

**AN EXPLORATORY STUDY OF INVOLUNTARILY CHILDLESS WOMEN'S
EXPERIENCE FROM POTENTIAL PARENTHOOD TO THE ACCEPTANCE
OF THEIR NON-PARENTHOOD STATUS.**

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ABSTRACT

We live in a society that continually reinforces the connection between femininity and maternity and for the majority of women, attempts to experience motherhood are successful. However, for others the world of motherhood is not so easy to enter. To date, research regarding the needs and life satisfaction of women who are unsuccessful in becoming mothers, is fairly limited.

The purpose of this study was to explore the transitional phase women endure from potential motherhood to non-motherhood and to highlight some of the complexities underpinning infertility and its impact on the lives of women in South Africa. The main objective was to gain deeper insight into how women incorporated this experience into their lives and relationships and how they began to create a future life without their own biological children. A secondary aim of this study was to investigate whether the women viewed aspects such as age and finances as having had an effect on their decision to discontinue treatment for infertility.

Feminist standpoint theory served as a theoretical framework for the study that recognized that each individual voice be heard. This study was a qualitative exploration, utilizing a short demographic questionnaire and an in-depth semi-structured interview. Five interviews were conducted with women from diverse backgrounds. These interviews were recorded; transcribed verbatim and thematic analysis of the data was conducted.

The following dominant themes emerged.

- Participants agreed that infertility had a negative impact on their lives. The main areas in which this negativity was felt included the emotional domain, leading to self-blame and eventually feelings of not being feminine.
- Each of the women reached a point when it became apparent that she could not continue with the process of actively pursuing biological motherhood. Particularly in the light of the physical discomfort, the financial burden and their age counting against them.
- The transitional phase highlighted the participants' attempts at establishing coping strategies and focusing on self enhancing activities. A general perception was the belief that it was God's will that they should remain childless.
- Living with this decision was seen to be difficult as the women came into contact with other women who are mothers. They were left with a sense of envy, and feeling marginalised.

It is hoped that this study will give credence to the silent voices of so many women in our society who have to deal with a condition that is normally cloaked in silence and only shared by infertile individuals.

DECLARATION

The author hereby declares that this entire thesis, unless specifically indicated to the contrary in the text, is her own work.

Signed: B.JURIES



Dated: 5 May 2005

DEDICATION

This thesis is dedicated to two of the most important people in my life:

To my dad, Sonny Abraham Edwards, whose sacrifices over the years to ensure that all his children are educated are highly appreciated. Thank you for all your encouragement, the pep-talks and the belief that I can do anything I set my mind to.

To my daughter, Jade Ann Juries, who had to share the attention with the computer.

Your unconditional love has made every second of this journey worthwhile. You truly are the sunshine in my life.



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Chapter 1

INTRODUCTION:

For many women the child begins when the decision is made to bear it. When a woman decides to become pregnant, her child, which hitherto had been only a potentially wanted thing, is transformed into an actually wanted thing. The child begins to exist. (Reinharz, 1987, p.9).

Infertility is a global phenomenon that can come as a devastating blow to the individual(s) concerned. An estimated one in ten couples around the world has difficulty conceiving at some point in their reproductive lives. In South Africa one in six couples are faced with the devastating impact of infertility and childlessness (www.vitalab.com). According to statistics about 15% of all South African couples of reproductive age have a fertility problem (www.vitalab.com).

Couples who would like to be parents but are unable to produce a biological child of their own suffer from the biological and/or perhaps the psychologically caused condition of infertility. They have the social status of being involuntarily childless (Matthews & Matthews, 1986). Unless otherwise noted, the terms infertility, involuntarily childless, involuntary childlessness and biological childlessness will be used interchangeably in this study to refer to the inability to conceive a child.

The causes of infertility are many and varied. Likewise, there are numerous and

diverse treatments for infertility, including procedures such as artificial insemination, In Vitro Fertilization (IVF), surrogacy and related treatments. Zoldbrod (1993) proposes that the pursuit of parenthood is becoming more accessible for previously marginalized groups (e.g., single women, lesbians), and increasing advancements in reproductive technologies and options are pushing the upper limits on when or if women choose to pursue a pregnancy. However, research indicates that fertility treatment works 20% of the time (Key, 1998). The lack of research focusing on the impact of the 80 % failure rate is quite conspicuous.

An increasing body of social science and biomedical evidence suggests that nearly 40-50% of infertility is attributable to problems suffered by men. Bernstein's (1999) findings indicate that the underlying cause of infertility may be a male factor (40%), a female factor (40%) or a combination (20%) of problems. In spite of these statistics women still bear the brunt of the blame for infertility problems. According to Horton (cited in Zoldbrod, 1993) the history of obstetrics and gynecology is littered with half-baked attempts by leading (male) members of the medical profession to blame women for involuntary childlessness. As a result, women may face guilt, anxiety, exposure to sometimes dangerous medical interventions, social ostracism, abuse, stigma and the threat of divorce or abandonment (Bharadwaj, 2002; Dyer, Abrahams, Hoffman & Van der Spuy, 2002)).

A study conducted by Gibson and Meyers (2002) indicates that in general women experience more negative effects than men throughout the entire involuntarily childless diagnostic and treatment process. Women experience a greater sense of loss of control than men, and have a greater tendency to blame themselves for the couple's infertility. Added to this, women are more likely to perceive childlessness as simply unacceptable. Many authors suggest that women experience a more difficult adjustment to infertility than their partners, due in large part to the emphasis in our society on the role of women as mothers (Gibson & Meyers, 2002; Walker, 1995).

There is substantial clinical and research literature available about the stressors, such as depression, anxiety and guilt involved in prolonged infertility treatment and difficulties in coping with a failed treatment (Baram, Tourtelot, Meuchler & Huang, 1988; Gibson & Meyers, 2002; Stanton, Tennen, Affleck & Mendoza, 1992, Zoldbrod, 1993). Attention has also focused on the challenges of making the transition to parenthood when medical intervention has been successful (Daniluk, 2001; Letherby, 1999; Matthews & Matthews, 1986). What has not been addressed in the research field is how individuals and couples whose treatment efforts were unsuccessful cope with the permanence of involuntary childlessness.

The rationale for this study is that very little is known about the consequences of involuntary childlessness for people who have abandoned their efforts to produce a child, or about how they significantly reconstruct their lives, or how they make decisions about their future after having been unable to conceive. My interest in this area was in gaining

deeper insight into how women personally and psychologically integrated this experience into their lives and relationships and how they began to construct a future life without their own biological children. Therefore, the focus of the current study was guided by the question: How do involuntarily childless women in South Africa make the transition from potential motherhood to non-motherhood?

This study aims to highlight some of the complexities underpinning infertility and its impact on the lives of women in South Africa. The main objective is to give a voice to the experiences of women whose attempts to conceive are unsuccessful. A secondary aim of this study undertakes to hopefully answer a few key issues such as whether the women feel that age, education and occupation, financial, marital, physical and emotional status influenced or forced their decision to discontinue treatment for infertility.



This study is located within a feminist theoretical framework. Specifically, a Feminist standpoint epistemology was utilised as it advocates that *it is expected that women should be able to reveal for the first time what women's experiences are* (Harding, 1987). Thus feminist research proposes research **for** rather than research merely **about** women (Oleson, 2000). Furthermore, it emphasises how the research process contributes to our understanding of the social world and the role of research in bringing about social change (Maynard & Purvis, 1994).

