were welcome to call me anytime if they needed to discuss the interview further. I also prepared a list of various organizations that deal with issues relating to infertility and ARTs. I was willing to give this list of resources to the informants, though none requested this information.

Another consideration that Cowles (1988) discusses is timing, both in terms of the researcher and the informants. When I began the interviews, I decided to space my interviews so that I would only conduct two interviews per week. Cowles (1988) believes that this helps to alleviate stress for the researcher. Timing is also important for the informants. I decided to keep in mind the recent experiences of the informants when making decisions about my own comments during the interview process.

Identifying the Sample

The sample for my study consists of women who defined themselves as having fertility problems. This labelling is evidenced by the fact that these women identify themselves, or their partners, as infertile. All of the participants volunteered for the study.

I am interested in women with three different types of (background) experience. Women who had no assisted reproduction at the time of the interview are in the first category. Women who had pursued some type of ARTs, but had not been involved with IVF, are in the second category. Women who had used IVF are the final category. The sample was evenly divided among these categories. Each of the primary groups consisted of women who stated that the cause of the infertility was either male factor, female factor or unexplained infertility. I had initially hoped to have the categories divided evenly into female and male factor, but this was not possible. As I began the process of contacting potential informants, I decided for practical reasons, that I would not limit my sample to female factor and male factor infertility. I also became aware of the fact that many women had unexplained infertility. It was at this point that I decided to have a sample that consisted of either male factor infertility, female factor infertility or unexplained infertility.

When the informants first contacted me by phone, I asked each of them to answer the questions on the screening questionnaire (See Appendix B). I specifically designed this questionnaire to draw a sample that suited my research goals. Primary groups and subgroups were created for comparative reasons. I wanted to discover whether differences existed for women who had used ARTs, as compared with those who had not. I also wanted to examine if differences exist among women who had sought some type of assisted reproduction but had declined IVF. It was also important for me to try to understand whether differences existed among women when the cause of the infertility was either male factor, female factor or unexplained.

Because of the nature and purpose of this study, I used a nonprobability sampling method. With the information that I acquired about women's experiences

with infertility and ARTs, as well as my own judgement, I drew a purposive sample. Although my sample was small, I deliberately tried to include a variety of informants in my study. Therefore, based on my theoretical knowledge, the sample I drew was diverse enough to provide some preliminary data as to the decision-making process of women who are experiencing fertility problems.

I obtained my sample in three ways. Some women in this study were selected by using a 'snowball' or 'network' technique (Glesne and Peshkin, 1992). This process involves making one contact and then using recommendations from this individual to identify other participants (Glesne and Peshkin, 1992). In January of 1995, I contacted the coordinator of an infertility support group in Winnipeg. The Winnipeg Infertility Support Group (WISG) is a nonprofit organization that provides emotional support to infertile women and couples. Besides this, WISG provides information on recent medical innovations and treatments, and explores various non-medical options for building a family. During our initial discussion, the coordinator and I talked about my study and the infertility support group. We then agreed to meet in-person to discuss the study further to see how she could help me contact potential participants. The coordinator offered to send a letter (See Appendix C) to the members of the infertility support group to inform them of my study. The letter described the nature and purpose of my study, and informed these women that they could contact me if they wanted to participate in the study, or if they just wanted more information. A total of twenty women were sent letters and seven women responded. Of the seven women who contacted me, three changed their minds and the remaining four decided to participate. The reasons for cancelling ranged from time constraints to holidays. One

woman who was going through DI at the time did not feel ready to discuss her experiences.

The second method of identifying my sample was word of mouth. Some informants contacted me because of their interest in my work. A few women had heard about my study through friends or co-workers, and then decided to contact me to find out more about the study. A total of seven women contacted me this way, and five of these women fit the criteria for the study. Besides this, some women were selected through a second 'snowball.' Three women contacted me after talking to women who had already participated. After each interview, I told the informants that they were welcome to tell whomever they liked about this study, and that it was okay to give out my phone number to potential study informants. In total, I identified eight of the informants through word of mouth.

The remaining three women in my sample were women in my acquaintance, which meant I was aware of their circumstances. I called each of these women and informed them about my study. I then told them that I was looking for women who might be interested in sharing their experiences. After this discussion, I asked them to consider if they would like to participate. All three women contacted me later and volunteered to participate.

The sample consisted of fifteen women. Table 1 shows the source of the study participants.

Table 1

Sample by Source	
	Frequency
WISG	4
Word of Mouth	8
Direct Researcher Contact	3
TOTAL	15

The Interviews

Between February and April of 1995, I interviewed the fifteen women in my study who were at various stages of their infertility experience. I conducted fourteen of the interviews in the informants' homes and one occurred at the informant's place of business. The informants chose the location of the interviews. The interviews took from thirty-five to ninety minutes. The sessions actually took longer because I spent time before and after each interview with the participants. In most of the interviews, the sessions began with the informants and their partners asking me questions. These questions often centred around the purpose of my study, why I was interested in this topic, and other general inquiries. I answered all of the informants' questions as much as was required and told them that they were free to ask me any other questions during the actual interview. I believe that this opening exchange aided in putting the informants at ease; it allowed us to begin building a trusting relationship. I felt that because of the sensitive nature of the topic, I would use this time to get to know the informants. What is more important, I wanted these women to feel comfortable. Most of the women expressed insecurities about their ability to provide anything meaningful

to the study. It was common to have women say to me, " I doubt I can really help you out." I tried to dispel this belief by highlighting the significance and benefits of their individual experiences.

I received permission from the Department of Sociology Ethical Review committee (See Appendix D) to conduct my research on women who defined themselves as having fertility problems. Before each interview, I gave the informants an information sheet and consent form (See Appendix E). The information sheet outlined who I was, the nature of the study, and the purpose of my research. I made it explicit that the information would be strictly confidential and that the informants' identity would remain anonymous. The signed consent form indicated that the respondents made an informed decision to participate in the study.

Before I conducted the interview, I spent time reiterating the purpose of the study, and the format of the interview. I told the informants that there were no right or wrong answers, and that I was interested in having them share their experiences and perceptions with me. During this time, I also made it clear that they could refuse to answer any questions with which they were uncomfortable, and that we could take a break whenever they felt it was necessary.

During the interviews, I did not present myself as an 'objective' social scientist, who was merely concerned with data collection. There were many occasions where the informants and I engaged in a conversation. The informants often initiated these conversations themselves. Many women questioned me about my views on infertility, motherhood, ARTs and IVF. I did not feel I could refuse to share my own views and perceptions. I believe that these discussions provided relevant information to the

research question, and to other areas of concern. The experience is consistent with Oakley's (1980: 58) observation that:

> a feminist methodology of social science requires that the mythology of 'hygienic' research with its accompanying mystification of the researcher and researched as objective instruments of data production be replaced by the recognition that personal involvement is more than a dangerous bias - it is the condition under which people come to know each other and to admit others into their lives.

All of the interviews were audio-taped, as I decided that verbatim transcripts would provide the most reliable information for a qualitative analysis. I also took brief notes during and after each interview. Many women continued to share their experiences after the interview session was completed, and the tape recorder was turned off. I recorded this information immediately following the interview.

As mentioned earlier, the interview was semi-structured (See Appendix A for the interview guide), but a free-flowing discussion was encouraged. Although I wanted to allow the women to express their experiences in their own terms, I kept in mind that this was a guided conversation aimed at uncovering the factors that motivated women to seek medical intervention in overcoming their infertility. In other words, I tried not to interrupt the discussion, except to probe for information about my research question, and to bring the conversation back on track. A few sessions did not flow easily. In these interviews, I relied heavily on the interview guide. I felt that this was the most effective way of generating a relevant discussion with the women who were uncomfortable with openly discussing their experiences and perceptions. In all of the sessions, this technique was effective.

I designed the interview to elicit information from women with a variety of experiences. Therefore, some questions were irrelevant to some informants'

experiences. These questions were omitted. I did give all of the participants the opportunity to read over the entire interview, if they wanted. The order of the questions depended on the informant's experiences, as well as the information that we had already discussed. The interview was flexible enough to allow me either to rearrange or omit some questions. In other words, I chose the sequence of the questions during the interview so that they were relevant and appropriate for each situation. I sometimes repeated questions to understand thoroughly the individual's experience, and to clarify something discussed.

Although the interview guide did not change over the course of data collection, my performance did. As the interviews progressed, I matured as an interviewer. I became more comfortable with probing and could generate information that was more relevant to my research question.

We explored a number of issues and topics throughout the interview; however, the overall goal of this interview was to obtain information about the decision-making process relating to motherhood, infertility, ARTs and IVF. I designed the first part of the interview to uncover demographic information about the informants. I asked all of the women to discuss a little bit about themselves. The informants were also asked to describe their reproductive history, until they realized a problem existed. The next stage of the interview tapped into specific areas related to motherhood. At this point, the informants discussed their perceptions and experiences regarding motherhood, families and children. These questions generated information on why women want children, what ideas women have about what makes a family and how women come to decide when to have children. The next part of the interview focused on the infertility experience. More specifically, it addressed the meaning of infertility for each

informant, and how this experience has affected them. This section also dealt with the infertility work-up. I designed this section of the interview to begin uncovering the decision-making process. I asked the women to discuss what they decided to do once they realized a fertility problem existed and why. These questions determined the questions to follow. The next section dealt with ARTs. This part of the interview aimed to uncover women's experiences with various ARTs. I devised this section to learn about the various reasons why some women pursued medical intervention for their infertility, and others did not. The last area dealt with IVF. These questions explored why women pursued this procedure, and their individual experiences with IVF. Although only five of the respondents had gone through IVF, many other women expressed their views on this procedure. Finally, at the end of each interview, I asked all the women to talk to me further about the decisions they had made.

After each interview, I spent a little longer with each informant. I felt that allowing the women to express their feelings toward the interview process was important and to discuss how this experience affected them. Most of the informants expressed their gratitude for being able to talk about an issue that has affected, and continues to affect, their lives. These remarks left me with a great sense of empathy and respect for these women.

Organization and Analysis of Data

As stated earlier, the goal of my investigation was to uncover similarities and differences in the decision-making process surrounding ARTs. To do this, I used an inductive approach in the analysis of the interview data. According to Tesch (1990:

90), "inductive analysis begins with empirical observations and builds theoretical categories, instead of sorting data pieces deductively into preestablished classes."

After each interview, I reflected on the interview process. At this time, I assessed the interview guide and evaluated my performance as an interviewer. I also used this time to reflect on the information uncovered during the interview. Moreover, I reflected on how the informants and I reacted to each other during the interview. I felt that considering this aspect of the research process was essential. As Paterson (1994: 301) states, "reactivity in qualitative research is not viewed as a limitation of the research process; it is an inherent element of the research which must be recorded." For future references, I recorded these reflections in my data journal and then transcribed them onto the verbatim transcripts.

Shortly after I conducted each interview, the informants' responses were transcribed verbatim. I transcribed my own questions, probes and comments, only when they differed from the interview (See Appendix A). I placed the relevant interview question number in the appropriate area of the verbatim transcripts. Each transcript was identified by the informants' name and pseudonym, date of the interview and the underlying cause of the infertile state. Moreover, I identified the appropriate decision outcome regarding assisted reproduction on the verbatim transcripts.

Once I had completed transcribing all of the interviews, I sorted the verbatim transcripts into one of the three preestablished outcome categories. I did this to make the data more manageable, and for comparative reasons. At this point, I listened to the audiotape recordings again to verify the contents of the transcripts, and to relive the emotional intensity of the interviews. I also made brief notes, reflecting on the content of the transcripts, but I did not try to interpret any meaningful conclusions at this stage.

Once this was completed, I read over the transcripts four times. I carefully read the data to identify and interpret emerging themes and differences in the women's responses, in terms of my research question. As Tesch (1990:90) discusses, data analysis "begins with a thorough first reading of the data to get a sense of their scope, and to check for 'recurring regularities,' or for 'emerging themes or patterns.'" I read the data on a case-by-case basis (Becker and Nachtigall, 1994) for themes that emerged in each case. I then read the data to uncover similarities and differences, in terms of the three primary groups I had established.

Once this was completed, I sorted the data into three separate categories - motherhood, infertility and ARTs (IVF). These categories were generated from the content of the interview guide. I intended to address each of these categories, and the common themes that fall under the categories, to fully understand the decision-making process. I used these pre-established categories specifically because I had an inordinate amount of data that fell into three distinct categories. I found this approach allowed me to better manage my data.

Once I created these separate categories, the description of the data within each category began. This stage involved a description of the women's responses to generate explanations of their behaviour. I read the data and placed relevant examples from the women's responses under each of the headings and subheadings that I had created. I continued placing examples under each category until I felt that the category contained all the relevant examples.

In the next stage of the analysis, I used elements of socialist feminist theory to try and understand how various social processes alienate women from their reproductive lives. In other words, I began with the subjective world of women, but I

also 'explained the explanations' of women (Currie, 1988). This stems from the understanding that to a certain extent women's lives, attitudes and behaviors emerge from, and interact with, the wider social context (Gerson, 1985). As Currie (1988: 250) discusses,

> feminist approaches which begin from the experiences of women as a rejection of established theory often perpetuate this process (obscuring the structural roots of women's oppression) by emphasizing women's accounts as self-evident explanations.

Problems with Data Collection/Analysis

Discussing briefly some problems I encountered during the data collection and analysis is important for me. One problem that kept arising during the interview was the issue of including partners in the data collection process. I had a number of women telling me that I should have included their partners in the interview session. When this issue came up, I dealt with it in the most honest and sincere way that I could. I informed the women who raised this concern that I realize infertility is often a couple issue, but that because of time constraints and the goals of my study, including their partners was not feasible. I tried to make it clear that this project is women-centred and is geared toward improving the well-being of women. Nevertheless, I approached this suggestion in a positive light and discussed further the significance this would have on understanding the decision-making process.

Another issue that arose for me was that some informants sometimes considered me an expert on certain issues, such as infertility, adoption, and ARTs. Questioning me about various factors that related to these issues was common for the

informants. When questions and concerns were brought up, I tried to provide as much information as I could, but made it clear that I was not an expert on these issues. More often than not, I suggested various resources such as relevant readings, organizations, and contacts that the informants could access to obtain more information on these topics.

Another problem that I encountered related to my views on ARTs and IVF. The informants were quite interested in my feelings and perceptions toward these techniques. I felt compelled to answer their questions honestly. In most cases, I informed the informants that I was somewhat skeptical about a number of ARTs because of their effects on women. I then went on to reiterate that the purpose of my study was to try to develop safer and more effective ways of allowing women to deal with their infertility. In a few cases, I remained somewhat neutral in my response. I felt that I had to respect the fact that these women were still considering using ARTs, but at that point were unable to use them because of financial constraints. I did not think that imposing my values and beliefs at such a crucial and emotional time was fair. As Cowles (1988: 171) suggests, when dealing with sensitive topics, "the researcher ... should present a generally accepting and sympathetic attitude to the respondent as a person." I also made it clear that I wanted the informants to express freely their experiences and perceptions about ARTs, both positive and negative.

I cannot deny that my views did play a part in this entire process. Although this may potentially be considered a problem with my data collection and analysis, I believe that this is unavoidable in any research endeavour. Nevertheless, to make this study more rigorous, I followed Patterson's (1994: 302) suggestion that

> the researcher must be willing and able to reflect about her values, attitudes, behavior and past experience in order to identify how the researcher's subjectivity has influenced the data collection and interpretation of research data.

I found this an interesting experiment in self-awareness. I managed, for the most part, to be conscious of how my personal beliefs have played a major part in the way in which the data was collected and is presented. In other words, I am aware that my personal beliefs guided me in the questions that I asked during the interviews as well as the examples I used to describe my findings. Although I tried to give equal weight to all of the responses, I know that my biases and subjectivity influenced this stage of the research process.

One of the most important issues for me, which ties into the above discussion, is maintaining the trueness of the women's responses. In other words, I want my analysis to stay close to the data. It is important for me to understand motherhood, infertility and ARTs as they are perceived by the women themselves. Therefore, I need to uncover information so that the informants themselves can identify with what I have found. My intentions are to make this study credible to the women that I have interviewed, and to all women who are experiencing problems conceiving. Sandelowski (1986: 30) states:

> a qualitative study is credible when it presents such faithful descriptions or interpretations of human experience that the people having that experience would immediately recognize it from those descriptions or interpretations as their own.

The final problem relates to my own emotional experiences throughout the interview process. Before conducting the interviews, I had not anticipated the effect these interviews would have on my own emotional well-being. Although I had clearly

thought about the possibility of triggering certain emotions in the informants, and had therefore developed certain provisions to deal with these feelings, I neglected to prepare for my own emotional needs. Often I felt very upset and emotional after an interview. I think that it is essential that researchers take into consideration the importance of developing various strategies to cope with their own emotional and psychological states during data collection. I believe this is even more crucial for students who are undertaking this type of research for the first time, and are often isolated during this experience.

Chapter 5 - The Sample

A total of fifteen women participated in the study. Fourteen of the informants are from Winnipeg, Manitoba, and one is from Vancouver, B.C. The women range in age from twenty-nine to forty-two. The average age of the participants is thirty-four years. Fourteen of the women are married and one is single. The length of marriage ranges from four to seventeen years. Nine of the women are employed full-time outside the home. Three of the women work full-time in the home and two of the women work part-time outside the home. One is a full-time graduate student. All the women in the study are white, and from middle to upper-middle class backgrounds.

Seven of the informants have no children and seven have children living with them. Of the seven women who have children, five have adopted a child, one has a stepchild living with her and her husband, and one woman has two children through IVF. One informant was pregnant at the time of the interview.

Of the fifteen women, six have had some involvement with the WISG. Two of the participants have paid for private counselling to help them in dealing with their infertility. The other women have not received any professional assistance or support concerning infertility. That just under half of my sample have participated in WISG may effect the findings in this study. This group of women have been exposed to information and discussion sessions that may make them more sensitive to various topics and issues surrounding ARTS. A common practice in the WISG support group is to present women with a wide range of information on infertility and ARTs. These women are exposed to information that informs women of both the positive and

harmful effects of these technologies. As well, women participating in support groups meet other women going through similar experiences. Quite often, these women not only share their experiences, they also make suggestions about books and other resources that have assisted them in dealing with infertility. Essentially, the WISG women may be more exposed to a variety of perspectives on infertility and ARTs., and may therefore be more critical and skeptical. However, by including women who have not been exposed to WISG, the study results should reflect a broader view of women's infertility experiences.

All participants have gone through the routine, non-invasive, medical testing to determine the cause of infertility. These procedures include daily recordings of the woman's basal body temperature and a semen analysis for the male partner. Many women have also gone through more invasive testing to decide the cause of the infertility. The most common tests performed included hysterosalpingogram (ten women) and laparoscopy (six women). A hysterosalpingogram (or dye test) permits visualization of the tubes to determine if there is any fallopian tube blockage (Clapp and Swenson, 1992). A laparoscopy is a procedure that "allows direct visualisation of the tubes, ovaries, exterior of the uterus and the surrounding cavities" (Clapp and Swenson, 1992: 504).

The cause of infertility is female factor for six of the women, two have been informed that it is attributed to male factor, and the remaining seven have unexplained infertility. Although all the participants have seen a medical doctor, the type of assistance they have sought varies. Of the fifteen women, five have declined any assisted reproduction; five have had some type of assisted reproduction, but have not pursued IVF; and the remaining five have gone through IVF. Not including IVF, the

types of medical assistance some of these women have received or used include fertility enhancement drugs (eight women), donor insemination (two women), intrauterine insemination (two women), artificial insemination (three women), and zygote intra fallopian transfer (one woman). Three of the participants have also been involved in non-traditional approaches to healing. These women have sought assistance from a herbalist and an acupuncturist.

Although I had initially intended to interview eighteen women, I reduced this number to fifteen. As the interviews progressed, I realized that I was not coming up with new information. I began to feel comfortable with the data that I had gathered by the fifteenth interview and I decided it was time to begin a thorough analysis of my data.

In Table 2, I include some sample characteristics of the women participating in my study. This table details the age of the women as well as the number of children they have and whether these children are adopted or born to the women. Furthermore, for each informant, this table shows whether the informant opted for medical assistance and the type of assistance she received. I also provide the source of infertility, if known.

Table 2

SAMPLE CHARACTERISTICS (n=16)				
Pseudonyms	Ages	Children	Medical Assistance	Diagnosis
Brooke	39	1 stepchild	none	female
Wendy	34	1 adopted	none	unexplained
Leslie	34	1 adopted	none	unexplained
Teresa	31	none	none	female
Heather	41	none	none	unexplained
Angie	31	pregnant	fertility drugs	female
Andrea	32	1 adopted	fertility drugs	unexplained
Kathy	31	none	fertility drugs, DI and IUI	female
Julia	30	none	fertility drugs, DI	male
Rita	33	1 adopted	fertility drugs	unexplained
Nadia	32	none	AI, IVF	male
Lori	42	none	AI, fertility drugs, IUI, IVF, egg donation	unexplained
Diane	39	1 adopted	fertility drugs, IVF	female
Melanie	29	none	AI, fertility drugs, IVF	unexplained
Sheila	34	2 - IVF	IVF	female

Individual Profiles

The purpose of this section is to provide a brief profile of each woman in this study. These profiles highlight the unique situation of each informant, and also her perceptions and concerns toward motherhood, infertility and ARTs. I use pseudonyms for all of the women to protect their identities. Any information that reveals the identity of a participant has been withheld. This information serves as an introduction to the unique experiences and lives of the participants.

No ARTs

Brooke

Brooke is in her late thirties and owns her own business. She has a stepchild who lives at home with her. Brooke and her husband are unable to conceive because of female factor infertility.

During the initial part of the interview, Brooke stated that she was not always sure that she wanted to have children. Her ideas about having children have changed over time. When asked to explain this further, Brooke discusses how at one point in her life she did not have the time for children. Brooke also did not want to have children if she was not married. According to Brooke, a relationship and financial security eventually motivated her to want a child.

When discussing her decisions about dealing with infertility, Brooke expresses a number of different reasons why she has not sought ARTs. Personal habits, finances and the success rates of these techniques have influenced her decision not to seek medical assistance. Brooke feels that she has done all that she is willing to do, and feels content with her decisions.

Wendy

Wendy is in her mid-thirties, and she and her husband have an adopted child. She works full-time in her home and says that she spends most of her time maintaining the household and taking care of their child. Wendy and her husband are unable to conceive because of unexplained infertility.

Because of a troubled childhood, Wendy has not always wanted motherhood. It was not until she met her present husband and had worked through some of her own issues that motherhood became important to her. Wendy also said that being financially secure before having a child was important to her and her husband.