Consequently this study utilised a qualitative methodology in order to engage a small group of infertile women in discussing the sensitive topic of involuntary childlessness. A qualitative methodology allows for in-depth exploration of these women's lives, eliciting

common themes as well as individual meanings of infertility for the involuntarily childless. The research method included five semi-structured informal interviews, which were transcribed and analysed using thematic analysis.

As a synopsis, this is an exploratory study which aims to understand infertile women's acceptance of their childless status. It is estimated that further research in this area will provide insight into the world of the involuntarily childless.

Having briefly discussed involuntary childlessness and its impact on women, Chapter two will provide a more detailed overview of the scholarship in this area. Chapter three details the research procedure which includes the methodology, participants, procedure, data gathering and data analysis. Chapter four provides a discussion of the results in which themes are identified and the section ends with a summary of the results. Chapter five deals with the discussion of the limitations of this study and concludes with recommendations for future research.

Chapter 2

LITERATURE REVIEW

2.1 DEBATING THE DEFINITION OF INFERTILITY

Miall (1986) argues that the lack of consensus on the prevalence of infertility is a consequence of differing definitions of infertility, the varying periods of time over which it is studied, and a failure to differentiate analytically between the voluntarily childless and the involuntarily childless. This view was shared by participants in a study by Meyers (2001). The participants expressed unease with the commonly used definition of infertility, stating that the *inability to conceive after a year of unprotected intercourse* applies almost exclusively to married women or to women in heterosexual relationships. They questioned the different meanings of infertility to single women or lesbian women. They also expressed concern that recurrent miscarriages is conflated with the inability to conceive, and that male infertility, which is more difficult to diagnose, can remain hidden, is less readily treated and still places the burden of treatment on the female partner.

A distinction **is** made between primary infertility and secondary infertility. Primary infertility is characterized by a lack of conception after one year of regular intercourse without contraception, and if conception has never occurred before. Secondary infertility is diagnosed if conception does not occur following one or more births, or following

conception, the pregnancy is not carried to term. Scritchfield (1989) has argued that this medical definition of infertility is not only relative but time-bound in that difficulty in conceiving quickly is often confused with the inability to conceive ever. The use of a time-bound definition of infertility results in many non-sterile couples being counted as infertile, thus contributing to the illusion that infertility is on the increase.

While highlighting this issue, no distinction was made between primary and secondary infertility within this study. Rather the approach was that any biologically infertile woman, whatever the cause of infertility, is a prime candidate for this study. For the purpose of this study the following definition was utilised. Involuntary childlessness is defined as the inability to conceive in spite of repeated efforts over a period of one year or more, resulting in unanticipated and undesired childlessness (Sabatelli, Meth & Gavazzi, 1988).

In light of this debate it seems then also important to review how motherhood, femininity and womanhood are described or defined within the literature.

2.2 PERCEPTION OF MOTHERHOOD AND WOMANHOOD

The “motherhood” myth positions motherhood as easy, natural and wonderful, the peak of women’s achievements and the only reason for their existence (Lee, 1997).

Conceptions of womanhood and motherhood are based on the assumption that motherhood is essential to women and that motherhood must be based on biological or

genetic links (Miall, 1994). In essence motherhood is the central site of gender categorisation as well as contemporary public debates about women's proper place. McMahon (cited in Hays, 1998) refers to the "older definition" of motherhood as women's *master status*. Contrary to this view however, in contemporary societies women still continue to be defined predominantly in terms of their reproductive capacities. Infertile women repeatedly face the belief that having a child is central to femininity and that without the ability or the desire to have children, women are perceived as unfeminine and abnormal. Society still takes for granted that *woman* equals *mother* equals *wife* equals *adult*, and this assumption still remains a part of medical, political and public thinking (Letherby, 1999). Herman (1993) so fittingly states that the desire to be a mother is uniformly described as natural, psychologically fulfilling, praiseworthy, and so compelling that to have children is, to be born again.

Women who are distressed by their infertility often take on an identity of themselves as infertile, pushing aside other important identities such as friend, spouse or partner, or family member. The result is social separation and disconnections from others as these identities become unimportant while the identity as infertile becomes central (Herman, 1993).

Two major fertility norms predominate in society, i.e. the one is that all married couples should reproduce. The second is that all married couples should want to reproduce. In fact, childlessness whether voluntary (i.e. women choosing not to have children) or involuntary (i.e. women who would like to have children but who cannot conceive) has

been designated as a form of abnormal behaviour in that it is statistically unusual and violates prevailing norms of acceptable conduct. Veivers (cited in Miall, 1994) has noted that societal acceptance of the fertility norms of having and wanting children appears to be extremely strong, transcending sex, age, race, religion, ethnicity and social class divisions. Therefore, the issue of whether or not to have children has the most profound impact on women's lives. Such choices impact centrally on women's identity as either mother's or non-mothers (Meyers, 2001). Women's identity is so strongly tied to motherhood that a discussion on identity is critical.

2.3 PERCEPTION OF IDENTITY



Hays (1998) declares that identity is a huge concept, and so is the number of its public and private features. According to Waldner (2000), a woman's identity is closely tied to her ability to reproduce. Infertility therefore interferes with a positive definition of self, creating a more negative view of her body. Because women equate fertility with nurturing, infertility interferes with her ability to express her culturally defined primary role. Women without children must deal with the meaning of childlessness. Fisher (cited in Waldner, 2000) refers to this as women's gendered identity.

Social identity is understood as consisting of those aspects of an individual's self-image, positively or negatively valued, which derive from his/her membership of various social groups to which he/she belongs. Thus, social identity involves women's own construction of an identity as mothers informed by the discourse of motherhood,

interceded by the practice of mothering, but not a simple derivative of either (Walker, 1995). Involuntary childlessness and non-parenthood are likely to have as significant an impact on family and personal identity as parenthood itself. According to Matthews and Matthews (1986) identity is situated in that it is a person's sense of who he/she is in relation to a particular situation. Thus, infertile women perceive themselves as stigmatised and not fitting in.

2.4 STIGMA OF INFERTILITY

Goffman (cited in Miall, 1986) defines stigma as a potentially polluting substance, a characteristic which is deeply discrediting to its possessor.



Research indicates that involuntarily childless women view infertility as a stigmatising or shameful attribute in terms of self-identity and in terms of reported social censure. Notably, physically infertile women felt more personally stigmatised than women married to physically infertile men, who more actively managed information to protect their husbands from stigma (Miall, 1994).

In a study conducted by Dyer et al, (2002) women expressed the view that they felt especially stigmatized and ridiculed in their families and in their communities. Participants' described how they were sworn at, shouted at, cursed and victimized, seeing themselves as outcast, especially within their husbands' families.

Miall (1986) suggests that prior to the realisation of involuntary childlessness; the individual probably identifies him/herself as a normal, conforming member of society. It may be therefore, that social reaction to the disclosure of infertility plays a part in the establishment of a stigmatised identity.

Women regard involuntary childlessness as discreditable, negative, and as representing failure. In addition, most experienced anxiety, isolation, and conflict as they privately explored the possibility of personal infertility. To avoid feelings of personal inadequacy, many women exclude themselves from gatherings such as baby showers or avoid their pregnant friends prior to revealing their being involuntarily childless (Miall, 1986).



Dyer's et al, (2002) findings corroborate these views as the respondents indicated they experienced pressure especially at family gatherings and they felt reminded, both intentionally and unintentionally, of their different status as infertile women. The women felt left out of the picture, so when they found themselves at such gatherings, would just sit there and listen, feeling that they cannot talk to the women who have children. Their childlessness is therefore shrouded in silence and only discussed with their spouses.

2.5 BREAKING THE SILENCE

Baram et al (1988) looked at infertile couples' attitudes towards discussing fertility treatment. After their spouses, infertile individuals most often discussed their feelings about infertility with parents and close friends. Women were more likely than men to

discuss their feelings about infertility with others. When asked who knew that they were involved in treatment for infertility, respondents indicated that close friends and family members were most likely to be told about their experience.

The findings of Dyer et al, (2002) are in keeping with these views, indicating that participants felt that they could discuss their problem openly. However, the participants stated that their confidants were often someone who shared a similar background. Employers, co-workers and siblings were usually not told. Many sufferers of infertility do not want to admit to others that treatment had failed and do not want to deal with sympathy, questions, gossip or criticism regarding fertility treatment.



However, in a study done by Miall (1986) it was argued that since infertile women tend to view infertility as something negative and that it represents some sort of failure, they often find it difficult to disclose to their families and friends that they were having problems. Most individuals engage in secretive behavior during the process to establish whether they are infertile or undergoing infertility treatment. Within this silence many feelings are hidden with regard to whom to blame for this unbearable situation.

2.6 GENDER AND BLAME

Horton (1993) provided a brief review of research suggesting that infertility was viewed in the early part of the 20th Century as a defense against feared pregnancy or as the outcome of a conflict between motherhood and a career. This perspective provides the

subtle suggestion that the woman is the sole source of the problem, a perspective however that has conclusively been found to be incorrect.

Bharadwaj (2002) states that a prevalent tendency of society is to blame the woman for failed conception. Consequently, the accepted norm is that infertility in a couple stigmatises the wife as barren and the husband as sterile. In this manner the implication of sterility presents men with an opportunity to abandon barren wives and de-stigmatise themselves by opting out of childless marriages. For an infertile man, this amounts to a public accommodation of male pride. Such assertions of virility and public denial of infertility are made easier by an entrenched patriarchal order that permits men to blame their wives, hence rendering a woman socially barren and condemning her to carry the burden of male infertility.



Participants' in a study conducted in Cape Town indicated that they had to deal with being called *Idlolo*, meaning barren and *stjoekoe* (failure). Traditional customs, such as wearing a scarf until you have a child also contributes to put more pressure on women who suffer from infertility (Dyer et al, 2002).

In certain cultures the situation is complicated further by concepts of manhood and virility. Anthropologists have documented procreation theories that consider men wholly responsible for the creation of a child. Men are thought to ejaculate pre-formed fetuses into women, who bring them to fruition. In certain countries, e.g. North Africa, such

cultural ideas about reproduction obscure male infertility from social and medical scrutiny, since infertility is viewed as a woman's inability to carry the ejaculated fetus Bharadwaj (2002).

While the gender imbalance in the attribution of blame and responsibility for infertility is generally true, many infertile couples resist such patriarchal and pro-natalist societal pressures (Bharadwaj, 2002). Based on the fact that women do tend to blame themselves for their childlessness, it would therefore be interesting to review if males and females respond differently to infertility.



2.7 GENDER AND RESPONSES TO INFERTILITY

Phipps (1993) postulates that although the inability to have a child is often devastating to both partners, men and women have very different reactions to infertility. She argues that prior research has tended to concentrate on the woman's experience while virtually ignoring the man's. Her findings indicate that both sexes experience strong feelings of sorrow, isolation, urgency, guilt, and powerlessness. But as a rule how these feelings are expressed, is very different.

In general, women are more verbal and tend to seek out support during times of stress, while men use avoidance, minimisation, and denial and mute their emotions. Consequently these differences are accentuated during the infertility experience. For example Phipps's (1993) study showed that husbands often viewed their wives' need to

talk about their infertility as a demand for the husband to find a solution, while the wives saw it as a coping strategy. In turn, the wives were protective of their husbands and didn't always share their feelings with the men. Women also described more feelings of low self-esteem because of their inability to have a child than did their husbands. Men also expressed more concern as to whether a child was worth the ordeal of infertility treatment, particularly when they wanted to protect their wives from the emotional and physical effects.

The views of infertile couples are strongly influenced by societal attitudes towards parenthood; which leads to the focus on how infertility is constructed within society.



2.8 SOCIAL CONSTRUCTION OF INFERTILITY

Recent research has focused on the social construction and interpersonal effects of infertility. The social construction in many cultures is that men and women are meant to become parents and that women are especially socialized to become mothers (Gibson & Meyers, 2002, Walker, 1995). Dyer et al, (2002) found that most of the participants in their study considered fertility a primary function of being a woman. The women did not seem to question this role but were aware of the consequences if they did not fulfill their function.

Evidence suggests that after the first year of marriage, pressure for married couples to have children increases and peaks during the third and fourth year. Becoming a parent

will often corroborate feelings of self-worth and sexual identity when people have been socialised into that role. In essence, the social construction of the roles of mothers and fathers has become a part of the identities of men and women in our society.

A research study conducted by Miall (1994) concerned itself with the claims-making surrounding reproductive impairments and the social construction of involuntary childlessness. In particular, it explored the constructs of infertility held by community members, and considered the extent to which these constructs may influence their ability to act as social supports for childless couples. The findings indicate that everyday discourse reflects cultural constructions of “fertility and infertility”, positively as in a “fertile mind”, “pregnant with hope”, and a “fruitful enterprise” and negatively as in “fruitless labours”, “a sterile approach”, and “barren soil”.



In conclusion, women seem to submit to what they perceive as the consequence of infertility. Dyer et al, (2002) mention that Muslim participants disclosed that they feared their husbands might take a second wife as their religion allows a husband to have a second wife, with the blessing of the first wife. However, this blessing is not required from a woman who cannot conceive. I deemed it crucial therefore to look at the role religion plays in infertility.

2.9 THE ROLE OF RELIGION IN INFERTILITY

According to Layne (1997) this commitment to motherhood in western society has been attributed, in part, to the Judeo-Christian tradition which sees children as blessings from heaven and barrenness as a curse or punishment. The term Judeo-Christian was invented during World War II, when Christians started realizing how rude it was to rail against the Nazi's for violating Christian decency since so many of the Nazi victims were Jewish. According to Riba (2001) it was a superficial attempt to appear diverse and inclusive. Judeo-Christian was initially adopted out of altruistic motivations, i.e. trying to rally and unite the nation. Riba (2001) believes the term Judeo-Christian is overused and usually misused. She states that it really should only apply in certain very limited circumstances, because the difference between the religions is so broad and fundamental that it's rare to actually refer to both at the same time.

However, the Judeo-Christian religious traditions provide numerous models for being tested by God and triumphing over hardships by placing one's faith in God. Judeo-Christian narratives often plot loss and adversity as spiritually enriching; and child loss stands at the apex of the story. In fact, both traditions provide models for the sacrifice of one's child. In the Old Testament it was a human, Abraham, who proves his devotion to God by his willingness to sacrifice his son. In the New Testament it is God who sacrifices his only son for some higher purpose. These incidents provide models by which some would-have-been parents understand their loss (Layne, 1997; Riba, 2001).

The issue of loss for infertile individuals has been debated and researched for decades. As early as 1969 Kubler-Ross identified certain stages associated with death and dying. Kubler-Ross's popular work on the stages, led to quite a following as researchers interested in infertility applied these stages to the emotional responses of the infertile. Menning (1988) identified and discussed eight stages of emotional responses to infertility. A more in-depth discussion follows.