Although Wendy had at one time felt that children were an important part of who she was, and that experiencing pregnancy and childbirth were something she wanted, she has come to the conclusion that she will not have these experiences. Wendy has rejected ARTs because her partner does not want to pursue anything that causes multiple births, and because infertility has consumed them emotionally. Furthermore, Wendy said that while children are important, they are not significant for who she is as a person. Both she and her husband are comfortable with the decisions they have made.

Leslie

Leslie is in her mid-thirties and works full-time at home. She has an adopted child and claims that it is the most eventful experience in her life. Leslie and her husband are unable to conceive because of unexplained infertility.

Leslie has always wanted children and has never considered otherwise. Leslie sees herself as a mother more than anything else, and feels that motherhood is an important part of her identity. When discussing the infertility experience, Leslie expressed how there were times that she felt like less of a woman because she is unable to conceive.

Leslie's decision not to seek ARTs is based on many different factors. Her husband's opposition to ARTs is the most important part of this decision. Furthermore, the adoption of their child, the experimental natures of ARTs and financial constraints all contribute to their final decision.

Although Leslie feels comfortable with her life now, there are times when she still thinks about having children because she would like to experience pregnancy. Leslie is still hopeful that this may happen.

Teresa

Teresa is in her early thirties, works full-time and has no children. Teresa and her husband are unable to conceive because of female factor infertility, her tubes are blocked. Teresa has not been involved with any ARTs.

Teresa was very emotional throughout the interview and made it clear that she is still in the process of resolving the infertility. Teresa feels that she is not at the point yet where she feels valued for who she is and what she does. Teresa feels as if she is not contributing anything to society because she is unable to conceive. Furthermore, she believes that she has disappointed many people, especially her partner's family. It was clear throughout the interview that Teresa blames herself for the infertility and is trying to understand these feelings.

Because Teresa has blocked fallopian tubes, her doctor told her that her only alternative is IVF. She briefly considered adoption, but feels it really is not an option because she wants a genetically related child. This is a big priority for her and plays a

fundamental part in her decision-making. Teresa and her husband are presently saving money to enter an IVF program.

Heather

Heather is in her early forties and has no children. Heather works part-time outside the home. Heather and her husband are unable to conceive because of unexplained infertility.

Heather was not always interested in having children and said that this was because of a troubled childhood. It was not until her early thirties that she claims she felt a natural urge to have a child - that her 'biological clock' was ticking. Many practical considerations such as age, finding a partner, and having friends who were also having children made her want children. She also discussed how, at that point, a child would have filled a void in her life. During the interview, Heather discussed how other people often pressure her to have children. Occasionally, Heather feels abnormal and guilty for not having a child.

Heather has decided against pursuing ARTs. The unknown effects of hormonal treatment and their failure rates contribute to Heather's decision to reject ARTs. She also does not want to be a guinea pig for the medical community. Heather said that being infertile had at one time consumed her life. Heather is now at the point where she feels comfortable with her life and the decisions she has made.

ARTs/ No IVF

Angie

Angie is in her early thirties and works full-time outside the home. At the time of the interview, Angie was pregnant. Angie's doctor told her that she would be unable to conceive because of female factor infertility. Therefore, she took fertility enhancement drugs. The pregnancy occurred a couple of months after she stopped taking the fertility enhancement drugs. Although Angie is now pregnant, she still gets very emotional when talking about the infertility experience. Angie's self-concept and self-esteem were very much affected during this time. Overcoming these feelings is very difficult for Angie.

Angie did not initially seek medical assistance for a fertility problem because she and her husband had only been trying to conceive for a short time. They went to see a fertility specialist for gynaecological reasons and this doctor told them that a fertility problem existed. Unfortunately, this was not even a concern for them at this point.

Once Angie believed a fertility problem existed, she became dependent on the hormone treatment and continued to use it because she thought this was her only solution to conceiving. Eventually the pills took their toll physically and emotionally so Angie decided she needed to take a break. During the time of the break, Angie and her husband conceived. When asked to talk about her feelings, Angie expressed her joy when this happened, but also her anger toward her physician for intervening too quickly. Angie is resentful because of all the emotional pain she has had to endure.

Andrea

Andrea is in her early thirties and has an adopted baby. She has taken a year off her full-time job to take care of the infant. Andrea and her husband are unable to conceive because of unexplained infertility.

Although Andrea has always wanted to have children, she believes it is important to establish a career, to find a partner, and to be financially stable before having children. Andrea and her husband have experienced some ambivalence toward having a child since they have discovered they are infertile. They feel that letting go of the desire to have a child may be their only solution in overcoming infertility.

Andrea has taken fertility enhancement drugs, but has stopped taking them because they affect her physically and emotionally. During the infertility work-up, the doctor suggested several other options such as intra-uterine insemination (IUI) and IVF, but Andrea and her husband feel they have gone as far as they are willing to go.

In discussing the factors that motivated her to discontinue ARTs, Andrea expresses a number of concerns she has with these techniques such as the success rates, the harmful side effects of the drugs and the experimental nature of these procedures. Moreover, Andrea feels that her most important need is to experience parenting and therefore adoption is a solution. Andrea and her husband have recently adopted a child, and now feel comfortable with the choices they have made. They are hoping to have the chance to adopt another child in the future. Andrea feels that if adoption was not an option, then they may have had to pursue ARTs.

Kathy

Kathy is in her early-thirties, single, and works full-time outside of the home. Kathy has just gone through her second IUI. Kathy is unable to conceive because she had a tubal ligation done years ago, and although she has since had a reversal, the tubal plasty reduced her chances.

When Kathy felt more independent, financially secure and emotionally ready, she wanted a child, but came up against many roadblocks. Kathy was hoping to have a reversal, but a physician told her to come back when she was married. Several years after this request, a physician offered to do the procedure. After the procedure, Kathy's physician told her that she now had an 80% chance of conceiving, and then a while later someone else told her that her chances of conceiving were 40%. It was at this point that Kathy decided to pursue medical assistance.

Kathy has gone through five DI attempts and is now going through IUI. Kathy believes ARTs are her only chance for having a child. Kathy feels that she would be discriminated against if she tried to adopt because she is a single woman. If the IUI does not work, Kathy will pursue IVF. The belief that ARTs are her only hope for conceiving a genetically related child drives Kathy to continue using these techniques.

Julia

Julia is in her early-thirties and works full-time outside the home. At the time of the interview, Julia was going through her fifth DI attempt. Julia and her husband are unable to conceive because of male factor infertility.

Julia has always wanted to have children and did not consider otherwise until she realized a problem existed. Julia feels that one factor that motivates her to try to have a family is that all of her friends are having children. Furthermore, she is happily married and can feel the 'biological clock' ticking.

Coming to terms with the fact that she cannot have her husband's child is the hardest thing Julia has had to face in coping with infertility. Julia and her husband have decided to use ARTs because their priorities are to have a genetically related child, and to have Julia experience pregnancy and childbirth. If these techniques do not work, then they will consider adoption.

Julia describes her experiences with ARTs as a roller coaster ride in which she swings back and forth from feeling hopeful, to feeling low and depressed. If the next DI attempt does not work, then Julia and her husband will pursue IUI. Although Julia is not at that stage yet, she believes that the IUI will be her last attempt with ARTs. She and her husband have decided not to pursue IVF because of the financial costs and emotional stress involved with this technique.

Rita

Rita is in her early-thirties and has an adopted baby. Rita works part-time outside the home and is a full-time student. Rita and her husband are unable to conceive because of unexplained infertility.

Rita views motherhood as an important part of her identity and has always seen herself in the role of a mother. Although Rita has an adopted child, she still wants to experience pregnancy and to have a child who is genetically related to her. Rita

believes that these factors make it difficult for her to resolve the infertility. This desire has been key in her decision-making process.

Rita hopes that, if she tries everything available to her, she may get pregnant. She also feels that if she does not try everything, then one day she will regret the choices she has made. Rita is optimistic that ARTs may give her an answer about why she and her husband are unable to conceive.

IVF

Nadia

Nadia is in her early-thirties and works full-time outside the home. Nadia and her husband are unable to conceive because of male factor infertility. Nadia believes that her desire to have a child has become more significant since she has realized a problem exists. Children are also more important to Nadia because her husband really wants them.

Nadia and her husband pursued IVF because they feel it is their best means of having a child. Nadia has gone through one IVF attempt, and conception did occur, but the pregnancy did not go to full-term. Nadia finds it very difficult to talk to anyone about the infertility and her experience with IVF. She thinks that discussing these experiences is hard because "they are not normal."

Nadia has positive feelings toward IVF because she believes it helps women. Still, Nadia believes that the doctors did not properly inform her of the true odds of conceiving through IVF. She feels that the clinic she attended misrepresented the

success rates of having a child through IVF. Although Nadia is now aware of some issues, she has decided to try two more IVF attempts and then she may consider adoption.

Lori

Lori is in her early-forties and works-full time outside the home. Lori and her husband are unable to conceive because of unexplained infertility. Lori has pursued many different procedures including IUI (three cycles), IVF (two attempts) and zygote intra fallopian transfer (two attempts). None of these reproductive techniques resulted in the birth of a child.

Lori has always wanted to have children and has never thought otherwise. Lori feels that having a child is one of her main purposes in life, and it will give her meaning and direction. Lori feels she needs to try everything available to her to have a child. At one time, Lori believed that ARTs would enable her to have a child that is genetically related to her.

In discussing her experiences with ARTs, Lori expresses a great deal of anger because of how the IVF practitioners treated her after the IVF attempts were unsuccessful. Lori is also unimpressed with the lack of information and answers given after the procedure did not work. When asked why she continued to use these techniques even though they were unsuccessful, Lori explains how she was always very hopeful that she could conceive with ARTs. She also felt compelled to try everything available to be able to finally let go.

Lori feels comfortable with the decisions she has made and has now accepted that she will not have a genetically related child. According to Lori, if there was yet another procedure with a reasonable success rate, then she probably would try that as well.

Diane

Diane is in her late-thirties, works full-time outside the home, and has an adopted child. Diane and her partner are unable to conceive because of female factor infertility; her tubes are blocked.

Diane has always wanted children and thinks that is the only reason she got married. Diane believes that the desire to have children stems from a biological urge, and that children are a natural progression in life. Diane has always seen herself in the role of a mother, and views motherhood as a normal part of her existence.

Diane initially pursued ARTs over adoption because she was afraid that she could not bond with a child who wasn't biologically hers. When asked to explain why she continued with ARTs, and more specifically IVF, Diane discussed how the availability of this technique, and her confidence in her physician, played a key part in her decision-making. Diane also feels that she needed to exhaust all of her possibilities to overcome the desire to have a genetically related child. Although Diane has an adopted child, she still sometimes thinks about trying IVF again. Diane would pursue IVF again because she would like to have another child and because she feels that another adoption would be difficult.

Melanie

Melanie is in her late-twenties and owns her own business. Melanie and her husband are unable to conceive because of unexplained infertility.

Melanie has been working through the infertility for several years and has now come to accept that she will not have a genetically related child. Melanie has let go of this desire because it is affecting her entire life. Melanie pursued ARTs as a last hope for a biologically related child. This is a big priority for Melanie and her partner. Melanie is also afraid that if she had not tried everything available to her, then she might have regretted the decisions she has made.

Throughout the discussion of the infertility work-up, Melanie expresses a great deal of resentment and frustration toward her physician and the techniques he prescribed. Melanie feels that doctors are trying out procedures without having any evidence that they are appropriate. Melanie said that the reasons why she continued trying are because of her desperate longing to have a child, as well as the trust she had in her doctor. Melanie and her husband are taking a break from this part of their life. They are now thinking more seriously about adoption. They have not ruled out the possibility, however, of another IVF attempt. At this time, Melanie does not feel as if she has the strength to go through another IVF attempt.

Sheila

Sheila is in her mid-thirties and works full-time outside the home and has two children conceived through IVF. Sheila and her husband were unable to conceive prior to medical intervention because of female factor infertility, her tubes are blocked.

Being a mother has always been an important part of Sheila's definition of self. The thought of not having a child was very devastating to Sheila, and still greatly affects her self-esteem. Sheila sometimes feels worthless because she is unable to have a child without medical assistance. Sheila feels that this part of her identity is very fragile. Sheila pursued IVF because she wanted to experience pregnancy and because she wanted a biologically related child. Both Sheila and her husband feel that exhausting all possibilities to achieve this goal was important for them.

In describing her experiences with IVF, Sheila expresses her devastation and sadness when the first attempt did not work. She also explains the horrendous nature of the procedure. When asked to explain further why she continued, Sheila talks about how her physician encouraged her to continue with the IVF. This, along with the fear of not having a child, compelled Sheila to continue. Overall, Sheila feels quite positive toward IVF. She does think that her feelings would be different if none of the attempts had been successful. Sheila believes that IVF should be available to all women, and that IVF is a cure for women who want to, but cannot, conceive on their own.

Chapter 6: Presentation of the Data

The preceding profiles provide a brief description of the informants regarding motherhood, infertility and ARTs. In this chapter, I describe the data in relation to the central categories of motherhood, infertility and reproductive technologies, and the several components that make up these categories. These themes begin to provide some understanding why women may or may not pursue ARTs in overcoming infertility. I also link these women's experiences to other research on this topic.

Motherhood

In this section, I describe in detail the common themes uncovered on motherhood, as well as the several properties that form these themes. Specifically, this section addresses the reasons the informants gave for wanting children, and how they came to decide about when to have children.

Why Women Want Children

I did not ask the women directly why they want a child. Nevertheless, I could extract a number of common reasons from the women's responses. The reasons the informants gave for wanting children consist of two properties; individual intentions (stemming from lived experiences) and social factors (stemming from the wider social context). Although I deal with these two properties separately, the distinctions between the two are not always clear. Isolating individual intentions from motives shaped by social pressures is difficult because individuals create their choices within a particular

social context. Therefore, I highlight the role society plays in influencing the motives that these women identify as individual intentions.

Individual Intentions

The informants identify a variety of individual intentions for wanting a child. These reasons include: wanting to experience social motherhood and/or biological motherhood, submitting to biological pressures, and wanting to fulfill one's life.

Social Motherhood

For many women in this study, the desire to experience social motherhood is one of the most important reasons for wanting children. These women feel a child will give them the opportunity to enjoy several experiences that they associate with motherhood. These experiences include the opportunity to love and care for a child, the chance to be able to shape another human being, and the potential for developing a special and intimate bond with a child. For example, Heather states 'a child right now would be someone that I have a lot of love to give to, ... I can focus my attention on nurturing and the love that I know I could give a child.' Andrea says 'I think the biggest thing is the opportunity to be parents. I think that is what is most important to us, to develop a special relationship with a child that is your own.' Leslie explains 'A child would be someone to love, someone to love me back for who I am; ... Just someone to spend intimate time with.'

The informants view raising a child as a highly rewarding and desirable experience. The desire to experience this life event drives most women to seek motherhood. Crowe's research (1987) supports this finding. In her study, most of the women she interviewed stated that social motherhood is the most important reason for wanting a child. Most women cherish the affective aspects of motherhood that allows them to develop an intimate bond with another human being.

Biological Motherhood

Most of the women in this study show a strong desire to experience biological motherhood. Biological motherhood refers to all the physical aspects associated with having a child (of one's own). This includes the opportunity to experience pregnancy, childbirth and breastfeeding, and wanting a genetic link.

Throughout the interviews, the informants highlight the significance they attach to these experiences. Many women emphasize their desire to experience the bodily changes associated with pregnancy. Moreover, the informants state the importance of genetic continuity in their desire to have a child. As Teresa said, 'children mean carrying out the line. It is genetic continuity, a part of you is going to be around in the future when you are not.' Rita says:

> Being pregnant was very much a part of it. My body has this incredible capacity to produce life. ... That was very important; the pregnancy and the genetic continuity, or whatever, which is somewhat secondary, but still, I wanted a kid with brown hair and brown eyes like me.

Leslie states

> I would like to experience pregnancy. I love the idea of something growing inside of you. I do not care much for the actual birth process, but it would be nice to have someone that is a part of you growing inside of you.

Other researchers have found that experiencing pregnancy and childbirth, and having a genetic link play a significant part in the desire to have a child (Williams, 1990b; Harris, 1994; Miall, 1994). Although the data does not allow me to quantitatively measure whether social motherhood is a higher priority than biological motherhood, the data does reveal that experiencing biological motherhood is important for almost all of these women. Unlike Crowe's (1987) study, which found that experiencing pregnancy and childbirth were not considered a major factor in the desire for a child, I found that many of these women place a great deal of emphasis on biological motherhood.

We cannot deny the joy and power that women experience during these events. As Rich (1986: 37) states, "To have born a child ... can mean the experiencing of one's own body and emotions in a powerful way." Unfortunately, the value society places on biological motherhood, and the way in which it is defined, is extremely problematic for those women who are unable to conceive. The media, medical and psychological literature, define motherhood as a biological relationship as opposed to a social relationship (Katz Rothman, 1989). Women come to believe that the physical aspects of motherhood are essential in developing an intimate bond with a child. As well, most women consider biological motherhood to be an essential aspect of motherhood and more specifically, womanhood. These beliefs stem from society's patriarchal definition of a 'family' (genetic relatedness), and from a powerful ideology of motherhood. Many women cannot escape the impact of these messages. Rita discusses it this way:

> I guess it has so much to do with being pregnant. I keep going back to that feeling. I know that my body has this capability. I can't let go of that idea - of wanting to bear a child. I wish so much that our adopted child was genetically related to us. If only I could have birthed her. It is just so important to me. I remember we used to put pillows under our shirts and pretend we were pregnant. I just remember that. When friends are pregnant, it is the hardest time for me. I even tell them that I don't want to see them. Especially when they get bigger and they start rubbing their bellies - all those things that pregnant women do. I hate all of it because I am so jealous. I thought that by now I could look at a belly and think it is beautiful, but I can't, I hate it. It is such a beautiful thing, it is the thing that we are all striving for, but all it causes me is pain. It continues to reinforce to me that my body can't do that.

Although pregnancy, childbirth and genetic continuity are significant to some women, they are only a portion of what motherhood means to the women. The ideology of motherhood pushes some women toward wanting biological motherhood. Even more important is the emphasis on biological motherhood as the essence of the parental bond, and of femininity. This, according to some women in this study, limits the choices available to women in pursuing alternative forms of parenting.

It is important to point out that although some women internalize this ideology of motherhood, other women do not adhere to this belief. In this study, a few women did not consider experiencing biological motherhood as a significant factor in their desire to have a child. These women have resisted defining motherhood in terms of genetic relatedness, pregnancy and childbirth. Wendy discusses it in this way:

> I am very peaceful and accepting that a natural childbirth may not be something I will ever experience. ...I didn't ever really mind whether it was a natural childbirth or adoption. When I was young I thought it would be very nice to adopt a child in need. Having a child to me does not mean a genetic child.

Submitting to Biological Pressures

Some informants believe that certain innate physiological factors motivate women to want children. These women refer to the existence of a 'biological clock,' as well as a maternal instinct as playing a part in wanting to have a child. For instance, Heather states that, 'when I was 30 or 32, ... I had this natural urge to have a child. ... The clock was kind of ticking. ... I just feel that, you know, that it is a natural feeling to want to have children.' Leslie provides a similar response: 'naturally there is a kind of inbred desire for the woman to have a child.' According to Julia, 'I could feel the 'biological clock ticking." Diane also feels that a biological drive plays a part in the desire to have a child. In her interview, she states: 'I think when you reach a certain age, you get a biological urge.'

These responses show that the informants have internalized the belief that a biological drive plays a part in the desire to mother. Some women consider motherhood a natural and inevitable process. This finding is not surprising and supports what other researchers have found. In her study, Miall (1994) found that the majority of respondents, both men and women, believe that the desire to mother is innate for women. Besides this, she found that although most individuals believe the desire to mother is innate for women, most of the respondents in her study felt that the desire to father was a learned behaviour (Miall, 1994).

A few women in this study discussed having felt a maternal instinct. This represents, in part, the ideologies that shape our society's thinking on motherhood. The idea that women want children because of biological programming continues to dominate in the medical/scientific literature (Richardson, 1993). Medical scientists, among others, often construct motherhood as a biological given, as part of nature itself

(Thorne and Yalom, 1982). Some women cannot escape this ideology of a maternal instinct. By linking motherhood to biology, these women come to accept that they have little choice over whether to have a child because 'biology is destiny.'

Although some women accept that the desire to mother is biologically driven, others question the origins of this desire. These women actively attempt to make sense of the notion of a maternal instinct. As Rita states:

> Society is not out there. It is my family, the messages I get from my parents, my sister, from my friends, from my school. All those messages were - girls have kids, like biologically. I often wonder where this is coming from. Where has this terrible maternal, ... I could live through this if only I didn't have such a desire. ... I have always thought, if only I didn't have this and I don't know where it comes from. I just think, I can't blame my parents and TV shows, and I am sure it is part of it, but I think that part of it is my body. You know, physically, monthly, it says to me that I have a body that should be able to make a child.

Lori says;

> To me it seems that it is not just training. It is also just naturally wanting to have a child. I guess I find this very hard to comment on because I don't think there are any definitive answers as to how much of wanting a child is a result of being trained, as opposed to it being innate. We just don't know. I just happen to believe it is not all training. I think part of it is, but I have no evidence to suggest that there is an inherent desire to have a child. I just believe there is. I feel as if there is.

The fact that some women in this study question whether the desire to have a child is innate, or imposed by societal expectations shows the tension women experience when trying to make sense of their life experiences. Sheila says:

> Society expects you as a woman to be nurturing, loving and compassionate, and part of that is nurturing a child. You know, it is our responsibility and I don't know if society has done that, or if it is intrinsic. I just don't understand.

Comments such as this can represent the initial stages of resistance and the move toward autonomy. As Alpern (1992: 156) explains,

> Autonomy is possible with the recognition of how socialization works and with some appreciation of alternatives to the values to which we have been socialized. In this way, we can gain critical perspective on our own socialization and values, and so be able, at least to some extent, to accept, reject, and reform the results of that socialization.

Nevertheless, that some women in this study continue to accept that 'biology is destiny' shows how difficult resisting oppressive ideologies is for women. As long as women, believe the desire to mother is largely due to a biological imperative, they are unable to imagine the powerful role society plays in creating this desire.

It is important to point out that although medicine and the media, among other institutions, reinforce the idea that 'biology is destiny,' this occurs only within the confines of marriage. For example, in this study, when Kathy decided she wanted to have a child, her doctor disregarded her because she was single. As she states in her interview, 'I went to see a gynaecologist and he told me to come back when I was married, he would not even look at me.' Kathy's response shows how the socially constructed idea that 'biology is destiny' ensures the continuation of a patriarchal view of the family - the nuclear family. As well, this also restricts women's control over the circumstances in which they can choose motherhood.

Many women in this study have internalized the patriarchal view of the family. For instance, many women in this study continue to accept traditional notions of when and under what circumstances women should have children. Most the women viewed the nuclear family as the right kind of situation for reproduction. The notion of a family is not limited to a mother, a father and their children but includes financial security, a home and all other amenities that contribute to the perfect family.