2.10 EMOTIONAL RESPONSES TO INFERTILITY

Within the field of infertility, there is considerable consensus about the type of feelings experienced by infertile individuals. Dyer et al, (2002) state that loss of self-esteem, anxiety, depression, hopelessness, guilt and marital difficulties are all recognised consequences of infertility.

The response process is seen as a succession of stages (Matthews & Matthews, 1986). Possible emotional responses to infertility include surprise (disbelief, shock), denial, anger (anxiety), isolation, guilt and inadequacy, depression, grief and resolution (Menning, 1988). A more in-depth discussion of each stage will follow.

▪ SURPRISE

Most adults take it for granted that they will have children, so the realisation of a fertility problem might come as quite a surprise. Individuals may feel distressed at the disruption of their life's plan.

- **DENIAL**

According to Menning (cited in Matthews & Matthews, 1986) the feeling of *this can't be happening to me* serves as a defense mechanism, especially in sudden diagnosis of absolute infertility, i.e. sterility. Findings signify that denial may alternate with defensive mourning during months of disillusionment or frustration before medical treatment is requested or seek (Menning, 1988). Matthews and Matthews (1986) state that there is evidence that this period of time usually ends once the couple is prepared to pursue medical investigation of their problem.

Van Keep and Schmidt-Elmendorff (1975) provided clinical support for the existence of a denial stage when they observed that personal happiness decreases when one cannot produce a hoped for child, but increases once medical advice is sought for the problem.

- **ANXIETY**

The infertile women may feel anxiety throughout the infertility experience. Anxiety may appear, subside and reappear (Menning, 1988). Zoldbrod (1993) states that women appear to experience higher levels of anxiety, depression and cognitive disturbance than men do.

- **ANGER**

Anger as a response to infertility is usually related to the loss of control involved in the treatment process (Matthews & Matthews, 1986). Anger is a typical and a powerful

feeling for infertile women resulting from a feeling that infertility is unfair. Research findings indicate that couples feel cheated out of something many take for granted. The infertile may direct their pain at child abusers, parents who undervalue their parenting, single mothers, etc. (Menning, 1988). Resentment may be felt against pregnant women, health care providers, family and friends who do not understand the stress and wide range of emotions associated with individual infertility. Lastly, anger towards the partner may be experienced as there may be conflict in the desire for treatment and resolution options.

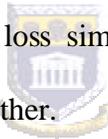
▪ **ISOLATION**

According to Matthews and Matthews (1986) the sense of isolation associated with infertility has received more attention than any other social psychological aspect. Menning (1988) attributes isolation to a combination of the following:

- The couple's felt need to keep their circumstance and treatment a secret in order to avoid being the object of pity and unwanted advice (Dyer et al, 2002; Miall, 1986).
- The couple's desire to withdraw from situations which bring them into contact with children or pregnant women (Dyer et al, 2002).
- A possible rift between the partners as they respond in different ways to their fertility problem (Dyer et al, 2002).

Zoldbrod (1993) expresses the view that men are more vulnerable than women in terms of their isolation from others as the traditional male sex role is threatened, leaving them feeling emasculated. Men therefore don't ask for support as their perception is that they should be supportive to their women.

The sense of isolation is further reinforced by the tendency of friends and relatives, who know of a couple's infertility, to avoid discussing the subject with them either out of embarrassment or from a desire to respect their privacy. Isolation also appears to result from the inability of infertile partners to be able to confide their feelings to one another (Letherby, 1999; Zoldbrod, 1993). According to Menning (1988) this is partly related to both partners experiencing a sense of loss simultaneously, and thus each having few emotional resources left to comfort the other.



▪ **GUILT AND INADEQUACY**

Guilt is a common response to infertility, and women seem to be more personally affected than men do. Some women experience infertility as a catastrophic role failure and consequently most women reported that infertility permeated every aspect of their lives. Self-incrimination and guilt often center on events in one's past that the infertile individual atones to the reasons for their infertility.

As stated earlier, one assumption being made is that infertility is a punishment by God for misdemeanors previously committed and that religion plays a major role in creating this

perception. Burgwyn (cited in Matthews & Matthews, 1986, p. 483) noted that Roman Catholic theology emphasizes that the sole purpose of sexual intercourse is procreation. He also cites the Talmudic statement that “He who has no children is as if he were dead.” Couples find it extremely difficult as they deal with their guilt, expressing anger at their God for the perceived injustice of having the burden of childlessness inflicted on them. This experience is perceived as a test of their faith, the belief in a fair and just God (Daniluk, 2001).

▪ **GRIEF AND DEPRESSION**

Grief often follows a diagnosis that infertility is permanent. The childbearing loss is real and it involves a loss of potential children, potential experiences and genetic links (Matthews & Matthews, 1986). More complicated is the personal nature of the infertility crisis. When infertility is certain, the grieving process may go unrecognised and unsupported. Menning (1988) suggests that the grieving may be difficult to express openly. Their ‘loss’ is of a **potential** and not an actual object and therefore may not be recognised as a loss; either by the infertile couple or those in their support system.

Baram et al, (1988) state that unsuccessful infertility treatment leads to sadness, anger and depression amongst couples and that these reactions were significantly more pronounced in women than in men. Their study indicated that almost all of the women (94%) reported symptoms of depression and anxiety following infertility treatment failure.

▪ RESOLUTION

The assumption is that at this stage you have worked through your powerful reactions to infertility and are ready to proceed with the rest of your life. Years of trying to conceive and of medical testing, a passage through surprise, denial, anger, isolation, guilt, depression, and grief, ultimately culminate either in a negative verdict or a decision by the couple to end the investigation and treatment process (Matthews & Matthews, 1986). Some writers suggest that infertile couples actually experience relief at finally being able to get on with their lives after years of dashed hopes (Daniluk, 2001). However, others suggest that resolution is rarely, if ever, complete. Baram et al, (1988) state that many infertile couples go through the classic stages of a grief reaction, i.e. anger, despair, detachment, and finally reorganization and acceptance. However, couples should be aware that they are at risk for experiencing an anniversary reaction. The reawakening of anger and grief could occur a year or more later on a significant date, i.e. a first menstrual cycle after unsuccessful infertility treatment, date of embryo transfer, etc.

With these different viewpoints in mind it stands to reason that the focus should therefore shift to parenthood vs. non-parenthood.

2.11 FOCUS ON PARENTHOOD vs. NON-PARENTHOOD

Matthews and Matthews (1986) posit that although the transition to parenthood has received considerable attention from social scientists the transition to non-parenthood experienced by couples who are involuntarily childless has received little consideration.

They state that the phenomenon of voluntary childlessness has been well studied by family life specialists such as Porter and Christopher, but the phenomenon of non-parenthood has been virtually ignored by family sociologists and psychologists. Porter and Christopher (cited in Matthews & Matthews, 1986) argued for the inclusion of material on infertility in courses and textbooks. They argue that just as couples have to make the transition to parenthood the same theory can be used to focus on the transition to non-parenthood. The involuntarily childless have also undergone a transition, from the anticipated status of potential parenthood to the unwanted status of non-parenthood.

According to Matthews and Matthews (1986) the involuntarily childless who are unable to make the transition to parenthood as they had anticipated, must undergo reality reconstruction, identity transformation and role readjustment. They argue for focusing on the social construction of reality, identity and role relationships of those who must undergo the often psychologically painful transition to non-parenthood.

In the only study that links directly to the views set out by the above mentioned researchers, Daniluk (2001), focused on how couples made the transition to biological childlessness after medical treatment has failed. The study looked at how couples who have abandoned their efforts to produce a child coped with the permanence of biological childlessness, as well as how couples meaningfully reconstruct their lives and make decisions about their future. The focus of this study was to discover the common meanings that the couples assign to their lives. This implies that the involuntarily childless have to re-envision their self and their lives based on the reality that they will

never know, i.e. what it is like to birth a child, to see the things they love most about their partners reflected in their offspring and to experience the sense of genetic continuity that for many is an important part of procreation (Daniluk, 2001). Referring to what Matthews and Matthews (cited in Daniluk, 2001), calls the reality reconstruction; couples had begun the process of incorporating the reality of their infertility and biological childlessness into their identity. This involved an acknowledgement of the many losses associated with this reality and an ability and willingness to reject the socially constructed link between fertility and self-worth. Findings in this study included a sense of being a survivor rather than a victim of circumstance; recognition of the gains associated with surviving infertility; integration of infertility into their self-structures; a renewed sense of efficacy and personal agency; strong sense of the rights of the infertile; a sense of normalcy and restored equilibrium, personally and in their relationships; and the feeling that their infertility experience is part of their past.

Emphasis in this study was also placed on identifying shared structures of meaning as couples. Reasons cited by couples for abandoning their procreative efforts included emotional exhaustion, health concerns, lack of financial resources, successful adoption and relationship strain. Limitations of this study included the fact that all the participants came from a white, middle class Canadian background (Daniluk, 2001).

However, this study provided the background to the current study with the hope of adding to the body of knowledge as participants in my study differed in terms of background and

status. Especially as there is a need to continue to work on developing ways of making the experiences of mothering available to women for whom fertility is problematic. As highlighted, there appears to be numerous gaps within this area which requires further investigation. The nature of this investigation is critical if situated knowledge that is less biased is to be obtained. Based on the views expressed, this study locates the issue of infertility within a feminist framework.

2.12 FERTILITY IN THE FEMINIST CONTEXT

Feminist scholars have argued that in western society, everything from childbirth to the reproductive freedom to use contraception, as well as abortion has been subject to medicalisation. Many female conditions have either been re-conceptualised as illnesses or understood in ways that indicate a deviation from some ideal biological standard. Feminists have argued that, although reproduction is, to a great extent, a social process, the cultural belief is that reproduction is primarily biological (Miall, 1994). From a feminist point of view, the medicalisation of involuntary childlessness in women reinforces biological constructions of women which, in turn, contribute to their continued oppression. Medicalisation also serves the interests of a medical-care system dominated by technology and a patriarchal capitalist economy (Riessman, 1989).

According to Layne (1997) feminists have worked hard to separate the evaluation of women's worth from their ability to bear children. A researcher named Sandelowski (1993) persuasively argues with regard to feminist stances regarding infertility, that one

must be careful not to condemn women (especially women who have difficulty) for wanting children.

2.13 FEMINIST THEORETICAL FRAMEWORK

As stated earlier, this study is embedded within a feminist theoretical framework as it provides the opportunity to look at non-parenthood from the perspective of the marginalized. Feminists have demonstrated that many women feel discrepancies between how they experience the world and the official or expert definition of their identity, for e.g. in relation to sexuality and motherhood. These discrepancies may result in guilt, fear, anxiety and feelings of ambivalence and exclusion (Letherby, 1999). Although the feminist approach situates the experience of childless women in a socio-political context, individual experiences of involuntary childlessness may feel personal and private. To ensure that participants' are provided with the best conditions in which to share their experiences, a Feminist Standpoint Theory will be utilized in this study.

2.14 FEMINIST STANDPOINT THEORY

Feminist standpoint theory is based upon post positivist critical theory informed by the political traditions of radical and socialist feminism as well as womanism. Working from the ontological assumption that there is no single objective truth, this theory claims that class, race, gender, and sexual orientation structure a person's understanding of reality. To survive, less powerful groups must be attuned to the culture of the dominant group. In

fact, these marginalized individuals have the potential for a more complete and less distorted views of social reality precisely because of their disadvantaged position (Hughes, 2002).

According to Standpoint theorist, Sandra Harding, the distinctive features of women's situation in a gender-stratified society are being used to produce empirically more accurate descriptions and theoretically richer explanations than does conventional research. The underlying philosophy is that differences between women's and men's situation give a scientific advantage to those who can make use of the differences. In gendered-stratified societies women and men are assigned different kinds of activities, consequently they lead lives that have significantly different contours and patterns. By using women's lives as grounds to criticize the dominant knowledge claims, i.e. based on the lives of men, the preconceptions and distortions can be decreased. Thus feminist research makes it possible for people to see the world in an enlarged perspective because they remove the covers and blinders that obscure knowledge and observation. Therefore, feminist standpoint epistemology reflects the way the world is and contributes to human emancipation (Harding, 1991).

According to another standpoint theorist, Hartsock (1987) by living out their lives in both the dominant culture and in their own culture, members of stigmatised groups can develop a type of double vision, and consequently a more comprehensive understanding of social reality. This standpoint, however, must be developed by appropriating one's

experiences through intellectual and political struggles against gender, race, class, and sexual orientation inequalities. The location of oppressed groups in comparison with their oppressors creates the potential for critical social analysis, but such a standpoint only emerges through consciousness raising experiences. Hence, standpoint theorists issue a challenge to find groups on the margins of social structures and actively engage them in describing their experiences and perceptions.

Practically, feminist standpoint research utilises a variety of methodologies (e.g., both qualitative and quantitative approaches) to engage research participants (typically members of oppressed groups) in reflection on how their gender, race, social class, and sexual orientation shape their experiences in the social world. In addition, from a feminist standpoint position researchers must reflect upon (and share with their readers) how their own social group status influences their interpretations of their data (Hartsock, 1987, 1998).

2.15 CONCLUSION

As mentioned before extensive literature exists about the attempts to “cure” non-motherhood through new reproductive technologies. Detailed discussion that validates the experiences of women who don’t mother children is still lacking. Therefore, the current study offers an exploration of women’s non-motherhood that is grounded not in medical or pathological discourses but in their own personal perspectives as biologically involuntarily childless women.

Chapter 3

METHODOLOGY

3.1 INTRODUCTION

According to Sarantakos (1998) the main principles of qualitative research center on fundamental concepts such as communication, understanding, subject and everyday life. In this study the focus was on understanding how women reconstruct their reality after accepting that they will remain childless. In this form of research, reality is created and explained in interaction. Therefore, in this process reality is constructed, explained, managed and presented (Lamnek, cited in Sarantakos, 1998). The purpose of this kind of research is therefore to identify the process of reality construction and the construction of patterns of meanings and actions. In the light of the above mentioned argument and since this study is exploratory in nature, it lends itself to a qualitative paradigm.

A feminist epistemology was utilized in order to create a setting within which women's voices would be heard.

3.2 FEMINIST QUALITATIVE RESEARCH

The argument for using a qualitative approach rather than quantitative enquiry to understand women's lives was embedded in a critique of what was perceived to be the dominant modes of doing research (Maynard & Purvis, 1994). Quantitative research was regarded as a 'masculinist' form of knowing, with the emphasis on the collection and measurement of "objective" social facts through a supposedly value-free form of data collection. Some feminist writers argued against this method stating that it translates

women's experiences into predetermined categories, which can result in distorting or silencing women's voices (Morawski, 1997).

The use of qualitative methods however focus more on the subjective experiences and meanings of those being researched and was regarded as more suitable to the kinds of knowledge that feminists wished to make available (Maynard & Purvis, 1994). According to Morawski (1997) qualitative methods were favoured because they were seen as correcting biases in quantitative methods. Because qualitative data are organised and evaluated subjectively in terms of themes, categories, and new concepts, they have been seen as more useful in capturing women's stories and legitimating those experiences as sources of knowledge.