The decision to have a child is often guided by whether or not these circumstances have been met, which therefore limits some women's choices further.

For those women who are unable to conceive, and have internalized these nostalgic notions of the right circumstances in which to have a child, the inability to do so deeply affects their sense of self. Many women in this study felt cheated and betrayed because they were in the right kind of circumstances for reproduction to occur, but were unable to realize the experience of motherhood.

The Need to Fulfill One's Life

Another commonly identified individual intention for wanting a child is the need to fulfill one's life. Most of the women in this study state that they have always wanted children and consider children an integral part of their lives. As Diane claims, 'a child is life, it is part of the natural progression of one's life.'

Some women believe that having a child will make their lives complete and this experience will give them a sense of personal fulfilment. These women experience a sense of emptiness in their lives when a child is missing. Teresa says:

> I think a child is like another piece of the whole puzzle, and it is a piece of who I am also. I think right now I would see it as a piece of the puzzle that is missing. I think of my career, and all the other things I try to do to make up for that piece, but when you look closely, it is still not there. There are occasions that you just have to let on that things are okay, but the void is still there. It is a hole.

Some of these women continue to believe that despite other personal attainments such as a career and education, their lives are somewhat meaningless without a child. Lori's response highlights this:

> For me, it would be having a purpose in life, or was a purpose in life. It wasn't just good enough to work. There was a need to, I do not know, it is as if it gives meaning and direction in your life.

Although the informants describe this motive as stemming from within, it represents the motherhood mandate. These women may experience a sense of emptiness because they live in a world that often informs women that without a child, they are not fulfilled. As Brooke's reveals, '(my mother) always tells me that I am not going to be fulfilled without a child.' Comments such as this perpetuate the belief that women need to experience motherhood to feel fulfilled. Mandating motherhood for all women denies many women the chance to gain a sense of fulfilment from other interests and activities outside motherhood. Although the motherhood mandate seems quite prevalent among many of these women, a few have resisted and transcended the idea that motherhood is the ultimate fulfilment for women. These women do not define their sense of selves in relation to motherhood. As Wendy says:

> Having a child never involved improving my self-esteem, or anything. I realized that getting my self-esteem from other sources was part of my personality. When I stopped working, it was a major realization that I got a lot of my self-esteem and self-worth from the job that I had. Having a child is not somewhere I get my self-esteem from. ... I have never thought that a child was going to fulfill my life in any way. Even before I adopted my child, I had found a great amount of peace.

Kathy states:

> I am not sure if children are an important part of me personally. You have a self-esteem no matter if children are there. Children are just one part of life, ... it has nothing to do with who you are. You should know who you are before you have children. I don't think having children changes you. It is just the choices you make, the commitments you make, or what you value in life.

Social Factors

The informants identify many reasons for wanting a child that show motives shaped by the wider social context. The social factors I identify fall under three separate headings: the intersection of motherhood and womanhood; children as an essential element in family formation; and the desire to avoid guilt and pressure from others.

Motherhood and Womanhood

A number of women in this study equate womanhood with motherhood. For example, Andrea reveals in her interview,

> I do feel like having a child is a significant part of being a woman. I would say that there is something about having children that is significantly tied to being a woman - a whole woman.

In essence, some of the informants have created an identity for themselves that includes the role of mother. Some informants consider motherhood the quintessential role for a woman to occupy. Melanie states 'I always wanted to have kids, which is what I was raised to do, you know, a career would not be as important.'

Some women seek motherhood to establish womanhood and to gain a sense of meaning in their lives. These women have internalized the culturally formed notion that motherhood is the most significant part of a woman's identity. As Leslie states, 'it is just that I am not a woman if I can't do this. ... I see myself as a mom more than anything. This is kind of who I am.'

Various structures and ideologies throughout society construct the association between motherhood and womanhood. That most of the women in this study equate motherhood with womanhood shows how this society has successfully socialized women to accept the norms of this society - that all women should reproduce and that motherhood is their central role (Whiteford and Gonzales, 1995). Many women are unable to escape pronatalistic attitudes that inform women that motherhood is central to a woman's identity, and her means to achieve adulthood. The negative impact of defining oneself as less of a woman for not having a child is evident in some women in this study. Sheila expresses this in the following way: 'It is very important for me to be a mother. It is a very important role in my psyche. ... The thought of not having a child was very devastating to me. It almost crushed my self-esteem.'

Children as an Essential Element in Family Formation

The desire to create a family is another reason for wanting a child. All the women in this study view a child as an essential element in family formation. As Teresa explains, 'I guess even the definition of a family; mothers and fathers and their children. Even single parents and children, but never just two adults.' Most of the informants believe that a family consists of a mother, a father and at least one child. In all of the interviews, the informants define themselves as in a relationship, as opposed to being in a family. The term "family" only describes a situation in which a child is present. Rita says,

> I always thought of a family as including kids. You see this beautiful family and we just don't have those things, those children. Somehow they just make a

> family. No one is pressuring me into believing that, it is just life. That is how the world is. That is my world view.

These women have internalized the importance of children in establishing a family. The informants perceive that a child is crucial to beginning a family.

Along with believing that children are an essential element of a family, a few women in this study consider children an expected part of marriage. Other research has supported this finding. Harris (1994: 20) found that the women in her study reported "the need to meet marital expectations" as a main reason for wanting to have a child. Most women learn that being a mother is a normal part of a heterosexual relationship. Some informants believe being married and having children are part of a woman's role in life. As Melanie states, 'my priorities were to get married and to have children.' Diane also feels this way, 'since I was a teenager I saw myself as getting married and then having children.'

A few women in this study also believe that children may make a marriage happier. For instance, Heather stated: 'Sometimes I just think a child will make the relationship that much happier.' Currie (1988) uncovered a similar theme in her study. The women in Currie's (1988: 20) study reported that one positive theme of motherhood is that "a baby would enhance a marriage or partnership."

The importance of children in creating a family, and in fulfilling the socially constructed responsibilities of marriage and womanhood indicate the norms of this society. North America remains largely a pronatalistic (and patriarchal) society. Gender socialization places pressure on many women to conform to society's expectation that eventually every woman will one day marry the man of her dreams and will then naturally go on to have a child or children. Socialization reinforces the

circumstances within which procreation is to occur, as well as the specific roles that men and women will eventually fulfill. The equation of heterosexuality, marriage and motherhood maintains the status quo. This ideology reinforces the belief that most individuals live in the nuclear family; that this arrangement is natural; and that motherhood and marriage are a woman's central vocation in life (Thorne and Yalom; 1982).

The Desire to Avoid Pressure and Guilt from Others

Another reason for wanting a child stems from the desire to alleviate guilt and pressures from friends, family members and acquaintances. Many women reveal several occasions during which they feel inadequate, guilty and abnormal for not having a child. This reality is evident in the following responses.

> Melanie: Even now in our community, people think I am a weirdo. I have even been verbally abused. People are always saying things like, 'What is taking you so long, and why don't you have a baby yet? What are you waiting for?' You go to a dance, you go to church, or wherever you go and you get this attitude - 'what is wrong with you.'
>
> Teresa: Well, especially with my husband's family I felt like I was a big let down. He is an only child and I felt pressure, you know; that this was his only chance to reproduce. I was just a big disappointment. I felt like I didn't count anymore.
>
> Heather: We will be out and people always ask me if we have children, they don't ask him. They put me on the spot. It almost makes you feel guilty; like it is you that doesn't have any children, as a woman. If you have a home and you don't have a child in it, society looks at you. We always have to be proving ourselves to people.

These responses exemplify the external social pressures that women feel regarding motherhood. Women report feeling a need to explain their nonconformity to

reproductive norms. Women in this study felt there was a widespread belief that motherhood is a woman's responsibility and duty in life. Those who experienced these judgements by others felt that such remarks affect women's sense of self-worth and well-being. Women come to believe that the only way to be valued and accepted in society is through the role of mother.

I asked the informants directly if they feel that the society we live in plays a part in women's desire to have a child. Over half the women reported that they believe this is true. Most are aware of the external pressures placed on women to want to have children. As Angie discusses in the following response, the pressure for women to want children still exists.

> Angie: I firmly believe that society plays a part in women wanting to have children. I mean even though women are supposed to be so liberated, you still see that girls are the ones being told to nurture and have babies. Women are still pressured to have kids. I think that a lot of women don't realize they are pressured to have kids, but when you can't have them, they think you are less than them.

Several other researchers have found that women report feeling pressured to reproduce (Miall, 1994; Crowe, 1987; Becker and Nachtigall, 1994). It is not surprising that women desire motherhood as a means of alleviating the guilt and pressure that they feel from the social context in which they find themselves.

Although many women in this study reported feeling pressured, a few women said that other people's comments or societal expectations did not affect them. For instance, Wendy says:

> People were always commenting on it [having children], but their comments, for me personally, didn't make me feel pressured. I imagine for another personality, it may have been extreme pressure. For example, I worked with a guy who was always saying 'when are you guys going to have kids,' but I never felt that the pressure bothered me. I don't think that is a very kind thing to do to

> someone. I think how the pressure affects you has a lot to do with who the person is. For some people a lot of comments may make them feel really pressured to have children.

As indicated previously, the reasons why women want children are in part a result of the social context in which these women find themselves. Other interacting reasons, such as personal beliefs, contribute to the desire to have a child. The following discussion reinforces how women's lives and the decisions they make are, in part, context-dependent.

The Decision to Start Trying to Have a Child

All but four of the informants have always wanted children. As Leslie states, 'I have always wanted children. I never considered otherwise.' Lori says, 'It was a foregone conclusion. I wasn't deciding whether or not I was going to have children. I was automatically going to have them.' For these women, it is not a matter of whether to have a child, but when to have a child. The actual pursuit of this experience depends on a number of different factors. The majority of informants consider motherhood something good, and as something they want, but the informants are unwilling to pursue motherhood until they are 'ready.' Several responses describe what being ready means for the informants, most of which indicate the ideology of the nuclear family, as well as these women's conceptualization of the ideal prerequisites needed to pursue parenthood.

Marriage

The informants identify a stable and loving relationship as an ideal prerequisite for having a child. More specifically, for most of the informants, the decision to have a child depends on whether they are married. As Wendy claims,

> The most important thing was that I was in a loving, secure relationship. I don't know how to say this, but I would have never wanted to have a child out of that particular situation.

In fact, some informants pursued marriage to have a child.

> Rita: Sometimes I think, 'is this why I got married, just to have kids?' I think that is maybe a selfish thing, but it is definitely a part of it. I saw him as a means to having a family.
>
> Diane: I have always wanted to have kids. In fact, that is the only reason I got married. I don't think I would have gotten married if I didn't want to have kids.

A few informants consider being married as a means of alleviating the stresses of raising a child, both in terms of financial considerations and time restraints. Some of these women feel that raising a child in a single parent home would be too demanding and strenuous. Wendy states, 'I think, for me, raising a child in a two parent home is difficult enough because there are so many things involved in raising a child that it is not something I would want to do by myself.' Teresa says, 'I always saw myself with another caregiver to those children. I guess I never thought that bringing up children with only one parent was fair. ... Money did not have to be everything, but the support was important.'

The fact that some of these women consider marriage as an ideal prerequisite to motherhood is not surprising. Similar studies support this theme. Both Currie (1988) and Gerson (1985) discovered that the women in their studies identified a

suitable and stable relationship as an important component of being ready to pursue motherhood.

For some women, concrete material restrictions exist to prevent women from being able to choose motherhood outside a heterosexual marriage. Although the existence of employment for some women has increased the potential for alternatives to marriage, many women do not have access to sufficient resources needed to raise a child. For some women, the lack of access to economic resources is compounded because of limited access to or availability of, day care. The ideology of the nuclear family permeates every institution, and reinforces the belief that all women must have a man to support them and that women should dedicate their lives to raising children. Because of these widespread beliefs, many women find themselves restricted in terms of employment options and alternative child care arrangements.

Women's lack of economic independence is not the only force that drives women to want marriage as a prerequisite to having a child. This is evident in the fact that although many women in this study define themselves as financially secure, these women continue to equate motherhood with marriage. This intensely personal motivation partially stems from the internalization of a patriarchal ideology of the family. Motherhood, as defined in this society, compels some women to view this experience as an integral part of a heterosexual relationship (Phoenix et al., 1991). Women learn that reproduction is normal only within the confines of a heterosexual marriage, and it is undesirable under any other circumstances. Although the negative stigma attached to having a child outside a marriage is slowly abating, it is far from being accepted. Religion, the media, the political, economic and legal system, and the medical profession continue to reinforce the belief that reproduction should occur only within the

nuclear family. Hence, any deviation from this prescribed norm represents an anomaly.

The desire to be married before having children is also indicative of the realities of parenthood in a society that assumes most women have partners to support them. Some women in this study may have chosen to postpone having a child primarily for convenience. As Lori says, 'It just makes it a lot simpler if you are married.' As discussed earlier, a few women sought marriage as a means to having a child. We cannot deny that these women are, to a certain extent, engaging in activity that allows them to assert some level of autonomy.

Although marriage and motherhood continue to be normative in this society, some women have resisted the belief that marriage and motherhood are linked. Only one woman in this study was single. Her experiences challenge the belief that the nuclear family is natural and inevitable. Kathy provides concrete evidence of a woman who has resisted oppressive ideologies that inform women under what circumstances they should bear and rear children.

Partner's Willingness

For most women, the decision about whether to have a child partially depends on their partners' preference as well. The decision does not rest solely on the woman's desire. The informants must consider their partners' feelings toward fatherhood. Some women do or do not pursue motherhood based on their partners' preferences at that point. Leslie states,

> I always wanted to have children and I remember that when I brought this up with my husband, he didn't want to. I don't think he never, ever wanted to have kids, but it seemed that way. ... Of course my desire to have kids was very strong, and his was nil, so it was quite a devastating moment when he said he did not want kids. I would have never married him if he did not want kids. ... He just didn't want them right then.

Some women may feel compelled to have a child because their partner wants children. This is evident in Nadia's reasoning for pursuing motherhood: 'It would make me very happy to have a child because my husband and I are so close. I know that he really wants a child. I think that is really important.'

Most women agree that the decision to pursue parenthood is a joint decision, in which both partners must be ready. Ideally, both partners should be in synch when they decide to pursue parenthood. However, given the unequal status of some women in marital relationships, the male's preference may determine the choices available to her. As Leslie says, 'we waited for about 4 years after we were married because it was until my husband was ready. It wasn't really anything else.'

Emotional Stability

The informants refer to being mentally ready as another prerequisite to having a child. Being mentally ready describes a stage in the informants' lives when they feel secure as a person, and when they no longer have any fears of parenting. Angie expresses it this way:

> Everything has just fallen into place, ... my self-esteem is a little better, and I am more secure as a woman. I am also not afraid to be a parent anymore. I used to be afraid because I thought I would screw the kid up or something.

Women's desire to feel mentally ready partially shows the psychological constraints placed on women in this society. Most women cannot escape the constant messages that inform them of what it is to be a good mother. Normative social constructs inform women they must be prepared to follow all the rules and regulations of good parenting. Most information dealing with the science of child development implicitly advises women to devote their lives unselfishly to raising a child (Jagger, 1986). This is evidenced further in popular representations of troubled children. Without a doubt, these representations place the blame on women. These messages reinforce a common belief that troubled individuals are a product of women who did not devote their lives to raising their children (Faludi, 1991).

The significance that the informants placed on being mentally ready reinforces how social processes partially influence the decisions women make. Some women feel inadequate because they cannot conform to the idealized image of good mothering. For instance, many women in this study alluded to not being ready to have a child until they felt they could conform to their own idealized notions of motherhood. These women's narratives on what a good mother entails represent the adherence to socially constructed notions of the ideal mother. For instance, Wendy says, 'It was not that I didn't care for children. It had more to do with who I was as a person and feeling like I wouldn't know how to be a good parent.' Angie states;

> I wasn't keen on having them in my early twenties. ... I realized I had self-esteem issues to work out before I brought a child into this world. ... I wasn't ready and I didn't have the room in my life for them. I would not be able to give them the proper time that they needed. ... I used to be afraid because I thought I would screw the kid up, or something.

Therefore, in deciding about when to have children, many women partially base their decision on their ability to be the perfect mother. These women's ideas of a good mother are based in part on notions constructed by society.

Appropriate Age

Age is another factor that plays a part in deciding when to have a child. Most of the informants do not feel that having a child at a young age is desirable. These women feel that having a child early in life will limit their chances in pursuing their careers and education. Andrea says;

> It was something that I always knew I wanted to have, but not right away. ...I wanted to get my career first. That probably also happened from seeing an older sister who wanted a career but couldn't until her kids were older. ... I saw her struggle with her decisions. So I knew while I was growing up that I wanted a career first, and then family. But I definitely wanted a family.

At the same time, the informants do not want to wait too long before they start trying to have a child. This is because women believe that their chances of conceiving lessen with increased age. Furthermore, some women do not want to be older when having children. Brooke says, "... I kind of thought, well I'm getting older, I better start thinking about this seriously." Rita states;

> Age was definitely a part of that. My sister had her first at 38 and she just seemed so tired and I just didn't want to be old when I had my children, so age was definitely a part of it.

Education and Career

Most of the informants said that completing their education and having established a secure career are ideal prerequisites and practical considerations before

having a child. Most women feel that part of being ready involves having fulfilled these personal goals. They state that this enables them to be emotionally and financially secure before venturing into parenthood. The following responses summarize the women's feeling about being ready to pursue motherhood.

> Lori: We were ready to have children long before we were married, but because of practical considerations, we waited. When I first got married I had just finished my degree and I didn't have a permanent job yet. I wanted to hold off because I thought it would be too difficult to get a job while I was pregnant. I thought it would diminish my chances. Also, when I was first hired it was on a probationary period and I wanted that period to be completed so I would then have a permanent job. It was the practical things. Just needing to have a little more security and then I would be able to take maternity leave, and therefore I couldn't be automatically laid off.
>
> Kathy: I became more independent, more secure. I had a house. I had been working for years. I felt more stable and it was something I wanted to do. It was more practical things. I was back on my feet and I sort of decided what was important in my life ... whether biological or not, I was going to have a family.
>
> Rita: I had worked at my job for six years and I thought I had gotten my career out of the way. ... I had ten years of pursuing my career and travelling, and so I felt ready. I wanted to start right after I got married, so I did.
>
> Andrea: I think financially we felt we were now ready to look at it. I felt that I had the chance to work at my career for a bit. I felt that I had achieved what I wanted to before I started to have a family.

These responses highlight that although most of the women in this study desire careers and an education, motherhood continues to be an important goal for them. Angie says, 'I knew while I was growing up that I wanted a career first, but I definitely wanted a family.' Melanie provides a similar response, '...It was something that I always wanted, more than anything. I always knew I wanted to eventually have a family.' Rita stated:

> I have always thought that I would be a mother. I saw that as part of where my life would go, that it would be a part of my life and it sort of hit me while I was

> thinking about my career and stuff. In the back of my head was, I am going to be a mother. ... I think that I was making it as part of my identity.

As Currie (1987: 244) found in her study, "motherhood remains an important (if not primary) source of identity for women." Most women do not make decisions about whether they are going to have children, but instead consider the practicalities associated with having children (Currie, 1987).

The informants' discussions on careers and education reflect the realities of women's lives in this society. Most women realize that, quite often, the structural arrangements of domestic labour are incompatible with waged labor. A conflict exists between economic independence and mothering in this society. Several women also feel that certain material circumstances must exist before they are ready to pursue motherhood. Therefore, in deciding about when to start having children, most women strategize according to various social processes. For instance, most of the women discussed the right time as when they could manage on their partner's income, when they had employment security and a house. Other research has reached similar conclusions. As Currie (1988: 245) discovered, "Although the questions raised were personal ones, they addressed structural or social processes: the organization of waged employment, the sexual division of child care labor, the privatized costs of reproduction."

Although women feel they are choosing to postpone motherhood until they establish a career, many women have little choice in the matter because of what Rich (1986) calls the institution of motherhood. The women in this study feel as if their decisions stem from within, but the institutional aspects of motherhood influence the decisions they make. As Rich (1986: 42) states, "the institution of motherhood creates

the prescriptions and the conditions in which choices are made and blocked; they are not reality but they have shaped the circumstances of our lives."

In this study, many women controlled their fertility until they felt ready to pursue motherhood. This suggests how women can, to a certain degree, make sense and respond to the institutional nature of motherhood within this society. When women control their fertility until they feel ready, they demonstrate (partially) how women recognize the situation of women in this society and therefore make choices accordingly. We cannot deny that some women have the strength and the power to control some aspects of their lives. These women recognize that women often cannot control the conditions of their lives and therefore work toward creating an alternative situation for themselves.

Infertility

In this section, I discuss the common themes uncovered in relation to infertility. More specifically, this section deals with the process of infertility. I refer to infertility as a process because it consists of various stages. I discuss the various stages experienced by the women in this study; from the initial awareness that a problem exists and how they come to recognize this, to the decisions made in dealing with infertility. Lastly, I discuss why some women decided they would not pursue assisted reproduction. Though the women in this study are at various stages of this process, many common experiences and phases emerge.

Many women in this study attempted to get pregnant on their own, on the assumption that conception would occur quite easily. These women said that they did not consider the possibility of fertility problems when first trying to conceive. In other words, conception is taken-for-granted. As Nadia said, 'you just don't think it won't happen. Everyone has children. I just assumed I would be able to have children.' Similarly, Kathy says, 'I never really had any concerns about not conceiving. I just always thought I would get pregnant. I never thought I would have any problems.'

Suspecting That a Problem Exists

The first stage of the process of infertility begins when the informants come to suspect that a problem in conceiving may exist. During this stage, the women do not yet formally define themselves, or their partners as infertile. A certain level of concern arises in the minds of the women, and often their partners as well. In other words, the women begin to detect on their own that something may be wrong, but are not at the point where they feel a medical diagnosis is necessary. The women try to make sense of the situation on their own by attributing the lack of conception to various reasons, such as stress and the short time they were trying to conceive.

I asked the women to talk about why they became concerned about not conceiving then and not sooner. I wanted to know what finally led them to believe that a problem existed. Often the women started to get concerned after having unprotected sex for some time and conception was not occurring. In the earlier stages of this awareness, many women just assumed that a certain amount of time trying was normal and therefore they did not become anxious. Suspicions around whether or not

a problem may exist also depended on the informants' understanding of how long conception normally takes, or on various circumstances in their lives, and on their past gynaecological experiences. For instance, Wendy said:

> Before my present relationship, I had been married. I had two pregnancies that were both miscarriages. In my mind, there were already difficulties and I knew that having a child may not be an easy process for me. ... So in my second marriage, when we were going to start, I kept thinking, 'what is this going to be like because of my previous problems?'