Feminist research is defined by its values and processes (Campbell & Wasco, 2000). The political ideologies, i.e. liberal, radical, and socialist feminism, and womanism provide a conceptual foundation for creating feminist approaches to research. At an epistemological level, feminist social science legitimates women's lived experiences as sources of knowledge. The ordinary and extraordinary events of women's lives (in this instance infertile women's lives) are seen as worthy of critical reflection as they can inform our understanding of the social world. Feminist researchers creatively borrow and innovate from multiple styles in their search to escape damaging limitations of the dominant social relations and their schemes (Oleson, 2000).

Harding (1987) argues against the idea of a distinctive feminist method of research. According to Maynard and Purvis (1994) Harding usefully makes a distinction between discussions of method, methodology and of epistemology. She posits that there cannot be a feminist method since a method merely refers to techniques for gathering information. She states that “method” is often used to refer to two other aspects, i.e. methodology and epistemology. However, feminist research does not possess a methodology; instead it is a commitment to a specific feminist epistemology (Harding, 1987). Feminist researchers use all the traditional methods of research with the important difference that they listen carefully to how women informants think about their lives and men’s lives. Feminist research challenges and critiques the dominant gendered views held in society. At a methodological level therefore, the process of examining these experiences must reflect an ethic of respect, collaboration, and caring.

The different models of feminist research, i.e. feminist empiricism, feminist standpoint and postmodern feminist research mirror the way in which feminist epistemology critiques and challenges the dominant conceptions of knowledge, and explains the relationship between what is known and what can be known (Harding, 1987; 1991). At the same time it reflects the challenges faced by feminists to define feminist social research (Maynard & Purvis, 1994). The overarching goal of feminist epistemologies is to capture women's lived experiences, in a respectful manner, as legitimate sources of knowledge. In other words, the process of research is of as much importance as the

outcome. It attempts to eradicate sexist bias in research and find ways to capture women's voices that are consistent with feminist ideals.

Fonow and Cook (1991) refers to feminist research as *reflexive, woman-centered, the deconstruction of women's lived experiences, and the transformation of patriarchy and corresponding empowerment of women*. However, to some social scientists, these unfamiliar words and phrases do not really answer the question what feminist research is. To others, these words resonate with their understanding of a complex literature.

In summation then, feminist research seeks to respect, understand, and empower women.

It is important to note that the writings that define feminist research are dense, span multiple disciplines, are highly philosophical, inherently political, and as with all specialised discourses, full of jargon. My goal in this paper is not to debate or to attempt an answer regarding the question what feminist research is, but rather to provide an overview of the theory as it will be used in this study.

As stated earlier this study is located within feminist standpoint research. Standpoint theorists are by no means identical, and in their differing versions they offer divergent approaches for qualitative researchers (Oleson, 2000). The feminist standpoint as explained by Harding (1987, 1991) will be utilised in this study. Feminist standpoint theory strove to build on to and from women's experiences. This clearly indicates that the role of the researcher changes from observer to that of participant within the research process. In essence it is an attempt to redress power imbalances between the researcher

and the participants. According to the feminist standpoint thinkers a situated woman with experiences and knowledge specific to her, replaced the concept of an essential and universal woman. This includes the view that all knowledge claims are socially located and that some locations, especially those at the bottom of economic and social hierarchies, are better than others as starting points for seeking knowledge. Knowledge not only about those exacting women but knowledge about others as well (Oleson, 2000). The diversity of our women and their experiences can only contribute to the research field, which predominantly used white, middle and upper middle class women in previous studies on infertility.

3.3 PARTICIPANTS



The issue of infertility is a very sensitive aspect and multiple failed fertility treatments may lead to painful experiences. Therefore, obtaining participants for the study posed a huge challenge. Recruitment of the five participants took imagination and perseverance. As a means of recruiting participants for this study snowball sampling was used. Sarantakos (1998) defines snowball sampling as the researcher beginning the research with the few respondents available to her. The researcher subsequently asked these respondents to recommend any other persons who meet the criteria for the research and who might be willing to participate in the project. The researcher was aware of the fact that this method of sampling might and finally did influence the diversity of the participants, i.e. socio-economic class, race, infertility problem, etc. However, all other means of recruitment (e.g. posters at fertility clinics, support groups etc.) failed miserably

and therefore the study was continued with those participants who were willing to be part of the process.

By virtue of the sensitive nature of the research topic as well as the descriptive, in-depth nature of the approach a large number of participants were not required. Whilst it was not my objective to present this study as representative of all infertile South African women, attempts were made to include women from a variety of backgrounds (see Table 1). Although the study hoped to include women from all cultures (as it is important from a feminist standpoint to discover and understand women's diversity as well as aspects of cohesion) this search was futile.



However, although all participants were from the 'coloured' community they do come from a diversity of backgrounds, in terms of socio-economic class, educational background and age. The participants' ages varied between 28- 59 years. Four of the women were married and one is currently single. Most of the participants have been living in a specific neighborhood for quite a length of time. Only one participant has been in her neighborhood for only two years. Academic qualifications varied from a high school education to post graduate studies. Two of the five participants completed post graduate studies; one completed a four year teaching diploma and is presently lecturing at a technical college; one is retired; whilst one is currently employed as a community worker

at an NGO. One of the commonalities within this group of participants relates to religion as all of them are Christian. In terms of the results, women from different religious backgrounds or no religious backgrounds might have shared different views and influenced the findings. However, further discussion of this aspect will be found in the results chapter. The study also required that the participants be verbally fluent in English or Afrikaans and have the ability to communicate their feelings, thoughts and perceptions in relation to the phenomenon being researched. All participants were able to express themselves fluently in either or both these languages. Two of the participants expressed the wish to do the interview in Afrikaans as they felt they will be able to articulate themselves better. Please note that participants have been assigned pseudonyms, to distinguish between them, in an attempt to ensure confidentiality.



TABLE 1**Demographic details of participants.**

Participants	Age	Home Language	Religion	Marital Status	Education/ Occupation	Years at current address
Amy	30	English	Christian	Married	BA Honours: Student	10
Beth	40	English	Christian	Married	MA degree: Clinical Psychologist	18
Claire	28	Afrikaans	Christian 	Married	High school: Community worker	28
Des	36	English	Christian	Single	4 years teaching diploma: Lecturer	2
Ella	59	Afrikaans	Christian	Married	Matric: Floor manageress. Retired	29

The participants were required to fulfill the following criteria: The women must not have any biological children and must have abandoned their efforts to achieve a pregnancy. Their last fertility treatment must have been at least two years prior to the commencement of this study and the women must have had no intention of applying for adoption or surrogacy. The argument for this stipulation was that at this stage women would have been in the transition period for a length of time and might probably be ready to talk about their experience of the transition process.

The following table provides a detailed view of the suitability of these women to participate in the study.

TABLE 2

Fertility Treatment Details of Participants



Participants	Kind of treatment	Duration	Last treatment	Where done	Treatment Success	Support Structure
Amy	IVF	2 years	2000	Private	never	Husband
Beth	AI	3 years	1999	Private	never	Husband, Certain family members
Claire	IVF	1 year	1999	Public	never	Husband, spiritual leaders, friends
Des	Others (Fertility drugs, operation)	3 years	2000	Private	never	Parents, Brothers
Ella	Fertility drugs	6 months	1981	Public	never	Husband, family. friends

All the participants underwent a form of fertility treatment and none had a successful treatment. The different fertility treatments included In Vitro Fertilisation (IVF), Artificial Insemination (AI), fertility drugs as well as surgery. The duration of the treatment varied from six months to three years, whilst the last treatment varied from five years to twenty three years ago.