While Nadia, Heather and Teresa said:

> Nadia: For the first 3 months it was just fun, there was no pressure or anything, we were just trying to get pregnant. And then I guess about the 5th or 6th month we were kind of wondering, looking into things and trying to find out what normal is - when most people get pregnant. I guess around that time we realized that it takes about a year and that we shouldn't be concerned in the first year and so we just kept trying.

> Heather: I started thinking and realizing that we had been pretty risky and nothing had happened. So that was when we started to think about it, thinking, hey, you know, nothing is happening. Yes, when it never happened we started to realize that something might be wrong.

> Teresa: It wasn't something I expected but overall I wasn't overly alarmed because there was a lot of stress factors at the time in our lives. A lot of things were happening that I associated with us not being able to have a child at the time. That first year I thought, 'no big deal, I can understand.' ... But I guess I became concerned about a year after nothing was happening. I guess it was also because my husband was asking me why nothing was happening.

Most of the women in this study became concerned after having tried to get pregnant for a certain period, however, Angie became concerned only after a visit to her doctor. She said:

> I became concerned at this time because Dr. X, whom I went to see about my periods, and nothing else, was kind enough to inform me that, 'by the way, you have a slim chance of ever having children.' I wasn't even expecting this. I wasn't there initially for this information.

Although many women did not initially feel that their concerns warranted further investigation, they did experience a variety of emotions when they first suspected a problem. These emotions included disappointment, shock, devastation and denial. As Andrea says, 'Probably for the first year of trying it was denial. There was this reason and that reason; someone had a cold. It was always something.' While Lori said:

> When I first tried to get pregnant, from the time of ovulation, until the time I got my period, I was just on pins and needles. It was probably the hardest time for me because I really felt that there was at least a 50% chance of getting pregnant. I remembered feeling so disappointed.

Melanie states:

> We started trying that first year and when it wasn't happening we were getting more disappointed, very disappointed to the point where things would annoy me very easily. I would watch a diaper commercial and I would start crying.

These women's emotional responses to the initial awareness that a problem exists are common. Several researchers have looked at how individuals react emotionally when they experience difficulties conceiving (Inhorn, 1994; Woods et al., 1991; and Miall, 1986). The majority of individuals in these studies experience shock, devastation and disappointment.

Some women call this period an emotional roller coaster. This emotional state involves feeling optimistic and hopeful, and then feeling let down because conception has not occurred. As Julia says, 'I think once it was 6 months already, I was on a roller coaster. ... Every month I would be, "Oh am I pregnant, yes I am pregnant, no I am not pregnant." It was this roller coaster ride.' Wood et al. (1991) discovered a similar finding in their study on women's experiences of fertility problems. According to these

researchers (1991: 180), "many women experience cyclic hope and despair corresponding to their menstrual cycle."

Some women experience a sense of self-blame when conception is not occurring. Wendy said she blamed herself for the lack of conception because she hadn't always wanted children. She said, 'I felt like I deserved this because for so long I didn't want to have one. I know there was no logic to my thoughts, but it was a feeling I had.' While Melanie said, 'I kept thinking, what did I do wrong?' Teresa says, 'I kept trying to figure out why it was happening to me? What did I do to deserve this.' Other researchers have found that women blame themselves for fertility problems (Wood et al., 1991; Stanton et al., 1991; Inhorn, 1994). As well, Abbey and Hallman (1995: 282) found that not only did the women in their study attribute more responsibility to themselves, the men also "attributed more responsibility to their spouses than did the women." Self-blame can be attributed, in part, to historical and modern constructs of infertility. As discussed earlier, women have been, and continue to be, faulted for infertility. According to Frank (1990: 56), women blame themselves because "women see reproduction as a more central component of their identity and typically undergo the majority of medical procedures for infertility; they are less able to distance themselves."

A few women were very frustrated with their partners at this time because they felt their husbands were not as concerned about the problem, as they were. Some women felt as if they were dealing with the problem on their own. Heather said 'His direction was that he was focused on school so he kind of left it up to me. He never really pursued it from his end.' The following responses further highlight this finding:

> Wendy: I remember feeling a lot of anticipation and let down. I called it an emotional roller coaster. And for my husband, he was not experiencing the same things because it was not his body that he was watching. I kept hoping that every month there would be a sign of a period so we would know when to try to conceive again. It was impossible for him to empathize because it was something that he had never experienced, nor could he ever experience it.

That some women in this study experienced more stress than their partners at this time can be attributed, in part, to the fact that reproduction centres around women's bodies and because many women internalize a sense of responsibility for childbearing. As Rita said,

> I think maybe it hit my husband a little later. His body doesn't go through the changes which I think is significantly different for men and women ... he didn't grieve every month. It is me that is hyper conscious of the day, ... he never knew what day it was. ... I would sob. I cried a lot, especially at night. It almost became that I was a wreck and he was fine, and I started getting mad and thought, 'where are you in all of this?' I wanted him to go through it also.

Other researchers have found that men and women respond differently to fertility problems (Wright et al., 1991; Stanton et al., 1991; Collings et al., 1992). As in this study, these researchers found that the women experienced more distress than the men. However, one possible reason men may appear less distressed is that men tend to be less vocal about their concerns and emotional pain (Frank, 1990).

Seeking Answers

After trying to conceive on their own, most of the informants began to search for answers to their problem. The most significant indicator for all these women was that after having unprotected sex for a certain length of time, conception did not occur. The

women who had previous problems already had an idea in their mind that conception may not occur easily because of past health issues. Wendy said,

> In my second marriage, when we were going to start, I kept thinking, 'what is this going to be like because of my previous problems?' Already having such an irregular cycle, the possibility for becoming pregnant was already decreased. ... When we decided to start trying and nothing was happening after about 6 months, I felt that it would be difficult to conceive on our own. I was now ready to go and get some assistance from a gynaecologist.

The length of time it took these women to detect that a problem existed varied, but eventually, they all came to the conclusion that something was wrong and they wanted answers. Andrea said, 'I just wanted to know what was wrong.'

The women in this study talked about what they decided to do once they realized a problem existed and why. Initially, some women decided to seek answers by questioning their friends and families and by accessing various resources on infertility. Rita states, 'Well, as each month passed, I got more and more concerned. Then I started asking people how long it took them. I found that it usually took people about 3-4 months, or 1 month.' Julia said:

> I guess about the 5th or 6th month we were kind of wondering, looking into things and trying to find out what normal is - when a lot of people get pregnant. I guess around that time, we realized that it takes about a year, and that we shouldn't be overly concerned in the first year. So we just kept trying.

The most common approach to seeking answers involved questioning a medical doctor about the suspected problem. All the informants eventually went to see a medical doctor to confirm their suspicions. Wendy said, 'Well I guess for me personally at that time, I didn't know all that was available to me, so I went to the gynaecologist.'

I asked the women why they decided to seek assistance from a medical doctor. Most of the women did not have an answer to this question. This is not surprising considering the social context in which these women find themselves. Infertility, in this society, clearly falls within the domain of biomedicine. As Becker and Nachtigall (1994: 508) reveal:

> the growing dominance of biomedicine has resulted in a cultural shift in control over reproduction: from control by women that emphasized health and natural processes to a biomedically controlled process that redefines reproduction in terms of illness and danger.

Along with this, the medicalization of infertility defines the approach women will take in trying to understand the problems they are experiencing. Most women in this study, and most individuals in our culture, view infertility as a disease. So, I was not surprised when the women in this study were unable to explain to me why they decided to seek assistance from a medical doctor. During the entire infertility process, only three women in this study sought assistance from someone other than a medical doctor. These women went to see herbalists and acupuncturists, but only after they became dissatisfied with the answers they were receiving from their medical doctors.

The women in this study played an active role in seeking medical assistance. These women wanted a child, but were unable to have one, and therefore, they actively sought and participated in what they believed was necessary to resolve the problem - a medical answer. This shows that women participate in medicalizing the infertility experience. To that end, we cannot view the women in this study as entirely passive in this process. Reissman (1983: 16) states that, "women have played and may continue to play a major role in stabilizing medicine in American society."

The Infertility Work-Up: 'Diagnosing' and 'Treating' Infertility

Once the informants visit a medical doctor to confirm their suspicions, the next stage of the process of infertility begins. For most of informants, depending on the diagnosis and type of medical intervention they were willing to pursue, this stage lasted anywhere from 2 months to 12 years. The infertility work-up refers to the various activities involved in the medical management of infertility (Harris, 1994).

For all the women in this study, the initial visit to a medical doctor led to one of two scenarios. In the first scenario, the physician agreed with the informant and she or he referred the client to undergo fertility testing. In the second scenario, the physician told the client that there is nothing to worry about, and that she and her husband should just keep trying. In both cases, the doctor begins to take control of the situation. The doctor is critical in determining whether to pursue the matter further, and what choices are available to each woman.

Most of the women in this study expressed a great deal of resentment and anger for having little control over the choices available to them. For instance, some women said they were angry with their doctors for not investigating further the difficulties they were experiencing. For many women in this study, feeling a "loss of control" over their bodies and decision-making begins at this point and lasts throughout this stage. The women begin to feel alienated from the decisions made about their fertility problems. Leslie says, 'we got the standard line that we were still young and it could still happen. She said they could really do nothing for us. I was very angry with her.' What Leslie had hoped for at this point was for her doctor to acknowledge her concerns by investigating the problem. Melanie said:

> I went to see a specialist right away and this doctor looked at me and laughed. He gave me the old line, 'you are young.' Actually, that was something they all told me and it really started to annoy me after a while. He kept saying, 'you are young, don't worry, go home and try to have babies.'

Kathy also experienced a loss of control when she wanted some answers. At one point, a doctor denied Kathy medical assistance because she was single: 'I went to see a gynaecologist and he told me to come back when I was married. He would not even look at me. I didn't know where to go, or what to do then.'

Angie feels that her physician intervened too quickly. As Angie reveals in her response, the physician generally controls the situation.

> He said, 'well, since you are here, we might as well do the tests.' ... I did ask him why he didn't check me, and he said, 'yeah, yeah, yeah, we will look into that too, but since you are here, why don't we save some time? Rather than you going home and trying for a year without me intervening, why don't I just intervene now? It will save you a year.'

These women also experience a loss of control over their bodies because they cannot control the infertility. Many women said they resented their bodies for not being able to have a child. Rita said, 'I just felt so betrayed by my body. I just assumed that my body would do that (get pregnant), that it would just work. I felt pissed off and of course I blamed myself even though we have unexplained infertility.'

Not only were the informants dependent on their physicians' decisions, they also had to rely on their partners' willingness to pursue the matter further. When attempting to 'diagnose' a fertility problem, the male partner is usually the first person checked (Clapp and Swenson, 1992). In other words, the male partner must agree to participate in the tests that are necessary to eliminate, or confirm male factor infertility. Some informants said they experienced some difficulties with this. The following responses highlight this:

> Leslie: When we got to the doctor's office, my husband froze and right then and there decided he couldn't go through with it, so we left. I was devastated. I couldn't understand why we hadn't discussed this before.
>
> Teresa: The subject came up that my husband should be tested. ... it took me a couple of months to convince him.
>
> Andrea: I was angry at my husband because he was reluctant to go to his doctor to get checked out.
>
> Kathy: When I was married, I couldn't get treatment because my husband wouldn't provide a sperm sample. He figured it was stupid and I should get treatment if I want it. It just wasn't something he was willing to do, even though I thought it would be nice to have children.

By refusing to participate in potentially solving the cause of infertility, these men not only increase the uncertainty experienced by their wives, they also perpetuate the notion that women's bodies are the locus of disease (Inhorn, 1994). However, these men may have been resistant to pursue the matter because of the fear that the diagnosis may uncover male factor infertility. A diagnosis such as this would inevitably affect these men's egos and would possibly lead to feelings of inadequacy and shame. Miall (1986: 273) found that "respondents felt that male infertility is viewed more negatively than female infertility and considered male infertility more discrediting to masculinity than female infertility to femininity." Just as women cannot escape the socialization process, neither can men

We can attribute the powerlessness and helplessness experienced by these women to many sources. As stated earlier, the medicalization of infertility has increased medical authority over this issue. If a physician does not believe a problem exists, or denies a woman treatment, then women become powerless when attempting to resolve the uncertainty surrounding their fertility problems. Further, medical practices thwart a woman's ability to exercise control over the situation because

physicians not only decide which women are eligible for a procedure, but they also control when treatment can be sought. The following responses highlight these findings:

> Rita: I was really frustrated with my doctor. I remember crying and crying because I had to revolve my life around her. I thought, 'couldn't you refer me to another doctor, why is it always around your schedule?' It was just so ridiculous.

> Kathy: I have heard stories about Dr. X, that you have an appointment to see if you get treatment or not. You know I think, 'wow, does he ever just turn people away because he doesn't like them, or whatever.' I have heard stories that he sits you down and asks you questions, and if he doesn't think you are appropriate, then you are denied treatment. I have also heard that he asks you questions about your job, your home, if you have a mortgage, how much money you make, and all I can think is, is that appropriate?

Feelings of powerlessness are further exacerbated when women have to negotiate with their partners' for further testing.

Another source of powerlessness is the desire to have a child of their own. To obtain this goal, women feel compelled to pursue all diagnostic and treatment options available to them. To have a child of one's own, women must depend on what they have been told as the only answer - a medical cure. These factors show that many women lose control over the process of infertility because others hold the power to define their problem and how they can resolve the infertility.

Diagnostic Tests

When everyone acknowledges that a problem exists, and is willing to pursue the matter further, the infertility work-up begins. In the initial stages of the infertility work-up, the women undergo various non-invasive and invasive tests to diagnose the cause

of infertility. The physicians' understanding of what the problem may be determines the type of tests performed.

Non-Invasive Procedures

For the majority of women in this study, the infertility work-up began with the physicians recommending that the woman take her basal body temperature and have or time intercourse accordingly. Most physicians suggest this procedure to learn the time of ovulation, and to find out whether ovulation has occurred (Clapp and Swenson, 1992). (This procedure is also used with various ARTs).

I asked the women to talk about their experiences with this procedure. According to the women in this study, this procedure is inconvenient, humiliating and interferes with the spontaneity of sexual activity. Although medical doctors call this technique a non-invasive procedure, it has a significant impact on some of these women's lives. The following accounts illustrate women's experiences related to taking one's basal body temperature.

> Wendy: We did take our temperature to try to know when I was ovulating and it didn't last very long because it was like sex on demand and the intimacy wasn't not there. It was extremely inconvenient.
>
> Leslie: We tried the basal thermometer. We did this for about 4 months. It was awful, just awful. I think my husband thought it was a big joke. And then you have the doctor telling you to stand up on your head, or lift your hips up after you have sex. My husband thought it was a joke because his wife would do just about anything to get pregnant.
>
> Julia: I was taking my temperature every bloody morning for a long time. I had been doing this for about a year. ... it makes you totally aware of your body. You are also supposed to record when you have sex. It is like, talk about having pressure. We stopped doing that. I guess they just want to make sure

you are following the rules, but we know whether or not we are following the rules.

Diane: They get you to take your temperature and it was horrible. It takes all the spontaneity out of your sex life, and you are very tense, and you become very focused on getting pregnant.

Invasive Procedures

If a physician is unable to identify the cause of infertility with a non-invasive procedure, or if the problem is not male factor, then doctors suggest more invasive techniques. Although physicians give women and their partners the choice to pursue these procedures, most women consider these procedures reasonable for the sake of having a child. As Teresa said:

Everything is going through your head, like your priorities, how society values motherhood. I guess if you were confident with who you are, or the way you are it wouldn't matter. It is part of the process of going through this. Learning who you are and accepting that you are valued for who and what you are.

Most of the women in this study had a laparoscopy and/or hysterosalpingogram (dye test). These procedures are invasive and often very painful. Several similar responses describe the informants' experiences with these procedures.

Brooke: They did a dye test. It is hell. The doctor told me it would feel like a contraction. After that, I thought, well hell, if this is what it is like to have a baby, then forget it.

Angie: This was the most humiliating experience. I had an x-ray on my tubes to make sure they weren't blocked. ... I can never forgive him for what he did. I went into the operating room ... and halfway through the procedure, the device they had inserted popped out. I was in a lot of pain and after the whole procedure was over, they left me by myself. I had no ideas what the hell was going on. This pain lasted for 3 days.

One woman said that it was at this point that she began to consider letting go of the desire to have a child. Teresa said:

> I think probably just after one of my surgeries I started to consider not having children. You go through, ... well you can't take away the physical pain, but you just start wondering if anything is worth this much pain. It is like, 'how much more can you take?' And I guess because there are no guarantees. I think if there was a guarantee, ... like if you are pregnant, the birth hurts but you know the out come is a baby, but the surgery is exploratory, invasive and you don't know what the end of it is.

Although Teresa questioned herself after she underwent the surgery, all of these women (except for when the diagnosis was male factor) felt they had to participate in medical testing because of their desire to have a child.

The Diagnosis

Once the informants undergo all the tests available to determine the cause of infertility, the doctor attempts to make a medical diagnosis. As stated earlier, in this study, two women were told that the cause of the infertility was male factor, six women found out it was attributed to female factor, and the remaining seven had unexplained infertility. The diagnosis plays an important part in the infertility process. Not only does a medical diagnosis lead these women to label themselves as infertile, this also sets in motion the course of action the women can take to resolve the problem. The medicalization of infertility has led most women (couples) to turn to medical interventions to solve their problems (Becker and Nachtigall, 1994; Whiteford and Gonzalez, 1995).

The women experience similar emotional responses to the medical diagnosis as when they first suspected that a problem existed. Again, most of the women said they were shocked, devastated and depressed. A few women said they even felt suicidal. Angie said, 'I remember when I was unable to conceive, I was almost suicidal.' However, some women experience a sense of relief and then hope when diagnosed. Rita said, 'I went to see if I was ovulating and they said I wasn't. I was excited that something came up. I know it sounds stupid, but it was a good thing to have because it is easy to fix.' Similarly, Melanie states:

> When I went to the doctor and they found something, I was crying from happiness because it was finally something. I mean they told me I was sick and here I was crying from happiness because I thought 'Oh good, now I know what the problem is and I can get all better. I know that is bad but your emotions are just going crazy.

Teresa said:

> Well my doctor came to talk to me and apologized that he had found what he hadn't hoped for and told me that he understood that I was very disappointed; that he felt it was one of the saddest cases he had ever seen. But, he basically told me that there was nothing more they could do for me. I was just oblivious at the time. And there really isn't much you can do because you are in pain and the physical pain isn't nearly as bad as the emotional pain. I was really lost, isolated, depressed. I never felt suicidal but I had a very low self-esteem. I felt like I had gone through all of the surgeries for nothing. ...The doctor told me at that time that my only alternative, well medically speaking, was IVF.

Not only did some women in this study have to deal with the diagnosis, they also had to contend with being told about the diagnosis in an inappropriate manner. The following responses highlight this:

> Teresa: Well, there were a lot of bad feelings about the way they told me. I was beside a woman who had just had a baby, and I thought, 'can they not put me somewhere else?' And then, my nurse was pregnant, really pregnant, her stomach kept bumping into me. It was really bad. I thought it was so insensitive. It was just a constant reminder. ... I guess also the hospital wasn't really prepared to deal with this. ... They told me that maybe I could see a

> chaplain, and I thought, 'I am not dying here.' I just wanted to talk to someone. And when I was leaving they said to me, 'don't worry, you will be fine.'
>
> Julia: It turned out that our doctor turned out to be a total asshole. He had no bedside manners. He left a message on our answering machine ... He said, 'it is a ghost town in there. You have no hope.' On our answering machine, bad news. Oh this guy was just awful, and actually, his secretary called to tell my husband that he needed to come in a couple of days before the appointment to watch a video before his vasectomy. They had scheduled him for a vasectomy, which is like, 'why would he get a vasectomy when he doesn't even produce any sperm?'

Although all the women experienced emotional distress when first diagnosed, the type of infertility factor did affect the informants differently. The women whose male partners were infertile did not identify themselves as infertile. As well, these two women said that it would have been more difficult for them if the cause of infertility was female factor. Julia states:

> I don't know if it would be the same if it was female factor. I am not sure. I know that my husband has gone through a lot. ... I don't know if I could have gone through what he has. I think I might feel sort of damaged. I think the cause of the infertility would make a difference.

In other words, the two women in this study whose husbands are infertile may have been less personally stigmatized by the diagnosis. Miall (1994) uncovered a similar finding in her study. "Infertile women felt more personally stigmatized than women married to physically infertile men" (Miall, 1994: 397).

Melanie and Rita's doctors told them initially that the cause of the infertility was possibly female factor, and then further in the process said it was unexplained. Melanie found this very frustrating and she became distrustful of her doctor. She said, 'I used to put a lot of trust into my doctor and what he said, but now I don't because they did things like say I had something when I didn't.'

The uncertainty of what causes infertility increases the stress associated with fertility problems. According to Connoly et al. (1992: 460), "the continuing uncertainty of unexplained infertility places a greater stress upon both partners and their relationship than does a definite diagnosis." In this study, unexplained infertility seems to have a unique impact on some women. Rita said, "my doctor would say, 'you have sperm, you have an egg, there is no reason why they shouldn't get together, we don't know why.' It was even more unknown, which is even more frustrating." These women said they would feel less frustrated and disappointed if they knew the cause of infertility because working toward a resolution would be easier. Moreover, if a physician cannot make a diagnosis, then they have to rely on empirical therapy (Becker and Nachtigall, 1994). This means that physicians cannot suggest a specific medical pathway and infertile couples may have to subject themselves to a variety of treatment options not suitable to their condition. Some argue that unexplained infertility is very frustrating for infertile women because it prevents them from accepting that they cannot conceive, and therefore, these women cannot move on with their lives (Whiteford and Gonzalez, 1995).

A few women continue to blame themselves although the diagnosis is unexplained. Heather said, 'they tested my husband and he had a low sperm count but not enough to hinder conception. So he wasn't the factor, I was. It was me more than it was him.' As Inhorn (1994: 460) states, women may take on the responsibility for infertility because "women are often the subjects of stigmatization and social ostracism - whether or not it is they who are the infertile ones.' Teresa supports this finding:

> My husband never blames me, but I know that it is me. But I have heard that even when it is the males problem, the woman takes the responsibility. This is

> what makes me think it really is a society thing. It is like you were made to do this. This is why you are born with these body parts.

Despite the cause, many women "take on an identity of self as infertile" (Woods et al., 1991: 182). For those women who took on an identity as infertile, their lives become almost entirely enmeshed in this identity. Many women begin to judge their sense of self in relation to their infertility and this dilemma becomes the central focus of their lives. At this point, many women lose control over their sense of self as a human being and view themselves as the infertile person, a 'faulty reproductive vessel.' Rita said, 'I feel like I am some defect.' Melanie said, 'It got to the point where it was running our lives.' Andrea states:

> It was affecting my work and everything. I could not focus on my work because I was too busy focusing on my infertility. I completely focused on my infertility. Every morning I would get up and check my basal body temperature, check my mucus, you know, my life just revolved around the infertility. ... It definitely was taking over our lives, at least my life. I was angry about everything, just life in general. My coping mechanisms were down the tube. It was affecting every area of my life.

Diane said:

> It was totally affecting my life, my work. If I started my period at work, I would run out and go to the bathroom and cry and just be really depressed for the rest of the day.

Rita states:

> I got depressed at work. ... I found I had no energy. Sometimes I would just sit all afternoon. I didn't want to talk. ... I just felt so, like it was affecting my whole self-concept. It seemed to be so tied with my ability. If I can't produce, then it was affecting everything.

Several researchers have addressed the impact of infertility on women's identities (Miall, 1994; Whiteford and Gonzalez, 1995). Most of these studies conclude that infertility has a great impact on a woman's identity because of the stigma attached

to infertility. In a pronatalist society, infertility represents a failure to fulfill the norms of this society. Women have been socialized to accept the norms of a pronatalist society, which informs them of the significance of motherhood for the adult female role. Therefore, women's identities are more likely to become spoiled when they are unable to fulfill this role. As Miall (1994) concluded in her study, the inability to reproduce strikes at the very essence of a woman's identity. This was evident in some of the women's responses in this study. These women called themselves failures, and they felt inadequate, devalued, abnormal and incomplete.

The impact of identifying themselves as infertile not only affected their sense of self, but it also changed their relationship with their partners, friends and family members. For instance, a few of the women in this study said at one point they even suggested that their husbands leave them, or look for someone else to have a child. These women did not feel worthy of being in a relationship if they were unable to have a child. Their entire sense of self revolved around their ability to conceive. Teresa said:

> You just (self-)doubt yourself. ... I remember saying to my husband, 'well you are still young and maybe you should find someone else, go and have these children.' I told him even if we are still married he can go and have children. I said all of these things that I know I couldn't deal with but I just said them. He thought I was nuts. He kept saying, 'what are you talking about?" He said it didn't matter to him if we could, or we couldn't. It took me a long time to believe that. Every now and then I still don't believe it.

Other research has supported this finding. According to Crowe (1987), the women in her study felt so guilty about not being able to conceive that they went as far as asking their husbands to divorce them.

Many women in this study isolated themselves from their friends and family members during this time because they were angry with the comments these individuals would make, as well as the lack of understanding they were receiving about this issue. Angie says:

> I felt that women who could have children were looking at me and patronizing me, and feeling sorry for me, and that was not what I wanted. I wanted other women to treat me like how I would treat them. I was very surprised by the way women behaved towards me, and I was very disappointed because here we are, this group that is supposed to be joined together and calling ourselves a sisterhood.

Teresa said,

> My parents were not very supportive at all. It was as if it didn't happen. And my in-laws were very, ... well they tried to be supportive, but they were like, 'move on with it.'

While Melanie says,

> A lot of people didn't understand. They would say the wrong things to me and that was what triggered a lot of really bad feelings, but I worked it out. You just have to deal with it.

Comments such as these increase the stress associated with infertility. Although not all of these women's social support had a negative impact during this time, many people's attitudes toward infertility did. Miall (1994: 411) found, "the support functions provided by interpersonal relations may exacerbate rather than alleviate the distress associated with involuntary childlessness."

Support systems may negatively affect infertile women because many individuals have internalized the myths and stereotypes associated with infertility. For instance, as Miall (1994: 405) found in her study, "27% of the respondents suggested adoption and 19% suggested relaxation as a cure for infertility." Certain individuals

also told some women in this study that if they 'just relax' conception would occur. A few women were also told that adoption is a cure for infertility. Rita said:

> I think that still part of it is because I am too uptight about all of this. I still think to myself that the day I finally let it go, I will get pregnant. It is a myth. I read just adopt and after we adopted, just a month after when I got my period I was crying. I thought, 'I believed that myth.' I just thought that once we adopted, my body would change. A lot of people say that once you adopt you relax enough and you will get pregnant. You just feel it is your own stress. ... They tell you about the stress, and it puts it on me again. So I tried to take time off work. I did yoga. I was blaming myself for all of this.

These attitudes and perceptions reinforce the belief that infertility is a matter of psychological malfunctioning (Miall, 1994). These myths continue to place the blame on the woman for infertility. This can have an effect on any individual experiencing fertility problems. Teresa said:

> I think there is no choice. There is no understanding as to why people can't have children. People just assume that this is a magical instinct and how could you fight this thing that is supposed to happen. But it doesn't just happen. I think that society just can't distinguish between the choices women make about reproducing or not, that we are more than one group. I think that society expects me to be able to do something about it.

Deciding What to Do

Once a doctor makes a diagnosis, the women in this study are then at a point where they must decide what options they are willing to pursue to have a child. Most women are presented with three options after a doctor makes a diagnosis; they can pursue medical/technological assistance to reproduce, adopt, or choose to remain child-free. For all except one woman, remaining child-free was not initially an option they were willing to entertain.

Deciding Against Medical Intervention

Although the desire to have a child was strong for all the women in this study, four women (Brooke, Heather, Leslie and Wendy) reached the point where they chose not to pursue medical intervention to achieve pregnancy. These women made it clear that they were not willing to purse medical intervention to achieve pregnancy. However, this decision took time and was based on various reasons. I asked these women to talk about the various reasons why they decided against ARTs.

Both Brooke and Wendy said that having a child was important to them, but because they did not feel children were a significant part of their identity, they eventually felt comfortable with letting go of the desire to have a child of their own. These women also said that they were not willing to subject themselves to more emotional upheaval to obtain this goal. Brooke said,

> I am not that desperate. I am comfortable enough. I am confident enough with myself as a person. As much as I would like to have a child, I am not going to beat my head against a wall and kill myself over it. I think the women that do this must have some sort of emptiness. They must lack fulfilment.

Wendy says,

> I think for me personally, who I am as a person was not affected by whether or not I had children. And when I hear people say, 'I have got to have a child. I have got to.' I feel like saying to them, 'No, you have to have food, you have to have water, you do not have to have a child. It is a very big desire, it is certainly not a need. The only thing that I can think about is that my value as a person was not wrapped around whether I reproduced, or had a child in my life. I now can't imagine my life without my daughter, but before we adopted her, I could imagine myself having a contented and happy life without a child. It was also taking its toll emotionally. I didn't want to keep guessing if I would get pregnant. It was already a 3 year process.

While Heather said:

> Having a child was a big part of my life at one time, but the obsessiveness to have a child wasn't there. The strong desire to want children was there, but I wouldn't go to any length to have a child. I think the reason why some women

> go to any length to have a child is because of society. I think a lot of it is family pressure and the individual wanting a child. I think some people feel that if they don't have this child and if they don't try everything available to them, then they will be frowned on. People always said to me, 'Have you gone to an infertility clinic? Have you done everything you can that there is to do?' I got that all the time.

Other reasons given for not pursuing ARTs included: fear of the various risks associated with these techniques; poor success rates; and the intrusive nature of these procedures. For example:

> Leslie: My husband and I talked about this quite a bit and we both decided that we didn't want to go any further. He didn't want them poking and prodding my body and neither did I. I felt I had to honour what my husband wanted and that is why we never continued with medical assistance. I told my husband that I also didn't want to go that route either. I didn't want all that stuff being done to my body. ... Well, I also didn't want to feel like a guinea pig; all those tests and drugs. We didn't know what our baby would look like and the basal thing was bad enough. Also, it is a privacy issue. This is very important to me and the basal thing was bad enough.

> Heather: I decided that if we couldn't have children, then I would have to learn to accept it, or maybe focus on adoption. I decided I was not going to put my body through that. ... I came to the conclusion that what was meant to be, was meant to be. I was not going to tamper with my body and use hormonal treatment and go through the agony that a lot of these women I had met, had gone through. Also, the success rates for pregnancy were just not there. Put it this way, taking the risk of all the treatment was not outweighing the risk of putting my body through all of that. I just thought, 'I am not putting my body through all of this, knowing that I maybe have a 20% chance of success, if that.' And I find that people in the medical community want to use women as guinea pigs. They just want us to be guinea pigs and I don't want to be a part of that. ...I did a lot of reading on my own and I think the hormonal treatments are not the be all and end all for conception. You really are not aware of the long-term effects of taking hormonal treatments, like putting stress on your ovaries each month to produce a number of eggs. No one really knows what the repercussions are. They just don't have enough studies and I wasn't going to be a guinea pig. So I decided I wasn't going to go ahead and do it.

Both Wendy and Brooke said that having a genetically-related child was not a priority. These women felt that the most important goal for them was to be able to

nurture a child and therefore they could consider alternatives to assisted reproduction, such as adoption. Brooke said 'To me, loving a child is just that, it doesn't have to be your own blood.' Wendy said 'I didn't ever really mind whether it was a natural childbirth or an adoption. When I was young, I thought it would be very nice to adopt a child in need. Having a child to me does not mean a genetically-related child.' However, all four women said that a biological child would be preferable.

Teresa has not yet pursued ARTs because of financial reasons. Both she and her husband are in the process of saving money to enter an IVF program (Teresa's decisions will be discussed further in the following section). Finances also played a part in Brooke's, Leslie's and Heather's decision. These women said they could not afford the costs associated with IVF. (Note: Manitoba Health does not cover any costs associated with infertility treatment, including drugs such as Clomid).

The various reasons for not pursuing medical intervention provided by these women show how women try to make sense of their lives and the options available to them. The four women who rejected medical intervention spent several years working through the infertility experience and came to the decision about ARTs by struggling with their personal desires and beliefs, societal demands and practical considerations. They did not feel that they were willing to go to any length to have a child. Although Brooke, Heather, Leslie, Wendy wanted a child and sometimes felt pressure to do so, they balanced this desire with the physical, emotional, and financial costs of continuing with medical intervention. This process occurred over time and involved a re-evaluation of priorities and desires. These women said they reached the point were they felt it was necessary to begin to refocus their energy on other aspects of their lives, such as nurturing an adopted child or focusing on their career. To that end, for

these women, the perceived risks and associated costs were greater than the desire to continue with medical intervention. Heather, Brooke and Leslie were also quite skeptical of the medical profession and ARTs. Evidently, these views were strong enough to decide against pursuing ARTs. In addition to this, Leslie and Wendy adopted a child early in process of trying to resolve their fertility problems. For these women, being a mother through adoption allowed them to resolve their desire to have a child. As Leslie said, 'I think my adopted child has fulfilled our desire. So we have left it at that. I have been blessed with the chance to nurture a child, and I think that has helped me a lot.'

What was evident in Brooke's, Wendy's, Leslie's and Heather's lives was that the process of infertility involves various stages which women go through. Throughout this process, women are faced with various decisions and dilemmas and each woman must go through what she deems necessary to let go of the desire to have a child of her own. The issue of infertility remains in their lives. This problem does not go away. However, women eventually reach a point where they feel they must reorder priorities and focus on new goals. Women also reach a point where they become comfortable with the decisions they have made thus far. Brooke, Wendy, Leslie and Heather (and their partners) came to the conclusion that they had enough, and were not willing to pursue the matter further. Engaging in medical intervention to achieve pregnancy was not a necessary part of resolving infertility.

Although Brooke, Wendy, Leslie and Heather reached some sort of resolution about their fertility problems without engaging in ARTs, eleven did not. The following section discusses the experiences of those women who pursued ARTs.

Assisted Reproductive Technologies

As discussed earlier, since the advent of ARTs, many infertile women now have the option to choose ARTs to have a child. These technologies hold out the promise of pregnancy, childbirth and genetic parenthood by overcoming infertility (Stanworth, 1987). If a woman has access to adequate resources, she can exhaust a variety of ARTs before choosing a childfree living or adoption.

This section addresses the decision-making process surrounding ARTs. I discuss the various reasons women gave for accepting, or rejecting various medical options. I also discuss how some women reached the point of letting go of the pursuit of pregnancy through medical intervention after having pursued ARTs. As with the women who did not pursue ARTs, these women worked through their decisions by balancing personal desires, societal demands and psychological and financial constraints. However, unlike the four women discussed earlier, these eleven women said that engaging in medical intervention was a necessary part of resolving their infertility.

This section shows how the existence of ARTs has increased the pressures to pursue various medical options when women are faced with fertility problems, and how ARTs inevitably prolong overcoming the desire to have a child of one's own. Although the women who decided to purse ARTs were deciding within the same social context as those who did not, differences did emerge in their reasoning for seeking medical interventions to achieve pregnancy. Because the women in this study differed on how far they were willing to go with medical intervention, I separate the women according to the type of intervention in which they engaged. Although hormonal therapy is an

invasive medical intervention in the lives of these women, I separate this group of women from those who pursued more invasive procedures, such as DI, IUI and IVF. I intend to show that women who experience fertility problems are not a homogenous group, and that variations do exist in terms of the types of medical intervention women are willing to pursue.

The Decision to Pursue Medical Intervention

Eleven women decided to continue with medical intervention to achieve pregnancy (at the time of the study, Teresa had not yet started using ARTs). Usually, both the woman and her physician initiated the pursuit of medical intervention. The physician was usually the person to suggest the options available and then the woman and her husband were left to decide whether she was willing to pursue the procedure. Sometimes, the informants themselves requested specific procedures from their doctors. Most often these women had heard about various technologies through friends or the media. The type of medical intervention offered or requested varied, and depended on the specific condition of the woman and/or her husband.

I asked all of the women to talk about the reasons why they decided to pursue ARTs and what their experiences of these techniques were like. The reason these women initially sought medical intervention was because of a strong desire to have a child. In addition, these women were optimistic that medical intervention would enable them to achieve pregnancy. Recommendations made by their physicians were other reasons for pursuing a specific medical pathway. The very existence and availability of

these techniques was of course another reason. These reasons will be further elaborated and discussed in the following section.

Hormonal Therapy

Angie, Andrea and Rita accepted hormonal therapy as a possible solution to their problem. Rita's doctor recommended the therapy and although her husband was against it, she felt that she had to try Clomid. She said:

> Right from the beginning my husband said, 'If it happens, it happens, and if it doesn't, then it wasn't meant to happen.' He is not one to take a lot of drugs and he didn't know why we would want to do this. But I thought, hell, if it works, then the pregnancy was more important to me. So we were like guinea pigs, but I guess I thought if it works, then it is worth it for a child.

Angie also took Clomid because her physician recommended it to her. She said that although she didn't initially think she had a problem, once the doctor labelled her as infertile, she was willing to pursue hormonal therapy. As discussed earlier, Angie had gone to see the doctor about a gynaecologic problem and he then told her that she had a fertility problem. The doctor said to her, 'I will put you on Clomid, and that should help your periods to become regular and it should also help you conceive.' Andrea's doctor also recommended Clomid to help her and her husband in conceiving.

These three women took the drug for less than a year and all had very negative experiences:

> Angie: The pills totally affected my moods. They were making me weepy and depressed, and I was moody. I kept crying, which is unlike me.
>
> Andrea: Oh it was awful. It just sent me off the deep end. Things were emotional. I was bizarre. I would be absolutely bizarre for a 10 day period and then just snap out of it. I would come home from work and just cry all night. ...

> And every month we would think, well, we should give it our best shot. So I didn't even tell the doctor that I was having these funny reactions, just in case he wanted to take me off.
>
> Rita: It was awful. I felt very bitchy. After the 3rd month of being on Clomid, we were having such scheduled sex that it was depressing. I finally quit. I just thought, 'this is sick.' We just started to think, 'why are we doing this?' Because it costs $55.00 every month and to me, that is a lot of money to invest. Then my doctor wasn't checking me at all, so I went to see my old doctor and she felt my ovaries and found that they were quite swollen and so we did an ultrasound and they found out I had a cyst from the Clomid. I was so mad at my doctor.

These women's accounts of their experiences with Clomid were negative, however, they all continued using this method for some time. Rita even considered trying it again. Andrea continued with the Clomid, and did not tell her doctor about her discomfort because she was worried he would stop treatment. Angie did go through a second round of hormonal therapy. She went back because she believed this was her only chance of having a child. She said;

> Once you realize that you have a fertility problem, these pills become like a life raft and if they are taken away from you, it is as if you are going to let yourself drown and you are never going to get what you want. ...We continued seeking medical assistance because I still wanted to have kids. I wasn't about to give up. I was willing to keep trying.

These responses show how these women became dependent on Clomid for some time. This dependency created a situation where women were willing to put up with some suffering to have a child. However, Angie, Andrea and Rita eventually decided it was time to stop. Many reasons played a part in women's decision to stop medical intervention. Both Angie and Andrea said they had to stop because the drug had affected them both emotionally and physically. Angie may have continued with assisted reproduction but she conceived a month after she stopped taking the pills. By contrast, Andrea felt that the Clomid was as far as she was willing to go with assisted

reproduction. As with the women who rejected ARTs, Andrea was hesitant to continue because of the risks associated with various techniques, as well as the success rates. She said:

> I had done quite a bit of reading myself, so I knew that even going any further with assisted technology wasn't going to increase our chances because our infertility was unexplained. If you know what you are trying to overcome, that is one thing, but if you don't even know what the problem is, well then you don't know what you are targeting. Unexplained infertility isn't a good indicator of what our success would be. ...Our doctor did suggest IUI. I asked what the chances would be with that and it wasn't high numbers. And around that time some studies came out on Perganol, how it increased your chances of ovarian cancer. So, we were thinking about this, and then we were also thinking about the chances of conceiving through these techniques. We realized how minimal they were, like a 3-5% chance. That still left us with a 95% failure rate. We were thinking that I would be injecting my body with things that are very strong chemicals, the results of which are not yet conclusive. ... We eventually became comfortable with not pursuing this any further. We decided that going further with assisted reproduction wasn't the choice that we would make.

Andrea also had a terrible experience when her physician was examining her. She said:

> My doctor was very inappropriate. He didn't have me gown. He just had me pull my pants down and get on the examining table, and then he said, 'Oh, I love my job. I get to see women with flat stomachs. I would hate to have to see women with big stomachs.' But I couldn't say anything because I was going under the knife in two weeks and he was also our only hope at the time. But after the laparoscopy, he told us that it was unexplained and basically he couldn't get us out the door fast enough because we wouldn't look good in his stats, that is the feeling we got.

Not only does Andrea's response show the harassment she had to endure, it reveals how powerless she was in this relationship. Andrea was afraid to say anything because she believed her doctor controlled her ability to have a child. This lack of power and control over her life eventually led to her decision to discontinue medical intervention. According to Andrea, one of the most significant factors in deciding not to

pursue more invasive procedures was that she wanted to regain control of her life. In other words, Andrea no longer wanted infertility to consume her life. She reached the point where she felt it was time to refocus her attention on other aspects of her life that were not all-consuming. To obtain this control, Andrea struggled with her goal of having a child and how she could achieve this goal without allowing it to be the focus of her life. The all-consuming nature of the infertility had emotionally depleted her and her husband. Andrea also feared a further loss of control over her decisions surrounding infertility. She said:

> I was going to say that one big reason I ended up making this decision was I went to this conference and they were talking about resolving infertility. One woman said that the one thing she had wished was that she had remained in control of her own body. She had let the doctors take control of her body. They had ceased to decide for themselves and they did everything the doctors had told them in order to have a baby. It was at that point that we started to think, 'Okay, this is still my body." What are we doing to my body to have this child and are we prepared to do that?' That really struck me and made me think over just how far we were willing to go. What kind of risks were we willing to take? What was important to us - to have a biological child or just to have a child? So, that is when we decided to go for adoption.

The reasons provided by these women for not continuing with more invasive medical interventions are similar to those who rejected ARTs. Emotional and physical exhaustion, fear of the risks associated with various procedures and the success rates all contributed to the decision to stop pursuing medical intervention. For Andrea, the desire to regain control of her life was also a significant reason for ceasing medical intervention. Again, as with the other four women, these women eventually reached a point where they had done all they were willing to do to achieve pregnancy. As Andrea said, 'we eventually became comfortable with not pursuing this any further. We decided that going further with assisted reproduction wasn't the choice we would

make.' However, Andrea did eventually adopt a child, and she did say that had this option not been available, her experience may have been different. Although these reasons appear to prevent some women from pursuing reproductive technologies, this of course is not always the case.

Donor Insemination, Intrauterine Insemination and IVF

In this study, seven women continued with more invasive procedures such as DI, IUI and IVF. Of these women, two had not yet used IVF. Only one woman pursued IVF immediately because her doctor told her she had blocked fallopian tubes and this was her only medical option. The remaining women first tried less invasive procedures and because these attempts were not successful, they ultimately chose to use IVF. Lori summarizes a common feeling among these women, 'we considered all options but we felt we would try our last chance, IVF, later. We thought we would first try the least expensive, and least disruptive.'

These women gave a number of reasons why they pursued assisted reproduction to have a child. Most of these women used ARTs because they felt they had to try everything available to them to have a child. Lori states,

> We always thought that if we try enough things, things that work for other people, we just thought we would do anything to make this work. I remember specifically telling my husband very early that if this doesn't work, it is not okay.

Diane said,

> I thought it (IVF) was something I needed to do. ... By then I figured I had tried everything, so I thought I would try this and then if it works great, and if not, at least I had tried everything and I thought by then I would be more psychologically ready to deal with the failure.

Melanie explains her feelings,

> At that time, I was reaching. I was reaching for anything. I mean if they had given me anything, I probably would have taken it. That is how stupid I was, just because I wanted to have a baby. You have to go through everything to get where I am right now. I know people that are not here, where I am, and I can see them and it makes my heart wrench that they have to go through all that, but they have to do it. You have to go through all that. It doesn't go away, you have to feel like you have done everything possible to have a child.

As Melanie's response shows, the women themselves acknowledge how far they will go to have a child. The existence of these techniques creates a need for and dependency on medical intervention to achieve pregnancy. These women said that they were willing to try everything available to have a child.

The need for infertile women (couples) to exhaust all possibilities has been well documented by other researchers (Beck-Gernsheim, 1989; Alpern 1992). We can attribute this relentless pursuit to a variety of reasons. For instance, Beck-Gernsheim (1989) argues that women exhaust all possibilities because if they stop trying, they will be considered failures. While Ilhorn (1994) attributes this pursuit to society's construction of motherhood as women's most important role. Becker and Nachtigall (1994:510) provide another explanation, "undertaking medical treatment for infertility is viewed as a socially responsible behaviour by women who wish to conceive." The very existence and availability of medical interventions to achieve pregnancy also plays a significant part in the decision-making process. As Lasker and Borg (1987) discuss, the existence of promising new alternatives offered by infertility specialists make it harder for infertile couples to say no to these procedures.