3.4 PROCEDURE

A researcher-generated personal and medical data sheet (Appendix 2) to gather relevant demographic and diagnostic information (i.e. age, race, socio-economic status, perception of remaining parenting options, source and duration of their fertility problem, extent of medical intervention undertaken, etc.) was completed by the participants. This data sheet provided conclusive evidence of participants' desirability for the study as well as provided background information on the fertility treatment they received.

A pilot interview was conducted which resulted in changes being made to the interview schedule as the collaboration between the researcher and the pilot interviewee indicated possible difficulties as well as gaps within the process. Questions had to be reviewed and formulated in a more structured manner as this interview ended up just focusing on the devastation of infertility as well as the traumatic experience of infertility treatment. As this was not the primary focus of the present study the questions had to be reworked. However, these experiences had to be acknowledged since it played a role in later decision making (as will be discussed in more detail in the results chapter) and therefore questions had to be structured more clearly. Nevertheless, it was also important to the

research process that a platform be created for the women to talk about the entire experience. Therefore, in-depth, semi-structured interviews, comprising mostly of open-ended questions, were conducted to gather the data (Appendix 1). The pilot interview did not form part of the data collection or data analysis process as the participant is currently in the adoption process.

The interviews were conducted in a setting preferred by the participants in which they felt comfortable. To ensure relationship continuity and to facilitate the development of trust all the women were interviewed in their homes. Attempts were made to conduct these interviews in an informal, non-threatening manner thus allowing for more flexibility in the interviews where the participants' understanding of their experience could be explored. As rapport was established during the interview process, answers or explanations were often accompanied by laughter which provided a warm, sometimes lighthearted and companionable atmosphere in which to complete the interview process. According to Sarantakos (1998), if research participants are to freely share their experiences and discover and express their understanding of these experiences, it is crucial that the interviewer be a receptive listener who can build rapport and trust. Maynard and Purvis (1994) argue for a genuine rather than, what they call an 'instrumental', rapport between researcher and researched. The assertion is that this encourages a non-exploitative relationship, where the person being studied is not treated merely as a source of data. In this manner research becomes a means of sharing

information and the personal involvement of the interviewer becomes an important component in establishing trust and thus obtaining good quality information. The interviews were tape-recorded with the permission of the participants. The use of a tape-recorder allowed for an accurate record of the interview and also allowed the researcher to concentrate all her attention on the participants. The researcher was aware that there are problems associated with the use of tape-recorders, i.e. the reluctance of some respondents to speak in front of a microphone (Sarantakos, 1998). However, since establishing trust and rapport with the participants was an essential part of the process; the tape-recorder was accepted without question by participants. Afterwards participants were requested to listen to their tapes and verify or add whatever information they regarded as missing from the conversation. Morawski (1997) mentions that one tangible way to realise a collaborative understanding is to engage participants in the collection, analysis, interpretation, and eventual evaluation of research. Re-listening to tapes provides a useful way of monitoring the legitimacy of the interpretation of participant's responses (Maynard & Purvis, 1994).

3.5 DATA ANALYSIS

The taped interviews were transcribed verbatim and the resulting texts analysed by using thematic analysis. Maynard and Purvis (1994) state that repeated listening to tapes of interviews with participants is an essential, yet often neglected area of analysis. An attempt was first of all made to extract broad themes from the transcripts and then

progress to identifying coded themes. In establishing themes, consideration was given to statements of meaning that were present in most of the relevant data. In line with feminist thinking, attempts were made to safeguard the distinctiveness of individual stories whilst also making comparisons. In an attempt to ensure the credibility of the findings independent coders were used to verify/corroborate the themes extracted from the data. The qualifications and interest of the coders will follow.

3.6 BACKGROUND HISTORY OF CODERS

Coder A

She has a PhD in Counselling Psychology with a keen interest in feminist theory. Besides managing a full time practice she also acts as an external examiner of theses for the University of South Africa.



Coder B

She has completed her internship in Research Psychology. Her postgraduate studies and internship included various projects using qualitative methodology.

3.7 ETHICAL CONSIDERATIONS

The women were informed that their participation is voluntary and that they could withdraw from the project at any time if they so wished. Participants were also told that counselling by a registered clinical psychologist would be provided if they required it. The researcher particularly asked one participant, who had periods of heart wrenching

tears during the interview, whether she would like to stop or whether she would like to see the psychologist. The participant however stated that she regarded the interview as therapeutic and wished to continue. Great care was taken to ensure that all information given during the interviews would remain strictly confidential and anonymous. Participants were informed that the tapes were at their disposal and once the analysis was done it would be returned to them, since the researcher was aware of the sensitive nature of the information.

3.8 REFLEXIVITY

Feminist research is characterised by a concern to document the subjective experience of doing research. Maynard and Purvis (1994) define this concern with reflexivity in two ways, i.e. reflecting upon, critically examining and exploring analytically the nature of the research process in an attempt to demonstrate the assumptions about gender (and increasingly race, disability and other oppressive relations) which are built into a specific project. Secondly, it can also refer to understanding the *intellectual autobiography* of researchers. Stanley and Wise, (cited in Maynard & Purvis, 1994) argue that the researcher is also a subject in her research and that her personal history is part of the process through which understanding and conclusions are reached. This means there is a need to be open and honest about the research process.

According to Sarantakos (1998) methods in qualitative research are designed to bring the

researcher closer to social reality and social interaction. The researcher is expected to become a part of the research environment and experience interaction as it is experienced by the respondents. Feminist researchers invest their personal experiences and emotions in the research process as a means of connecting with their respondents. The advantage of this altered dynamic is increased trust, which may enhance the quality of the data. The researcher was constantly aware of her subjectivity and influence on the research process because of her own experience with reproductive treatments. As a woman who had experienced multiple fertility treatments, I found myself very much a part of the process under investigation. I have experienced first hand the emotional roller coaster participants referred to, as I also had to come to a decision regarding my own future a few years ago. However, I chose a different path and hope that any bias on my part contributed positively towards this study.



Based on the participant-researcher relationship, feedback from all the participants was that the interview process, although eliciting emotional responses, was therapeutic. Participants also acknowledged that the interviews were bearable in that it was conducted by a woman who can identify with their stories and that reading the interviews later resulted in more clarity. In spite of the emotional responses participants felt they had to continue with the interviews since it was important to them that their voices were being heard and their views and opinions valued.

On a personal level it was at times overwhelming being immersed in this study. Often during a particular phase of the process I had to create distance between myself and this study. The research process at times became so emotionally stressful that my individual counselling sessions during this period was important. However, in retrospect these emotions played an important role in the quality of the analysis as it provided clear insight into the women's individual experiences, as well as allowing me the opportunity to clearly comprehend my own choices. It is also an undeniable fact that my personal struggle with infertility made me uniquely able to articulate the questions that needed to be asked and the sensitivity to ask them.



Chapter 4

RESULTS AND DISCUSSION

4.1 INTRODUCTION

Results of the analysis yielded many common themes in the lives of the women who have to live with being regarded as involuntarily childless. In this section attempts were made to categorize and understand salient themes. These themes include the following categories:

1. The negative impact of infertility.
2. Reasons for reviewing options.
3. The Transitional Phase
4. Acceptance of status as involuntarily childless.