Some women in this study also felt that if they don't try everything available to them, they will one day regret their decision. A few women mentioned fear of regret as a reason for seeking assisted reproduction:

> Rita: The idea that maybe I will regret, that maybe one day I will say, 'if only we had done that.' Which is why I have done everything else. I am glad I have done all of this. I hear about people who don't do everything and I think, no we tried because it is something that is very important. It is something we really want.
>
> Melanie: You know what it was? It was that I wanted to use up all of my options. Like when I reached a certain age, say 35, or something, and I don't have children, then I could say to myself, 'you know we tried everything and it didn't happen and that is the way it is.' That is what would bug me. I would be afraid to think that damn, maybe I should have tried that idea. This is why I did what I did. .. You have to feel like you have done everything possible that there is to have a child.

Becker and Nachtigall (1994) addressed the role that fear of regret plays in the decision to persist with medical treatment. They conclude that "the prevention of regret through persistence is central to decisions to use medical technology, suggesting that individuals want to prevent negative feelings later that may result from a wrong choice" (Becker and Nachtigall, 1994):

Reproductive technologies not only compel some women to seek these techniques to have a child, they inevitably prolong the process of overcoming infertility. ARTs will often prevent these women from seeking alternatives to medical intervention. Reproductive technologies also prevent some women from accepting that they cannot conceive and therefore, these women cannot move on with their lives. Both Julia and Rita said that one reason they were willing to continue with ARTs was because this would possibly provide the answer to why conception had not occurred. As Julia said, 'the more I thought about it, the more I realized this was the route I wanted to take; that I at least wanted to try it (DI and IUI) to find out if I was fertile.' Unfortunately, using reproductive technologies does not necessarily mean that doctors will discover a

fertility factor. As happened to a few women in this study. These interventions did not provide any answers about the cause of the infertility.

Although not all of the women in this study pursued ARTs, we cannot deny the pressure some women feel to keep trying a variety of treatment options. Diane said she felt that she would have been more psychologically ready to deal with the failure only after she had exhausted all of her possibilities. She, like many other women, was constantly faced with new hopes and possibilities, and a variety of treatment options. Women themselves view the decision not to pursue all treatment options as representing a lack of commitment and dedication to having a child. For instance, Sheila discusses her view on some infertile couples she met:

> We joined the infertility support group. I thought it was just useless, there was a bunch of bitter and twisted people there that weren't doing anything about their problem. We went there for support because infertility was not something we were ready to accept then, but I think a lot of people there were also not ready to accept it, but they were also not ready to do anything about it yet. I think you should either just exhaust all you avenues, or accept it.

The medical community has strongly reinforced the push to try everything available. Throughout this study, women reported that doctors told them that if they were truly committed to having a child, they should be prepared to try what was necessary. In some cases, such as Sheila, this meant going to another country to try IVF. She says,

> We went to see Dr. X and he went over our options. He said one option was a tubal plasty, the others were adoption, or not having children. He then looked at us and said, 'well, obviously these are not options for you, or else you wouldn't be sitting here.' This was totally true, we wanted to exhaust everything. Then he talked to us about IVF. ...So he talked to us about that, he explained to us that there are clinics throughout the world, that there is a long waiting list in Canada and the U.S, he then said we could go to England and get there in a month. He also said that if we are serious about having a child, we would go to the best place.

Clearly, some women in this study internalized the belief that ARTs were their last hope for a child. These women also placed a great deal of trust in their doctors' recommendations. Kathy said:

> I want to try everything. If the hyperstimulation doesn't work then the only other thing I can try is IVF. ... I hope that something will work. Part of the reason why I have chosen medical treatment over other things is that in some ways, I feel it is the only way.

Diane believes that her doctor played an important part in her decision-making. She said:

> My doctor suggested it to me, he said I was the perfect candidate for it. I continued with medical assistance because I trusted my doctor and he suggested it and he was the one that was doing it. It had a lot to do with him, a lot, and also my trust in him.

Sheila said that the need to exhaust all possibilities, her belief in the efficacy of this procedure and her trust in her doctor all contributed to her decision. She said,

> It (IVF) was the end of the line. I really believed that we were going to succeed with it. ... I just naturally assumed that we were going to get pregnant. We sat down with the physician and she said to us 'if you do three attempts, you will get pregnant.' She told us that we had a 30% chance of getting pregnant. That doesn't mean you will get pregnant the first attempt, but if you do 3 attempts, you probably will have a child. I am an eternal optimist so I believed I was going to get pregnant the first time. ... Well, and I also wanted a child and this was the only way I was going to get a child. I wasn't prepared to pack it in, and even as uncomfortable as it was to have that procedure done, the anxiety of not having a child was greater than packing it in.

The above responses show two prevalent themes - the strength of a doctor's recommendation, and the realities of misleading medical practices. Sheila's physician was suggesting a 30% success rate, and that Sheila would simply have to make three attempts to have a child. The trust that some women feel toward their doctors makes it difficult for them to view their physicians' suggestions skeptically. Melanie also feels

that the suggestions made by her physician influenced the choices she made. She says, 'I used to put a lot of trust into my doctor and what he said...they told me to do the IVF and I trusted them with that because they told me that we were prime candidates. I really put a lot of hope in the IVF.' Other studies support the strength of a physician's recommendation, or advice in influencing the decision-making process. Lasker and Borg (1987: 17) found that

> almost everyone we surveyed who attempted conception through AIH or AID cited a doctor's recommendation as the reason. The choice of IVF was explained as "our last hope," "our only chance," a message that is so strongly reinforced by the medical community.

Other responses in this study reinforce the impact of misleading information. For instance, after attempting seven cycles of DI, Kathy decided to pursue IUI. When she went to question her physician, he informed her of the chances of conceiving. Evidently, Kathy believed her chances were much higher than they told her. She said;

> I went back to see my doctor, and he said, 'now instead of a 7% chance, you will have a 14% chance of conceiving with IUI.' I didn't even know that the statistics were 7% and 14%, I was still sticking to my understanding that I had a 40% chance of conceiving. When I found this out, I was really upset.

Teresa has not yet entered an IVF program but is prepared to do so once she is financially ready. Of interest was her description of the success rates of IVF and her general optimism. She says,

> I am hoping to go this year, but I am not sure if we are financially ready. I do want to go before I am 33 because they say between the ages of 30 and 35 you have a 47% chance of conceiving, and the actual take home baby rate is about 12%. I think there is a lot of potential there. I think as a technology it was devised specifically for people with blocked tubes. I think it is quite a medical break through.

Teresa's reference to a 47% success rates shows how misled some women are when it comes to ARTs.

Nadia feels as if the doctors did not adequately inform her about certain aspects of IVF, including the side effects and success rates. She said:

> I think IVF is good, but I think that they should warn people that there are often-times that there will be problems. Even if you do conceive, it doesn't mean that the baby will be healthy. I don't think I knew enough about that side of IVF. Like they have a chart that says how many births they have and how many deaths they have, and when I think about this, I remember thinking that it was an even number.

According to Melanie, she underwent a variety of therapies even though the doctors were unsure of her condition. She says, 'we took the antibiotics, the hormones, and we took a lot of fertility drugs. We did AI because they didn't know what was wrong with us, they didn't know, they were just playing. They were just doing trial by elimination.' Rita also engaged in unnecessary treatment that ultimately damaged her health. She said:

> My doctor wasn't checking me at all, and I was having this pain. So I went to see my old doctor and she felt my ovaries and said they were quite swollen. So we did an ultrasound and they found out I had a cyst from the Clomid. I was so mad at my doctor. And then I saw another doctor, and he told me that I was ovulating and that he couldn't understand why I was on Clomid.

Misleading or inadequate information concerning ARTs has been well documented by various researchers; as has the experimental nature of various techniques (Corea, 1985; Klein, 1985; Lasker and Borg, 1987; Steinberg, 1990). Nevertheless, some women know the risks and chances of success, but continue to persist in treatment. As some women in this study said, the desire to have a child outweighed the risks associated with the procedures. Several other researchers have found that women feel that the possibility of having a child through ARTs is worth

the physical, emotional and financial risks (Frank, 1990; Harris, 1994). As Becker and Nachtigall (1994: 511) found, "women's perceptions of risks in infertility treatment are strongly affected by the goal of parenthood." Many women describe themselves as guinea pigs. This reference to being a guinea pig shows how some women acknowledge the experimental nature of their treatment, but feel it is worth it for a child. Denny (1994: 72) uncovered a similar finding in her research. She said "some of the women in this research described themselves as guinea pigs and recognised the experimental nature of IVF, but felt their participation to be a risk worth taking." That some women are willing to suffer physical and emotional risks for the sake of having children suggests how powerful the desire to produce a 'child of one's own' can be, and to fulfill the cultural norm of motherhood.

The most striking difference between those women who decided against ARTs, or more invasive ARTs and those who did seek invasive procedures was the desire to have a genetically-related child. Having a genetically-related child also meant that these women could possibly experience pregnancy and childbirth, which was a big priority in these women's lives. Sheila said:

> I wanted the life experience of having a child. The pregnancy itself was almost seductive. So, I wanted to experience that and I wanted to nurse a child and I wanted to have that intense bond. ... Having a child that was biologically mine was a priority. Actually, ... my sister-in-law had met a girl that was pregnant and she wanted to give her child up for adoption. The girl said she would give the child to us because she got to know our family, so we actually had an offer but we decided to not take the child. We decided we wanted to try everything to have a biological child. And that was very important to my husband also - to have a child of our own.

Lori said:

> I really think it has something to do with wanting to have a child that is genetically ours. We still really believed that there was a good chance that we

> would be able to have a genetically related child. So we just thought it would be better for us to go ahead with IVF.

While Julia says:

> I wanted to be pregnant and have a child naturally, one that I could breastfeed and all that mother stuff. And the more I thought about it, the more I realized this was the route I wanted to take. At least I wanted to try it and find out if I was infertile and then, if it didn't work then we could look into adoption. ... I guess it is sort of a hierarchy of things. Experiencing pregnancy and the baby being genetically partly ours, that is highest up there and beyond that is raising it from birth.

As discussed throughout this study, experiencing pregnancy and childbirth and having genetic continuity are significant priorities in the lives of some of these women. This finding has surfaced throughout this study.

As discussed earlier, the alternative options to ARTs, are adoption or remaining childfree. Women's perceptions and feeling toward adoption play a significant role in the decision-making process. I spoke to all of the women about their feelings and perceptions about adoption. Although most of the women did not feel negatively about adoption, they considered this option as a last resort. The most common reasons given for not wanting to pursue adoption were that many women wanted to experience pregnancy and childbirth and to have genetic continuity. As well, many women hoped that having 'a child of their own' was still a possibility. As Julia said,

> Well, we went to see Dr. X and he recommended that we put our names on an adoption list right away because it can take so long. This rubbed us the wrong way. We were both still hopeful of at least having a baby that is genetically mine and having me go through pregnancy and childbearing. That was a big part of it. We hadn't decided yet what route we were going to take, but we didn't want to go the adoption route yet, we weren't ready for that yet.

Lori states,

> Adoption went through our minds but we thought , no, I am getting close to 40 and most of the women who are placed with adopted children are younger. ... We still really believed that there was a good chance that we would be able to have a genetically related child. I really think it has something to do with wanting to have a child that is genetically ours.

Melanie said:

> We have not yet thought about adoption because at this point, we have tried everything that might give us our own child. ... I mean my own biological child. It is the most important thing to me, but as time has gone by, adopting a baby may be okay. You know though, you always have to consider your partner also. It isn't just you, and my husband wasn't ready for adoption at the beginning. ... Having a child that is biologically mine is very important to me. Of course it is. I think that every couple would want to have their own. It is just something that bonds you together.

Some women were skeptical about adopting because of the nature of the adoption process. For a few women, waiting lists for adoptive children, the fear of having the child taken away from them if the birth mother changed her mind, and the lack of knowledge about the prenatal environment, made them question adoption.

Andrea said,

> Both of our doctors suggested adoption, but at the time, it wasn't something we considered as an option. We had just heard so much about it. We were worried about not being able to control the prenatal environment. That was our main concern and also that the birth mother has up to 7 months to reclaim the child. That would have been too hard for us to deal with.

Heather states,

> I guess adoption scares me. The laws on private adoption really scare me because if you go through it, the mother can take the child back within six months. The laws have really made me hesitant. I don't have any objections to the birth mother being involved, but I couldn't handle it being taken away from me. I am also scared about not knowing anything about the prenatal environment, like cigarette smoke, alcohol, drug taking, or not having proper nutrition. ... And well, if I could have my own biological child, as opposed to adopting, well then I would definitely opt for a biological child.

These women's feelings and concerns regarding adoption are real and cannot be ignored. What is significant about these comments is the importance placed on genetic ties, experiencing biological motherhood, the certainty about gestational environment, and the certainty about retention of the child. If some women view these factors as important, adoption will not present itself as a suitable option. For instance, Rita has adopted a child, but she still wants to have a 'child of her own':

> It just always nags at me. I think that I am getting stronger but I went to a shower not too long ago and I came home and I cried. I thought, 'I am still not over this.' I even saw a counsellor after we adopted our child and she said to me, 'it sounds like you are not done, you are not finished with this.' ... Something is just nagging at me, but at the same time I am feeling guilty because I now have adopted. It really gets confusing. ... I guess it has so much to do with being pregnant. I keep going back to that feeling. I know that my body has this capability. I can't let go of that idea, of wanting to birth a child. I guess I wish our child was genetically related to us. If only I could have birthed my child. It is just so important to me.

Other research has found that women want to experience biological motherhood even after having become adoptive mothers. Williams (1990b) conducted a study on women who had pursued ARTs after having adopted a child. Similar to this study, the women in her study said they wanted to pursue the matter further to experience pregnancy and childbirth and because they wanted another child, which is often difficult with adoption. As Andrea said,

> There is such a poor ratio of adoptees to adoptive parents. There just aren't any easy answers. It used to be the chosen child and now it is the chosen parent. You sit in line waiting, hoping. We have put our names in for another adoption, even though we are at the bottom of the list, but we may want another child again. Infertility may also become an issue again, or we may spontaneously conceive because we have unexplained infertility, or we may have to reconsider our options. ... Just in talking about the adoption, if there hadn't been the option of adoption, then perhaps we may have gone with reproductive technologies.

Although adoption was an option of last resort for many women in this study, for a few, adoption satisfied their desire for a child. When both Wendy and Leslie became adoptive parents, they chose not to pursue assisted reproduction. Having an adoptive child was not the only reason these women did not seek medical intervention to have a child, but it was a very important reason in the decision-making process. As Leslie said, 'I think that our child fulfilled our desire, so we left it that. I have been blessed with the chance to nurture a child and I think that has helped me a lot.' Some researchers argue that this reflects a difference in women as to "whether their desire is to bear" a child or rear a child (Daniels, 1994: 10).

Because of the small number of women participating in this study, their views on adoption may not represent the population. However, in a study conducted by Frank (1990), the participants (n=147) rated adoption as their fourth treatment preference, which was preceded by medical regimens, artificial insemination and surgical procedures. In another study (Daniels, 1994), the couples did not pursue adoption because they wanted to explore options that would give them the opportunity to be pregnant and to experience childbirth. As well, one-fifth of the participants identified the biological-genetic linkage as an important reason for not pursuing adoption. Lasker and Borg (1987) also asked their study participants why they wouldn't choose adoption over medical intervention. Their findings led to the conclusion that "the social norm is not only to be a parent; it is to be a biological parent. We are urged to create new life, to perpetuate the species" (Lasker and Borg, 1987:14). Although these reasons play a significant part in the decision-making process, the adoption system itself also prevents individuals from pursuing this option. As discussed earlier, the women in this study said adoption was risky and quite difficult in many cases. Nevertheless, as

shown earlier, ARTs are described in a similar manner but many women continue to pursue these alternatives.

To summarize, the belief that ARTs can produce a miracle baby suggests how some women internalize the messages given by the medical community. When a physician explains to a woman that her last hope for that much wanted child is through assisted reproduction, she is faced with a new pressure and dilemma. This suggestion, coupled with messages in the media of miracle babies being born, and her own desire to achieve pregnancy, creates a very complex situation for the infertile woman. The messages she receives from a pronatalist society further exacerbate her dilemma. Besides this, the success rates, the experimental nature, and both long and short-term effects of these procedures are sometimes not well known. As well, adoption, which is the other option available to women, is not necessarily considered a suitable alternative for many women. For women, the decision to adopt a child means that they will have to resolve the issue of not having a child of their own, and will also have to deal with the possible risks associated with this process. For instance, a woman/couple may be denied the opportunity to adopt because they do not satisfy adoption criteria. As well, if a woman does adopt, she runs the risk of having the child taken away from her if the birth mother changes her mind. What these factors indicate, is that the two options available to women are risky, unsafe and often a last resort, but women have very little choice but to seek either option if they want to have a child. The above discussion shows how a number of interacting reasons play a part in the decision to pursue medical intervention to achieve pregnancy. Although it is impossible to quantify the reasons why these women pursued ARTs, as compared with those who did not, some interesting findings did emerge. For the women who

used ARTs, the desire to have a genetically-related child played a significant part in the decision-making process. Women viewed ARTs as their only means for achieving this goal, and therefore they felt compelled to pursue this avenue. Women were also more likely to view adoption as an option of last resort. As discussed earlier, these women wanted to try anything that would potentially give them a child of their own, whereas those who did not use ARTs stressed that social motherhood was their most important priority. The women who sought ARTs did not consider adoption initially because biological motherhood was a priority.

Many women who used ARTs were also more likely to consider motherhood as an essential part of their identity. As discussed earlier, Andrea, Rita, Lori, Diane, Melanie and Sheila said this in their interviews. Although Leslie also said this, and didn't pursue ARTs, she admitted that if her husband wasn't against ARTs, she may have pursued this option. In the interviews with the women who pursued ARTs, the theme of not feeling satisfied or fulfilled without a child was more prevalent, than with those who had not tried ARTs. For instance, Diane says, 'you just feel hopeless, you feel like you are never going to be happy, you will never be fulfilled.' These women were also more inclined to say that they had always considered children as a part of their life plans.

The women who used ARTs also said that they felt the need to exhaust all possibilities before they could move on with their lives. Unlike the women who did not pursue ARTs, these women felt unable to resolve the infertility until they had used ARTs. As Teresa said, 'I won't be able to move towards a resolution. I will always think that this (IVF) is the last step of the line for me. Even if they design something after IVF, I will probably try that too.'

Another interesting finding was that the women who were willing to try more invasive procedures were more likely to feel that the desire to have a child outweighed the risks associated with these procedures. The women who did use ARTs were also initially less skeptical of medical practices. These women had a stronger belief in the efficacy of these procedures and said that they believed using ARTs would likely result in a child. It was clear from the interviews that the women who did not pursue ARTs were quite skeptical of these procedures and their associated risks. Without prompting any of these women, they all referred to the experimental nature of these techniques and to studies that have addressed the long-term effects of such procedures.

The Experience of ARTs

It is impossible to capture the emotional intensity experienced by these women as they worked through their experience of infertility and all the decisions they faced. As well, it is difficult to discuss in great detail how much time these women committed to going through medical interventions and the impact it had on all aspects of their lives.

I asked all of the women to discuss their experiences with ARTs. These women experience similar emotional responses to infertility treatment as they did when they were first going through the infertility work-up. Julia discusses her experience with DI.

> I am now on my fifth DI attempt. It is almost like the same emotional experience as that first time when we were first trying. It is a roller coaster ride. I don't think a day goes by where I don't consciously or subconsciously think of where I am in my cycle because every morning I am seeing it on paper.

While Melanie said, 'You feel frustrated, but you feel hopeful that it is going to happen this time. Then you feel it is a downer, and then the depression.'

Lori and Melanie describe their experiences with the IVF procedure and how they reacted when the procedures did not work. Their responses highlight some anger and frustration they felt toward the medical team:

> Lori: There was a whole bunch of us at the same point in the cycle. We would all walk virtually every morning to the lab to have blood drawn and I just remember thinking 'This is crazy." But this is actually starting to feel like the normal way of having a baby. Intellectually , I know that most women go to bed, get pregnant and go on to have a baby, but in my heart I thought, that is not true, you have to have injections, you have to have ultrasound. It just seemed like the normal way of having a child. ... So anyhow, we were just kind of thrilled, everything had gone well in that cycle, and when we had the egg retrieval. They got 9 eggs, 9 nice mature eggs, everything looked perfect. After the retrieval, we had to phone back to see if the eggs had fertilized, we were counting down the minutes. When we phoned, they said to us, ' I am sorry, but no fertilization has occurred. You do realize that your husband has a very poor sperm count.' Well, this was the first we had heard about any male factor infertility. I was totally devastated and I cried for the next two days. We felt that the care we received in the clinic was good up until the point when fertilization did not occur. It was like we became a treatment failure.

> Melanie: We started with the shots every day. That was really weird because you are going there thinking that your are going to come out of there with a baby, that is what you are thinking. So you go everyday, and do your shots, take your pills, and then go for the procedure. Then you go home and bloody well wait. They put the egg and the sperm together and nothing happened. At that point, when they phoned me that morning, I was ready to go back in, but they told us not to bother going in. I was just numb, I thought, 'I don't believe my ears, this is not happening to us.' So what do you do. We went for our meeting with the doctor, and thought, 'okay, maybe they found something out.' When we got there, they looked at us and said, 'there is no explanation, there is nothing wrong with your eggs, there is nothing wrong with his sperm, it must be bad luck.' I thought my husband was going to ring the doctor's neck. And after that you think, 'I just spent thousands of dollars, the least you could do is tell me something.' They didn't say anything, nothing at all. They recommended that we try it again, that was what they said. They basically said, 'you guys should try it again, the second time your success rates are better because you have already gone through the protocol and they will know if they have to make any changes. So I asked them what protocol they would put me on the second time and they said the exact same one. It is horrible because they are not consistent. I would rather they just tell me they can't do anything for me. I would rather suffer with the pain instead of them just doing things for the sake of doing them.

Melanie's and Lori's responses illuminate the psychological impact of going through an IVF procedure, but they also show how ARTs alter the process of reproduction. For instance, when Lori said IVF started to feel like the normal way of having children, we begin to see how this procedure redefines women's view of their role in reproductive process. More specifically, these responses show how reproduction is now in the control of reproductive specialists and not the women themselves. Nadia describes a scenario which further demonstrates how women/couples become alienated from the reproductive process. She said:

> When they put the eggs in, it was kind of funny. The doctor was really nice because when he was doing this, my husband was sitting in the corner of the room. My legs were open and everyone was joking, so the doctor told my husband that he wasn't in the best position and told him to come over to me.

Although these women did not say that these technologies negate the role they and their husbands played in the whole process, their description of the IVF process clearly shows this. These women refer to the doctors, not themselves, as the creators of their baby.

Nadia's experience with IVF differed in that she could conceive but was forced to terminate the pregnancy because the fetuses did not develop. She talks about her experience when the pregnancy had to be terminated:

> With my pregnancy, I was spotting a lot around my third month. My doctor kept telling me that I just needed bed rest. And then I got really upset and was scared to move around. We had also found out that we were having twins. When I was spotting I got really scared, but the weird thing is that I said, 'please God, don't let me lose these, I don't care what happens, I just want them. I should have lost them then. When I was 5 months pregnant, I went for an ultrasound. I had gone for an ultrasound almost right from the beginning because of IVF. When I went back that time, I sensed that something was wrong with them. The woman doing the ultrasound said she would check with my doctor. I knew there was something wrong then, but I guess they are not allowed to tell you if there is something wrong until they check. And then she made another appointment and that is when I started to really get suspicious. That was when the doctor came and said that there

> was something wrong with their brains. They told us that they weren't really developing a brain. Then they told us to go and see our doctor. I guess because they are not your real doctor, they don't want to talk to you about it, or maybe they are not allowed to give out that information. So anyway, we went to see my doctor right away. She told us that one had a problem for sure, and that the other one didn't look very good either. She said she wanted to do more tests to make sure. This was a Friday and of course we had to wait for the weekend. I think you still cling on to some hope, you want to think that maybe one will be okay, but in the back of your mind you know it won't be. The doctor then told us that they both had it, and of course I started to cry. Then I said I didn't want them because I was told they wouldn't live for mor than 24 hours anyway. I had to deliver them. I was at 20 weeks exactly. I kept crying all the time and my husband was strong.

I asked Nadia if she would talk more about her emotions at this time. She said she didn't feel she could. Nadia says she still has trouble talking to people about her experience.

Sheila was the only woman in this study who was able to carry a pregnancy to term with IVF. Conception occurred on her second attempt. She currently has two children conceived through IVF. Sheila talked about her experiences with the procedure, and why she pursued a second attempt even though the first time was difficult:

> The IVF attempt itself is a horrendous procedure. It is very, very invasive, you are getting massive doses of drugs. The second IVF attempt was bad, you get all the side effects and every day you get blood drawn, and an ultrasound which is vaginal, that is very invasive. Every day you sit in this room with 15 other women, and you get to know them. You talk about it like it is nothing, everyone just discusses it. So it is a very good support system, but it is also very competitive. I just thought in the back of my mind, 'well, one in three is going to succeed, who is it going to be?' I was also very nervous during the second attempt because I kept thinking, 'oh now, two more.' I didn't know if I could do two more. I know a lot of people only do one IVF attempt and then say that is it. I can understand why, and I think you have to be really, really motivated to want to have a child in order to go through this crap more than once (to have a child). I felt really degraded because the first attempt hadn't worked and I was back there again. I felt like a failure. I also think there was a change in my thought process between the two attempts. The first time I prayed for a child, that was how desperate I was and the second time, all I prayed for was for the strength to get me through this and to make it okay if I couldn't have a child. I prayed for the strength to carry on.

The IVF procedure is traumatic. These women had to endure physical and emotional hardship throughout the process. Dealing with the failure of IVF was particularly devastating for these women. Many women who participated in ARTs resented how negatively reproductive specialists and technicians treated them after the technologies did not work.

The Exit from Medical Intervention

At the time of my study, Kathy, Nadia and Julia were still actively involved in medical intervention to achieve pregnancy. Teresa was saving money to pursue IVF. The remaining seven women stopped pursuing ARTs. Although Andrea and Angie stopped this pursuit before engaging in more invasive ARTs, the other women did this much later in the process. Sheila, however, stopped when she became pregnant.

For some of the women, the exit from medical intervention occurred because, as they said, 'they had reached the end of the line.' In other words, women had exhausted their treatment options and felt it was time to move on. As Lori said,

> we decided to not continue after our last attempt. We knew before we got the results ... because there wasn't any reason to believe that if everything hadn't worked up until now, that anything would work from then on. If there was a procedure with a reasonable success rate, well then maybe we would have gone on, but we just felt there wasn't. It was as good as it got. We thought, look, we had an excellent cycle, these people are experts in reproductive technologies, and the chances of anything being successful now is very, very minimal. So we thought that it just didn't make any more sense putting more money into this. Overall I feel at peace. We have done the best we could have. By going through this whole process, we feel like we put everything we could into it. I don't feel that there is a great gap in my life. I went through this for 5 years and right up until the last time it didn't work, we were still hoping it would work. There was a period of grieving, for about a month. It was more grieving than I had expected, but not devastation, just sadness for both of us.

While Diane says, 'I discontinued treatment because the program closed in Winnipeg and my doctor moved to Toronto. I don't like the current doctor. So if there was a doctor here that I liked, and that I trusted, I probably would have tried it again.' Diane also stopped because she eventually became comfortable with the idea of adopting a child. Diane said that although she was at one time obsessed with having her own child, she eventually began to reevaluate her priorities. Interestingly enough, after having adopted a child, Diane changed her feelings toward both adoption and motherhood, she said:

> I don't think women who have this real desperation to have a baby, those who are running around the world having IVF, really know what it is about. I think some people are very idealistic and unrealistic. I was definitely like this back then. I mean it is wonderful, but I think you have to be more realistic. Now I think that I am lucky that I didn't have to go through gaining weight and the labor. I wanted a baby , and I was afraid that I could not bond with a baby that wasn't mine biologically. But I now think it is the same.

Melanie decided she needed to stop seeking medical interventions for many reasons. One reason was that she became concerned about the risks associated with these procedures. As Melanie said, 'I started thinking about why I was taking all these pills and what effect they would have on me in 10 years.' Financial constraints also contributed to the decision to stop. Melanie said that they had already invested thousands of dollars in reproductive technologies and a few more on alternative medicine. She felt that she couldn't continue to do so. Another reason Melanie decided it was time to stop was that she felt she had to regain control of her life. Melanie says,

> My ideas about having a child changed over those years. I think once you use up all your options and you finally realize you are not going to have a child, you have to change because if you don't, you get affected with this; you become obsessed

> with it. It gets to the point where it runs your life, and so we both had to say, no more.

Rita also began to feel this way, she said:

> I went to a conference in 1993 that really had an impact on me. It was so good, and what really affected me was when this women was saying things like, 'are you going to continue to be a victim of this, or are you going to take your life back.' It was just what I needed to hear. I just felt so depressed and justifiably so. I just felt like poor me, I was angry, I had quit work. I just thought it was a very important time to say, move on.

Other studies have found similar reasons for why women/couples discontinue medical treatment (Lasker and Borg, 1987; Litt et al., 1992; Harris, 1994). These reasons are similar to those which were given by the women who did not pursue ARTs, or by those who pursued less invasive procedures.

These women wanted a child, but decided they could not continue on the medical pathway. Physical and mental exhaustion, financial depletion and a need to move on pushed these women to cease medical intervention. For some women, the desire to regain control of their lives also contributed to this decision.

For Kathy, Julia and Nadia, ARTs continue to be a part of their lives. Teresa had not yet experienced assisted reproduction because of financial constraints. At the time of the study, Kathy was going through her last IUI attempt. If this procedure was not successful, Kathy was prepared to try IVF. We talked about why she would continue. Her reasons were no different than those provided by the other women who continued with ARTs, except that Kathy felt adoption would be more difficult for her because she is single. Kathy said:

> I feel that if I don't try everything, I will never know. ... I am going to have a harder time adopting through Child and Family Services. They have told me that being single shouldn't really matter, but I have heard about the problems other people have. I will continue with IVF because I want to try everything. If the

> hyperstimulation doesn't work, then the only other thing I can try is in vitro and I do sort of want something that is genetically related to me.

Julia does not believe she will continue with ARTs if the IUI is not successful. I did ask her if she would pursue IVF if the IUI is not successful. She said:

> I don't know. We would first have to find out that I was having problems and even after the year, we wouldn't know for sure if I was having problems. IVF wouldn't improve the situation because it still wouldn't be my husbands child, and it is a lot more expensive. I don't think we would go that route. No, if we were not successful after the year, we would probably try a little longer and then look into adoption. We also wouldn't have any better chance of success and we would just be on a worse roller coaster ride.

Nadia has gone through one IVF attempt and has decided to try two more attempts before considering adoption. She says:

> What I would like to do, if we can, is the last time I had 10 eggs retrieved and they froze five. They keep the frozen eggs for you for $100.00/month and then they will submit you in for only $300.00 and that will be the whole cost. This means they won't have to retrieve the eggs anymore. They will just have to put them in. I am planning to go this fall and later again in the winter, and then after that, no more. I know there are a lot of people out there who have tried IVF 12 times. Some people really want children that bad that they would go so many times, but I think that I could look into adoption.

All of the women who participated in ARTs said that they did not regret having done so, and that in fact, this intervention helped them to work toward resolving the infertility. In other words, their having participated in IVF led to some sort of closure. Lori said, 'I feel that for us, we needed to go through that to let go. If we hadn't gone through with it, we would have always thought, what if?' While Diane says, 'I don't know if I have any regrets. I don't know how I could have done things any differently.'

For these women, and all the women in this study, infertility does not disappear. These women continue to live with this problem and often the stigma attached to being

infertile. However, the women work toward reaching a stage where they feel comfortable with the decisions they have made.

Chapter 7: Discussion and Conclusion

The main purpose of chapter 6 was to allow the women's voices to be heard and to show the similarities and differences between women who are faced with infertility in an age of ARTs. The purpose of this chapter is to discuss how the decision-making process surrounding infertility, and the options available to women for overcoming infertility are alienating in several respects.

According to some socialist feminists, we can best understand women's oppression in this society through the examination of alienating social experiences. This involves addressing those experiences that "separate women from all those processes and people she needs to achieve wholeness as a person" (Jagger, 1983). Jagger (1983) states that "women's alienation from their sexuality and from motherhood are among the most obvious forms of women's alienation in contemporary society." Women's alienation from these experiences occurs because society restricts women's control over their reproductive lives. As shown throughout this study, various social, economic, political and technological conditions shape women's view of the world and ultimately influence the decision-making process surrounding their reproductive lives. Further, these conditions shape women's experiences of ARTs and adoption. Regardless of whether a woman opts for adoption or ARTs, she is alienated from herself, others, the process of reproduction and the products of reproduction because of the social context in which she finds herself.

According to socialist feminism, society alienates women from the products of their reproductive labour because others decide if, and when, women will have children (Tong, 1989). As well, a woman is alienated from the process of her reproductive labour because others take control of the birth process and now, because of ARTs,

doctors take control of the process of conception. Society further alienates a woman from herself and others because she is denied personhood outside of socially constructed gender roles. For socialist feminists, "reproductive freedom is incompatible with compulsory heterosexuality and mandatory motherhood, or with economic inequality" (Jagger, 1983).

Like women in previous studies, the women in this study had similar experiences and reasons for making certain reproductive decisions. I did not find any substantial differences between women when the infertility factor differed. I did discover, however, that when women are faced with fertility problems, they do not all make the same choices. Although the women differ in their final decisions, they all eventually reach the point where they feel they have done everything they are willing to do to have a child. Some women may choose to seek ARTs to have a child. When they do not have a child, even with ARTs, the quest eventually ends because of physical and emotional exhaustion. Women also reach the point where they need to refocus their priorities and regain control of their lives. These factors contribute to the exit from medical intervention.

According to the women in this study, the final decision about whether or not to pursue ARTs occurred by balancing their and their partners' personal desires and beliefs with social constraints and practical considerations. Not all of the women chose a similar path, but they all described their final decisions (which may have changed over time) as a personal choice, and not necessarily as a choice imposed by outside forces. When prompted, some women in this study did talk about societal influences and constraints, but typically, these women viewed their decisions as stemming from within and as something they needed to do for themselves.

Although women described their decision-making as stemming from within, I used elements of socialist feminist theory to try to unravel how women are alienated from the decision-making process. I found the concept of alienation relevant to this study because throughout the data, I found evidence of how women are excluded from the decisions affecting their reproductive lives. More specifically, the data shows that women's reproductive decisions are often constrained and/or influenced by social, economic, political and technological factors. I used the concept of alienation to understand how various beliefs and practices shape how women view the world so that the decisions they make are often to please others and not themselves. I used alienation to conceptualize how oppressive ideologies and structures limit women's control over their reproductive decisions and hence limit the choices available to women. Pronatalist ideologies, the privatized costs of ARTs, the patriarchal nuclear family and the medical system prevent women from having reproductive freedom. As well, technological changes have altered women's experiences of procreation. These factors shape if and under what circumstances women will have children. Further, the concept of alienation helped me to understand how women are separated from all of the decisions surrounding ARTS and adoption. It is not women who decide whether they can have access to ARTs or a child, nor do women control the process of reproduction when choosing either option.

The data suggests that the women in my study were alienated from their reproductive decision-making. No matter what option these women chose, they had little choice over these decisions because society has limited the choices available to women who want a child. Many women in this study described adoption and ARTs as their option of last resort, as risky and unsafe, but felt compelled to pursue either of

these options to have a child. I discovered that whether the decision was to adopt or pursue ARTs, the women in this study experienced a sense of alienation from themselves, others, the process of reproduction and the products of reproduction.

The women's narratives on adoption suggest that this experience alienates women. Most women cannot freely consider adoption as an alternative because it does not give them a child of their own (i.e., with a genetic link). The women in this study struggled with oppressive ideologies (some of which they had internalized) that push women to view motherhood as necessary for women, and biological motherhood as an essential aspect of femininity. If a woman chooses adoption, she is alienated from herself as a woman. She comes to believe that her body, the source of her creativity and potential as a human being, has failed her. She views herself as less of a woman because she has not given birth to this child. When women view reproduction as central to a woman's identity, adopting a child cannot satisfy this socially constructed belief. Adopting a child also alienates women from others, primarily other women. When a woman adopts a child, she feels a sense of 'otherness' from women who have had their own children, because she has not fulfilled her biological destiny.

Adoption alienates women from the products of reproduction because others control if she will have a child. As some women said, only the chosen parents get a child. Many women find adoption frustrating not just because of the limited number of adoptees, but also because others have control over who is worthy of having children. The parents do not freely choose whether to adopt. Essentially, the child care workers, and the private agents have the final say in who can adopt. The adoption process is very intrusive and potential parents are subjected to rigorous screening. Potential parents must meet certain criteria before the adoption program accepts them.

Adoption is generally more difficult for older couples, and single women (Denny, 1994). As with the medical system, the adoption system functions as a gatekeeper, determining who can and cannot adopt. The inability to control the gestational environment and the laws on adoption further reduce women's control over the adoption process.

A woman's potential to choose adoption freely as an option is thwarted because she is alienated from the process of reproduction. Women cannot escape the way in which parenthood is defined in this society. The focus on genetic parenthood prevents many women from seeing the value of nurturing and caring relationships outside biological motherhood. It is not the woman who bears the child and therefore she feels alienated from the child.

When women/couples do not meet the adoption criteria, or if a child is unavailable, they have little choice but to purse ARTs, or remain childless. As discussed earlier, remaining childless is rarely an option for most women until they have exhausted other possibilities. The lack of alternatives may push some women to pursue ARTs to have a child. Furthermore, the ways in which women are alienated from themselves, others, the process and product of reproduction, if they choose adoption, are the reasons why they may opt for ARTs. Women believe that through these technologies they can achieve wholeness as a woman, by experiencing pregnancy and childbirth. If a woman does not choose to seek ARTs, she will continue to feel alienated from herself and from others because she does not have a child.

Social norms constrain women when deciding about these technologies because they inform women of the significance of motherhood for women's identity. If women believe that they derive their sense of self-worth from their reproductive capacities,

then their freedom to choose these technologies will be denied. Economic factors also constrain women when making decisions about ARTs. If women do not have access to adequate economic resources, then they are unable to seek medical intervention to achieve pregnancy because of the privatized costs of ARTs.

Besides social and economic conditions, technological changes have altered women's decision-making. The availability of ARTs contribute to women's alienation because women feel compelled to pursue techniques that will give them a genetically-related child. As discussed throughout this study, there is a great push toward having a child of one's own in this society. These technologies give the promise of providing a woman/couple with a child of one's own. Technological changes also limit women's control over their reproductive decision-making because they have become the socially acceptable alternative for overcoming infertility. In other words, women feel compelled to seek ARTs because this is an expected pattern to follow. As has occurred historically with other medical practices, reproductive experts have transformed ARTs into routine reproductive practices. For those women deemed eligible, seeking medical intervention to achieve pregnancy is not necessarily a choice, but most often an expectation. If a woman does not pursue ARTs, she is alienated from others because she is just not trying hard enough to have a child. The women in this study said that others queried them as to whether they had tried everything available to achieve pregnancy. If a woman doesn't try everything, then others view her as not being serious about wanting to be a mother.

What was evident in this study is that when women use ARTs, these technologies further alienate women from themselves. For many women, reproductive technologies deny women the freedom to experience a sense of personhood outside the role of

biological mother because ARTs reinforce the significance of genetic parenthood. These technologies also make it more difficult for women to accept the significance of nurturing relationships as opposed to biological motherhood. When ARTS do not work, a woman's potential to achieve wholeness as a person is further denied because she views herself as a failure.

When others decide if women will have children, they alienate women from their bodies. In other words, society prevents women from freely developing their reproductive capacities because women are pressured to make decisions according to what is valued by society. As well, these technologies control who is worthy of having a child, and reinforce to women the significance of having children. When society interferes with women's rights to decide whether to have children, or when it informs women of the conditions under which motherhood is acceptable, society denies them a sense of control or mastery over their bodies.

Lastly, conceptive technologies alienate women because doctors manage and control the reproductive process. Technological developments have alienated women from the birth process ever since doctors took control of this experience. Now, however, women experience new forms of alienation. Doctors largely control the process of reproduction for those women using ARTs. Doctors inseminate women, 'harvest' eggs, and then unite these eggs with sperm in a petri dish to produce a fetus. In other words, doctors are making babies, not women. Women are no longer 'real' participants in reproduction. These technologies redefine a woman's view of her role in her reproduction. Reproductive technologies reduce a woman's role in this activity to a reproductive vessel - someone who houses this precious product. These technologies reinforce that women are merely instruments in the reproductive process,

and negate and devalue women's role in this process. When ARTs fail women, as the frequently do, women are then seen as empty vessels - with bodies that have let them down.

Conclusions

Infertile women have few choices when trying to overcome infertility. If a woman wants a child, she is left with two choices, adopt or seek ARTs. Both options are risky, and do not necessarily give a woman a child. If one approach doesn't work, or if it is inaccessible, then women generally seek the other alternative. Both options alienate women because they limit women's control over their reproductive lives. In many ways, infertile women are damned if they do, or damned if they don't. These women choose either ARTs, or adoption, or both, out of necessity and not necessarily because they have been given the rights, the power, or the control to choose either option freely.

Clearly, the women in my study were making choices in a world that rewards some choices and frowns on others. Society continues to value women for their motherhood role. Although women have made great strides in other areas of their lives, society still values them for their ability to have children. Society continues to socialize young girls to accept motherhood as their ultimate role in life. However, there are restrictions placed even on this. Society teaches women that motherhood represents womanhood, but only within the confines of the nuclear family. By shaping women's options and beliefs, women become alienated from their reproductive lives. In other words, various social processes restrict women from freely choosing motherhood, adoption, or ARTs.

Women relinquish control of their reproductive lives even further when faced with infertility. These women experience the greatest sense of alienation from their reproductive lives. What was once an experience unique to women has been appropriated by a male-dominated profession. Recent technological developments have redefined a woman's role in reproduction so that men, not women, produce babies. These technologies have pushed many women to pursue medical intervention to achieve pregnancy. In trying to overcome infertility in an age of ARTs, many infertile women place themselves at great risk and are denied the opportunity of letting go of the desire to have a child of their own until they have exhausted all of the options available to them.

We cannot deny that women's decisions surrounding motherhood, infertility and ARTs are inextricably linked to the wider social structure. Although appearing as personal choices, reproductive decisions are influenced by the social, economic and political structure. Pronatalist forces condition women to want children, and more specifically genetically-related children. For those women who want to, but cannot have children, this can be a very traumatic experience. Women live in a society that views the childless woman as a failure, and she comes to believe that her body is diseased. With these feelings, she must deal with a system that tells her that her only hope is a medical cure. However, this medical cure involves an endless array of reproductive technologies that women must exhaust before they can accept childlessness. These women are further limited because adoption is not presented as a suitable option because many women accept biological motherhood as the essence of the maternal bond. As well, the process of adoption prevents women from having

much control over this situation. In the adoptive process, child care workers, private agencies and the legal system control who is worthy of adopting a child.

To that end, we can begin the process of understanding why women pursue ARTs, or why they persist in treatment at any cost. In many ways, women have little choice when it comes to ARTs. Clearly, women will continue to seek ARTs, or any other method that has the potential to bring a child into their lives. This study has shown the importance of continuing the struggle to increase women's control over their reproductive lives. However, in doing so, we cannot forget that women want children and will continue to want children. This desire creates a great deal of pain and frustration for those women who want children, but cannot have them. These women are left to make decisions in a world that gives them few real options.

Strengths and Limitations of this Study

To begin with, this is an exploratory study and only fifteen women participated in this study. Therefore, I cannot generalize my findings to all women experiencing fertility problems. As well, my sample consisted of women who were white, mostly well-educated, and middle-to upper-middle class. This is usually unavoidable when dealing with reproductive technologies. These technologies are expensive and often limited to a select group of women. Another limitation of my sample is that four of the women participating in this study belonged to the WISG. This support group may have exposed the participants to information that increases women's awareness of ARTs. Of interest, however, is the fact that none of the WISG women resisted ARTs, at least not initially. Nor were they more likely to be skeptical of these procedures. I found the

other women more likely to question these technologies. Another limitation of my sample is that all of the women were self-selected. Individuals willing to participate in studies differ in that "they are frequently the most articulate, accessible, or high-status members of the group" (Sandelowski, 1986:32).

My own experience as an interviewer is another limitation of this study. As discussed earlier, as the data collection progressed, I became more comfortable with the interview process. Essentially, I was better able to elicit information from the women as I matured as an interviewer. Therefore, the data may better represent some women because I was more experienced at interviewing and not necessarily because these women had more to say.

That men did not participate in this study is another limitation. Infertility is often a couple experience and for the most part, I have not addressed men's experiences of infertility in this study. As I discussed earlier, I did not talk to men because this research was woman-centred. I wanted to understand the decision-making processes of women. Nevertheless, infertility does affect men as well, and therefore understanding this experience from a man's perspective would add to the current state of knowledge on this issue. It would be worth trying to uncover whether men perceive fatherhood, adoption and ARTs differently than women.

Lastly, my own values, beliefs and emotions have influenced this study. I chose this topic because I feel passionately about it and therefore my subjectivity has influenced both the collection and interpretation of the data. However, as I stated earlier, I never intended to represent myself as an 'objective' social scientist who can be indifferent to her research subjects. I also believe the notion of "value free research" is often misleading. Researchers are human and hold values and beliefs

that influence every stage of the research process, from the selection of the research topic to the analysis of the data. This does not mean that as a researcher, I could not distance myself from the women's responses during the data analysis. I tried throughout this study to reflect on how my feelings and values influenced my perception of these women's lives and decisions.

I chose to allow the women's voices to be heard in this study because I believe it is our responsibility to consider the present day circumstances of infertile women. Although I firmly believe that these technologies are not in the interest of women, I cannot ignore the subjective reality of the 15 women participating in my study. We must respect and consider women's desire for a child. As feminists, we must develop a system that gives women as much control over their reproductive lives as possible.

This study contributes to the current state of knowledge on infertility by allowing women's voices to be heard. The data suggests that overcoming infertility in an age of ARTs is an alienating experience for infertile women. This study also provides a unique approach to understanding the decision-making process when women are faced with fertility problems. As stated earlier, women who decide to pursue ARTs are damned if they do, or they are damned if they don't. We need to acknowledge that women may choose these options not because they want to, but out of necessity. Society has left many infertile women with little choice over the decisions surrounding their reproductive lives.

BIBLIOGRAPHY

Abbey, A. And L.J. Hallman. (1995). "The Role of Perceived Control, Attributions, and Meaning on Members of Infertile Couples Well-being." Journal of Social and Clinical Psychology 14(3): 271-296.

Achilles,R. (1990). "Desperately Seeking Babies: New Technologies of Hope and Despair." In K. Arnup, A. Levesque, and R. Roach Pierson (ed.). Delivering Motherhood: Maternal Ideologies and Practices in 19th and 20th Century. London and New York: Routledge. pp. 284-312.

Alpern, K.D, (1992). The Ethics of Reproductive Technology. New York: Oxford University Press, Inc.

Antonis. B. (1981). "Motherhood and Mothering." In Women in Society: Interdisciplinary Essays The Cambridge Women's Studies Group. Virago Press Ltd. pp. 55-74.

Becker, G. and R. Nachtigall. (1992). "Eager for Medicalization: The Social Production of Infertility as a Disease." Sociology of Health and Illness 14: 456-470.

Becker, G. And R. Nachtigall.(1994) "'Born to be a Mother': The Cultural Construction of Risk in Infertility Treatment in the U.S." Social Science & Medicine 39(4): 507-518.

Bequaert, Holmes, H. (ed.) (1992). Issues in Reproductive Technology: An Anthology. New York: Garland Press.

Bryant, H. (1990). The Infertility Dilemma. Faculty of Medicine, University of Calgary: CACSW.

Connoly, K. J., J. Elelmann., I.D. Cooke and J. Robson. (1992). "The Impact of Infertility on Psychological Functioning." Journal of Psychosomatic Research 36: 459-468.

Corea, G. (1985). The Mother Machine: Reproductive Technologies From Artificial Insemination to Artificial Wombs. New York: Harper & Row.

Cowles, K. V. (1988). "Issues in Qualitative Research on Sensitive Topics." Western Journal of Nursing Research 10(2): 163-179.

Crowe, C. (1987). "Women Want It: In Vitro Fertilization and Women's Motivation for Participation." In P. Spallone and D. Steinberg (eds.). Made to Order: The Myth of Reproduction. Toronto: Bergen and Garvey Publishers, Inc. pp. 67-83.

Currie, D. (1988). "Re-thinking What We Do and How We Do it: A Study of Reproductive Decisions." Canadian Review of Sociology and Anthropology 25(2): 231-253.

Daniels, K. (1994). "Adoption and Donor Insemination: Factors Influencing Couple's Choices." Child Welfare League of America January-February: 7-15.

Downey, J. and M. McKinney. (1992). "The Psychiatric Status of Women Presenting for Infertility Evaluation." American Journal of Orthopsychiatry 62: 196-206.

Denny, D. (1994). "Liberation or Oppression? Radical Feminism and In Vitro Fertilization." Sociology of Health & Illness 16(1): 62-79.

Eisenstein, Z. (1979). Capitalist Patriarchy and the Case for Socialist Feminism. New York: Monthly Review Press.

Ellis, C. and M. Flaherty (eds.) (1992). Investigating Research on Lived Experience. Newbury Park, California: Sage Publications.

Everingham, C. (1994). Motherhood and Modernity. Philadelphia: Open University Press.

Faludi, S. (1991). Backlash: The Undeclared War Against American Women. New York: Doubleday.

Farganis, S. (1986). The Social Reconstruction of the Feminine Character. Totowa, New Jersey: Rowman & Littlefield.

Ferguson, A. (1989). Blood at the Root: Motherhood, Sexuality and Male Dominance. London: Pandora.

Fonow, M. and J. A. Cook. (1991). Beyond Methodology: Feminist Scholarship as Lived Research. Indianapolis: Indiana University Press.

Frank, D. (1990). "Gender Differences in Decision-Making about Infertility Treatment."Applied Nursing Research 3(2): 56-62.

Frank, D. (1990). "Factors Related to Decisions about Infertility Treatment." Journal of Obstetric, Gynecologic, Neonatal Nursing 19(2): 162-167.

Franklin, S. (1990). "Deconstructing 'Desperateness': The Social Construction of Infertility in Popular Representation of New Reproductive Technologies." In McNeil, M., Varcoe, I. and Yearly, S. (eds.), The New Reproductive Technologies. London: Macmillan. pp. 200-226.

Gerson, K. (1985). Hard Choices: How Women Decide About Work, Career, and Motherhood. Berkeley and Los Angeles, California: University of California Press.

Glenn, E. N, C. Chang and L. R. Forcey. (1994). Mothering: Ideology, Experience and Agency. New York: Routledge.

Glesne, C. and A. Peshkin (1992). Becoming Qualitative Researchers: An Introduction. White Plains, New York: Longman Publishing Group.

Gormly, A., J. Gormly, and H. Weiss. (1987). "Motivations for Parenthood Among Young Adult College Students." Sex Roles 16 1/2: 31-39.

Grant, K. R. (1994). "The New Reproductive Technologies: Boon or Bane?". In B.S. Bolaria and H.D. Dickinson (eds.), Health, Illness and Health Care in Canada. (2nd Ed.) Toronto: Harcourt Brace and Company. pp. 362-383.

Greil, A. L. (1991). "A Secret Stigma: The Analogy between Infertility and Chronic Illness and Disability." Advances in Medical Sociology 2: 17-38.

Hallebone, E. (1991). "Non-genetic Mothers and Their 'Own' Children: Infertility and IVF Donor Birth." Australian Journal of Social Issues 25: 124-135.

Hammersley, M. (1992). "On Feminist Methodology." Sociology 26(2): 187-206.

Harris, F. (1994). "The Process of Infertility." In P.A. Field and P. B Marck (eds.) Uncertain Motherhood: Negotiating the Risks of the Childbearing Years. Thousand Oaks, California: Sage Publications. pp. 15-81.

Hubbard, R. and W. Sanford. (1992). "New Reproductive Technologies." In The New Our Bodies, Ourselves. The Boston Women's Health Book Collective. New York: Simon and Schuster, Inc. pp. 386-393.

Hynes, G., V. Callan., D. Terry., and C. Gallois. (1992). "The Psychological Well-Being of Infertile Women After a Failed IVF Attempt." British Journal of Medical Psychology 64: 269-278.

Inhorn, M. C. (1994). "Interpreting Infertility: Medical Anthropological Perspectives." Social Science & Medicine 39 (4): 459-461.

Jaggar, A. (1983). Feminist Politics and Human Nature. Totowa, New Jersey: Rowman & Allanheld, Publishers.

Katz Rothman, B. (1989). Recreating Motherhood: Ideology and Technology in a Patriarchal Society. New York: W.W. Norton.

Klein, R. D. (1989). Infertility. Women Speak Out About Their Experience of Reproductive Medicine. London: Pandora Press.

Klein,R. D. (1991). "Women as Body Parts in the Era of Reproductive and Genetic Engineering." Health Care for Women International 12: 393-405.

Kraft, A. D., J. Palombo, D. Mitchell, C. Dean., S. Meyers., and A.W. Schmidt. (1980). "The Psychological Dimensions of Infertility." American Journal of Orthopsychiatry 50: 619-628.

Lasker, J. N. and S. Borg. (1987). In Search of Parenthood: Coping with Infertility and High-Tech Conception. Boston: Beacon Press.

Lauritzen, P. (1990). "What Price Parenthood?" Hastings Center Report March/April: 38-47.

Lewin, E. (1994). "Negotiating Lesbian Motherhood: The Dialectics of Resistance and Accommodation." In Glenn, E. N, C. Chang and L. R. Forcey. (eds.). Mothering: Ideology, Experience and Agency. New York: Routledge: pp. 333-353.

Lindsey, L. (1994). Gender Roles: A Sociological Perspective. Englewood Cliffs, New Jersey: Prentice-Hall, Inc.

Litt, M. D., H. Tennen., G. Affleck, and S. Klock. (1992). "Coping and Cognitive Factors in Adaptation to In Vitro Fertilization Failure." Journal of Behavioural Medicine 15: 171-186.

Luxton, M. (1980). More Than a Labour of Love: Three Generations of Women's Work in the Home. Toronto, Canada: Women's Educational Press.

MacIntyre, S. (1976). "Who Wants Babies? The Social Construction of Instincts." In D. L. Barker and S. Allen (eds.). Sexual Divisions and Society: Process and Change. London: Tavistock. pp. 150-173.

Mackie, M. (1987). Constructing Women & Men: Gender Socialization. Toronto: Holt, Rinehart and Winston of Canada, Ltd.

McKinlay, J. B. (1982). "From Promising Report to Standard Procedure: Seven Stages in the Career of a Medical Innovation." In J. McKinlay (ed.). Technology and the Future of Health Care. Cambridge, Mass: MIT Press. pp. 233-270.

Miall, C. E. (1986). "The Stigma of Involuntary Childlessness." Social Problems 33: 268-281.

Miall, C.E. (1994). "Community Constructs of Involuntary Childlessness: Sympathy, Stigma, and Social Support." Canadian Review of Sociology 31(4): 392-421.

Mies, M. (1991). "Women's Research or Feminist Research? The Debate Surrounding Feminist Science and Methodology. In M. Fonow and J. Cook (eds.) Beyond Methodology: Feminist Scholarship as Lived Research Indianapolis: Indiana University Press. pp.60-84.

Newton, C.R., M.T. Hearn., A.A. Yuzpe and M.Houle. (1992). "Motives for Parenthood and Response to Failed In Vitro Fertilization, Implications for Counselling." Journal of Assisted Reproduction and Genetics 9: 24-32.

Oakley, A. (1980). Woman Confined: Towards a Sociology of Childbirth. Schocken Books: New York.

Oakely, A. (1981). "Interviewing Women: A Contradiction in Terms." In H. Roberts (ed.) Doing Feminist Research. New York: Routledge and Kegan Paul Inc. pp. 30-61.

Overall, C. (1987). Ethics and Human Reproduction. London: Allen and Unwin.

Overall, C. (ed.) (1989). The Future of Human Reproduction. Toronto: Women's Press.

Overall, C. (1991). "Access to In Vitro Fertilization: Costs, Care and Consent." Dialogue XXX: 383-397.

Patterson, B. L. (1994). "A Framework to Identify Reactivity in Qualitative Research." Western Journal of Nursing Research 16(3): 301-316.

Phoenix, A., A. Woollett, and E. Lloyd. (1991). Motherhood: Meanings, Practices and Ideologies. London: Sage Publications.

Rehner, J. (1989). Infertility: Old Myths, New Meanings. Toronto, Canada: Second Story Press.

Rich, A. (1986). Of Woman Born: Motherhood as Experience and Institution. New York: W. W. Norton & Company.

Richardson, D. (1993). Women, Motherhood and Childrearing. Toronto: Macmillan Press, Ltd.

Royal Commission On New Reproductive Technologies. (1993). Proceed with Care. Final Report of the Royal Commission on New Reproductive Technologies: Summary & Highlights. Ottawa: The Commission.

Rowland,R. (1987). "Of Women Born, But Not for Long? The Relationship of Women to the New Reproductive Technologies and the Issue of Choice." In P. Spallone and D. Steinberg (eds.). Made to Order: The Myth of Reproduction. Toronto: Bergen and Garvey Publishers, Inc. pp. 67-83.

Rowland, R. (1989). Woman Herself: A Transdisciplinary Perspective on Women's Identity. Melbourne, Australia: Oxford University Press.

Sandelowski, M. J. (1990). "Failures of Volition: Female Agency and Infertility in Historical Perspective." Signs 15: 45-49.

Sandelowski, M.J. (1990). "Fault Lines: Infertility and Imperiled Sisterhood." Feminist Studies 13: 543-552.

Scott, W. J. and C. Morgan. (1983). "An Analysis of Factors Affecting Family Expectations and Perception of Ideal Fertility." Sex Roles 9(8): 901-914.

Shattuck, J. C. and K. K. Schwartz. (1991). "Walking the Line Between Feminism and Infertility: Implications for Nursing, Medicine, and Patient Care." Health Care for Women International 12: 331-339.

Spallone, P. (1989). Beyond Conception: The New Politics of Reproduction. Toronto: Bergin and Garvey Publishers, Inc.

Stanton, A. L., H. Tennen, G. Affleck, and R. Mendola. (1991). "Cognitive Appraisal and Adjustment to Infertility." Women and Health 17: 1-13.

Stanworth, M.(ed.) (1987). Reproductive Technologies: Gender, Motherhood, and Medicine Oxford: Polity Press.

Steinberg, L. (1990). "The Depersonalization of Women Through the Administration of In Vitro Fertilization." In M. McNeil, Varcoe, I. and Yearly, S. (eds.)., The New Reproductive Technologies. London, Macmillan. pp. 74-98.

Strickler, J. (1992). "The New Reproductive Technologies: Problem or Solutions?" Sociology of Health and Illness 14: 111-129.

Strother-Ratcliff,K. (ed.). (1989). Healing Technology: Feminist Perspectives. Ann Arbour: The University of Michigan Press.

Tesch, R. (1991). Qualitative Research: An Analysis of Types and Software Tools. Bristol, PA: The Falmer Press, Taylor and Francis, Inc.

The National Action Committee on the Status of Women. (1991). "The New Reproductive Technologies: A Technological Handmaid's Tale." Issues in Reproductive and Genetic Engineering 4: 279-296.

Thorne, B and M. Yalom. (1982). Rethinking the Family: Some Feminist Questions. New York: Longman Inc.

Tong, R. (1989). Feminist Thought: A Comprehensive Introduction. Boulder, Colorado:
Westview Press.

Ursel. J. (1992). Private Lives, Public Policy. 100 Years of State Intervention in the Family. Toronto: Women's Press.

Wajcman, J. (1991). Feminism Confronts Technology. University Park, Pennsylvania: The Pennsylvania State University Press.

Whiteford, L. M and L. Gonzalez. (1995). "Stigma: The Hidden Burden of Infertility." Social Science and Medicine 40(1): 27-36.

Williams,L. (1990a). "No Relief Until the End: The Physical Costs of In Vitro Fertilization." In C. Overall (ed.). The Future of Human Reproduction. Toronto: Women's Press. pp. 120-138.

Williams, L. (1990b). "Motherhood, Ideology and the Power of Technology. In Vitro Fertilization Use by Adoptive Mothers." Women's Studies International Forum 13: 543-552.

Woliver, L. (1989). "The Deflective Power of Reproductive Technologies: The Impact on Women." Women and Politics 9: 18-40.

Woods, N.I., E. Olshansky, and M.A. Draye. (1991). "Infertility: Women's Experiences." Health Care for Women International 12: 179-190.

Young, I. (1990). Throwing Like a Girl and Other Essays in Feminist Philosophy and Social Theory. Indianapolis: Indiana University Press.

APPENDIX A
INTERVIEW GUIDE

INTERVIEW GUIDE

I. **General Information:**

1. I was wondering if you could begin by telling me a little bit about yourself?

2. Now, can you tell me a little bit about your reproductive history?

II. **Questions Related to Motherhood:**

3. While you were growing up, do you recall thinking about having children? Do you remember what your ideas of a family were when you were growing up? Can you tell me about this?

4. Did your ideas about having children change while you were getting older? Can you talk to me about this?

5. Did you ever consider not having children? Can you tell me why, and if yes, what changed your mind?

6. What does having a child mean to you personally?

7. A number of people think that the society we live in plays a role in women wanting to have children. How do you personally feel about this?

8. Can you take me through your experiences when you first decided to start having children? Could you tell me what motivated this decision?

III. **Questions Related to Infertility and Assisted Reproduction:**

9. Can you tell me a little bit about what you experienced when you first realized that you could not conceive, or when the pregnancy did not go to full term? Can you explain why you became concerned at this time, and not earlier? What were your feelings?

10. Can you now tell me about what you decided to do once you realized a problem existed, and why?

11. I was wondering if you could tell me about your experience with assisted reproduction. How did you learn about A.R? When did you first have contact with this, and why? Or can you tell me why you decided to not seek medical assistance?

For Women Who Have Had Medical Assistance

12. Now, can you tell me in greater detail the medical treatment you received, and what your experiences were with these? Walk me through that experience.

13. Can you tell me about what made you continue seeking medical assistance?

14. Can you tell me when you discontinued medical treatment and why? Or can you tell me what motivated you to not enter into an IVF programme?

Women in IVF: I would now like to ask you some questions about your experiences with in vitro fertilization.

15. What made you finally decide to try this procedure?

16. Could you take me through your experience with IVF?

17. I want to ask you a little bit more about IVF. More specifically, what are your general feelings towards this procedure?

18. Is there anything else you would like to share with me?

19. Can you talk to me about your hopes, dreams and maybe even regrets you have had about the decisions you have made?

APPENDIX B
SCREENING QUESTIONNAIRE

SCREENING QUESTIONNAIRE

1. Have you had any experience with assisted reproductive technologies? Could you please tell me what type of fertility enhancement methods you have received, such as fertility drugs and IVF?

2. Are you aware of the cause of the infertility problem? In other words, has a diagnosis been made as to whether or not the cause is female factor, male factor, or unknown (idiopathic).

APPENDIX C
WISG INFORMATION LETTER

Greetings from the IAAC/Wpg.:

I hope this letter finds everyone well and in good spirits. I'm writing to inform you of an opportunity some of you may be interested in. Recently, I was approached by a University student by the name of Yvonne Spyropoulos. She is working on her Masters in Sociology with specific interest in women's issues. In her thesis, she is pursuing the topic of infertility from a woman's point of view. As her enclosed letter states, Yvonne is focusing upon the decision-making processes women go through while contemplating options available to them - ARTs, IVF, adoption, child-free living.

I have met with Yvonne and am satisfied of her genuine concern for women with regard to these issues. She has asked me to approach anyone I feel might be willing to participate in an interview. Her letter provides more detail regarding duration and process of these interviews. Yvonne is looking for women who have tried or are in the process of trying Artificial Reproductive Techniques such as artificial insemination, drug therapy, etc. but not IVF; women who have tried or are trying IVF; and women who have opted out of any treatments other than the initial tests and procedures. The project is also open to women whose partners are infertile, those with unexplained infertility, as well as those who are infertile themselves.

If anyone is interested, you may get in touch with Yvonne at the number listed on her letter. If you would like to speak with me further before contacting Yvonne, feel free to call me at 669-4913. I hope some of you do decide to help Yvonne as projects such as hers can only help to emphasize our special needs and problems.

Sincerely,

Candace Propp
IAAC/Wpg -WISG facilitator

APPENDIX D
ETHICS COMMITTEE APPROVAL

University of Manitoba Department of Sociology
Ethics Review Committee

ETHICS EVALUATION REPORT

January 8, 1994

INVESTIGATOR: Yvonne Spyropoulos

PROJECT TITLE: Overcoming infertility in an age of assisted reproductive technologies

The proposal as currently described is

__X__ethically acceptable as is

_____ethically acceptable if changes below are met

_____ethically unacceptable

Problems with the project:

Require the researcher to:

K.W. TAYLOR,
Chair, Ethics Review Committee

APPENDIX E
INFORMATION SHEET AND CONSENT FORM

Overcoming Infertility in an Age of Assisted Reproductive Technologies

I am presently in the graduate program, in the Department of Sociology, at the University of Manitoba. In partial fulfilment for my Masters degree, a thesis is required. This thesis involves conducting a study that is relevant to sociology. The area I have decided to study relates to infertility and assisted reproductive technologies. The title of my study is "Overcoming Infertility in an Age of Assisted Reproductive Technologies." The research will involve interviews with women who have experienced infertility problems. The overall purpose is to discuss your feelings and experiences about motherhood, infertility and assisted reproduction, with a view to understanding the decision-making process that women use.

Your involvement in this study consists of an interview lasting approximately 60-90 minutes. This interview can be conducted wherever you feel most comfortable. I will be using an audio tape recorder, and I will take notes during our session. Our discussion will remain confidential and your identity will remain anonymous. You will also have a chance to review the transcripts. I will also send you a copy of the findings, if you would like. This study is completely voluntary, and you can withdraw your participation at any time. You may also decline to answer any questions you would rather not talk about.

Thank you very much. If you have any questions, or would like further information, please feel free to contact me, or my faculty advisor.

Evanthia (Yvonne) Spyropoulos, BA

Principal Investigator
Yvonne Spyropoulos
#10A-220 Hugo St. North
Winnipeg, Manitoba
R3M 2N3
(204) 475-8489

Faculty Advisor
Karen R. Grant Ph.D
Associate Dean
Faculty of Arts
University of Manitoba
Winnipeg, Manitoba
R3T 5V5
(204) 474-9912

Overcoming Infertility in an Age of Assisted Reproductive Technologies

CONSENT FORM

I, _____, agree to participate in the study, "Overcoming Infertility in an Age of Assisted Reproductive Technologies."

I have read the attached information sheet on this study. I have also been informed as to the nature and purpose of this study. I agree to meet for an interview of approximately 60-90 minutes to discuss my experiences and feelings with regard to motherhood, infertility, and assisted reproductive technologies. I agree to have my responses audio taped. My identity will not be revealed in published reports on this research. I have also been informed that I will be able to review the transcripts, and I will receive a summary of the results, if I so desire. I understand that the information gathered in the course of this research will be used in the preparation of a Master's Thesis in the Department of Sociology.

I understand that participation in this study is completely voluntary. I also understand that I can refuse to answer any questions, and that I may discontinue my participation at any time.

Do you wish to receive a summary of the findings?

[ ] I wish to receive a summary of the findings.
[ ] I do not wish to receive a summary of the findings.

_____
_____
(date) (signature in ink)

_____
_____
(date) (researcher)