Within each of these themes sub themes were identified. In-depth discussion of these sub-themes will follow in the following paragraphs. Furthermore, where noteworthy different opinions were voiced, these will be noted and regarded as divergent views. These themes are described in this chapter using the participants' own words wherever possible to explain the essence and meaning of the experience of being unable to produce a child for the women in this study.

4.2 THEMES

4.2.1 THE NEGATIVE IMPACT OF INFERTILITY

The sub-themes that characterized this component of the participants' experience included the following:

- Emotional impact of infertility.
- The issue of blame.
- Femininity in question.

EMOTIONAL IMPACT OF INFERTILITY:

Irrespective of whether these women suffered from primary or secondary infertility, the knowledge that they are unable to conceive forced them to live through a myriad of emotions, such as anger, sadness, depression and avoidance, obsession and even putting up a front. The feeling of anger was shared by four of the participants' who described these feelings as follows.

Amy: Um I was very angry, shocked cause I thought that one day I will definitely get married and have a child.

Des: The anger part was there it was there for a long time.

Claire: I think the pain makes me angry ... because the pain ... there are no tubes but yet the pain is there.

Beth: I have never before in my life felt so out of control. Such deep seated anger was new to me.

Most of the participants suffered through multiple-fertility treatments without the satisfaction of a positive result. They had to deal with a very personal event, that is the ability to conceive a child, over which they suddenly realised they had no control and which for them is now not a natural extension of their lives. There is an acknowledgement that the anger they experienced is linked with feelings of not being in control. These findings are also consistent with the findings of earlier research on infertility. As stated earlier in the literature feelings of anger is a typical response to infertility. Research findings identified three foci of such anger, namely: focused and rational anger at the pain and inconvenience of infertility tests, at the social pressure from family and friends, and the unthinking insults of people commenting on their childlessness (Dyer, et al, 2002, Menning, cited in Matthews & Matthews, 1986).



Matthews and Matthews (1986) discussed what they termed more irrational anger, which is focused at broader targets such as abortion rights advocates, people who appear to reproduce at will and those who mistreat children, anger at those who may control their potential parenting experience such as the fertility specialist, nurses and adoption workers. Previous research has also indicated that anger as a response to infertility is usually related to the loss of control involved in the treatment process (Gibson & Meyers, 2002, Menning, 1988).

What triggered these emotions and the reasons varied from participant to participant.

Amy elaborated and said when she first heard the news: *It felt like a slow death cause um even though you hanging on and trying to trying to come up you know it's in vain.*

This helplessness being experienced by the participant emphasised again the fact that these women found themselves in a situation, not of their making over which they had no control, just like we don't have any control over death. According to Matthews and Matthews (1986) responses to the realisation of personal infertility are often linked to the response stages of death and dying, as developed by Kubler-Ross. The idea expressed is that just as the living mourns the dead, so do the infertile mourn the fact that they cannot create the living. Couples expressed profound feelings of sadness and grief over the loss of the child they had hoped to create, referring to the "tragedy" of their infertility and their complete helplessness to "do a damn thing about it", (Matthews & Matthews, 1986; Menning, 1988). They struggled to reconcile the reality of their identity status that is, being involuntarily childless or infertile, compared to those who were fertile.

Claire, in spite of having taken care of her siblings, stated that *not being able to have my own child catapulted me into depression. I even became avoidant; I could never visit my friends immediately after giving birth to their babies.*

One of the participants who miscarried at six months and due to complications could then never again conceive summarized her feelings in the following manner: *For me it was so*

sad because I am someone who loves children and always asked God to bless me with children.

The women also reported that faced with the futility and hopelessness of their situation led them to having to deal with depression as they have to deal with their profound sense of loss at never being able to experience motherhood. These feelings of grief, loss and depression provide comprehensible proof that infertile women do go through specific stages, as precisely outlined in the literature reviewed. Layne (1997) states that the sense of real loss, created by infertility is associated with mourning and depression. This comes with the sense of failure and from the inability to accomplish the goal of building a family. Consequently infertility is viewed as encompassing a series of losses including loss of children, social role and self esteem. The emotional response to infertility has been characterised as a grief reaction.

THE ISSUE OF BLAME

In their search for answers and in an attempt to understand why infertility happened to them, all the women in the study blamed themselves for their condition.

Ella said: And I also thought that and wondered did I maybe do something wrong for which I am being punished now ... I mean this is a question that you always ask yourself when something happens to you or you don't get something. Then you think you've done something wrong ... did you sin or did you anger someone or what.

Amy explained her views in this manner: *I didn't know who to blame um because the problem was with me. I felt it was my fault so I blamed myself.*

Claire elaborated: *Yes, 50% of me say yes this is consequences. That is the word I want to use. I started dealing with the fact that this is consequences of actions. You have done things to your body and it had an impact that I never thought it would have, because when I look at my friends who have done the same things and they have kids. I think I have done something wrong. I was wild and was treated in a wild manner. I think it is my history of abuse that had an impact on my life and my future.*

B: In my anger I questioned God. I wanted to know what I did wrong that this had to happen to me. I always thought that I must have done something terrible and that is why God is not blessing me with a child.



The women clearly needed to understand why infertility happened to them and in this process questioned their behavior as a possible explanation for it. Guilt plays a major role in why these women blame themselves. They looked at their own lives through a magnifying glass in an attempt to find a reason for why this was bestowed upon them. It seemed as if the women were looking for a guilty act to put their infertility into a cause and effect relationships, for example failure of religious performance, do something terrible or sexual promiscuity. These guilt feelings seem to have led to the women trying to atone for whatever they imagined they did wrong, and mostly found it in religious support. As discussed in the earlier chapters of this study, research has established that

women do tend to blame themselves for the inability to conceive and feelings of guilt is one of the stages discussed in the literature chapter.

Matthews and Matthews (1986) stated that infertility is associated with a sense of guilt. This sense of guilt is a clear example of infertile women blaming themselves. Certain writers associate this guilt with the traditional Judeo-Christian belief that infertility is a punishment by God (Layne, 1997; Matthews & Matthews, 1986). Here they quote the Old Testament story of Rachel being made barren as punishment by God.

Menning (cited in Matthews & Matthews, 1986) indicates that many involuntarily childless women that she has treated regard infertility as a punishment from God for their premarital sexual activities. This view is clearly illustrated in Claire's belief that since she has done things in her past, she is now being punished, and in a sense that she deserves to be infertile. From these narratives it is quite clear that these women have endured quite a lot and their experiences clearly influenced their perception of themselves; which links to the third sub-theme in this category.

QUESTIONING FEMININITY

The literature reviewed focused on the important link between motherhood and femininity. As stated earlier the link between fertility and being a woman is so enforced by society that any deviation from this leads to a negative perception of the self. *Claire*

and *Beth* commented on how their infertility negatively influenced the way they perceived themselves:

Beth: Sitting with all these mothers and mothers-to-be chattering on and on about giving birth ...I felt so excluded and less a woman.

Claire stated: I thought this can't be happening, something is wrong with me. I am not a woman.

Amy for a while had a more positive outlook on her femininity after her infertility treatment caused her to menstruate for the first time.

Amy: Um and then when I first got my period even though it was only for three days I think um I was very thrilled. I felt very much like a woman.



The women in this study undoubtedly showed that they did and do buy into this notion of equating femininity with motherhood. Therefore, because they cannot conceive they don't truly feel like *a woman as dictated by society*, which is conceiving, giving birth, nurturing, etc. This negative view of their femininity had a profound effect on their self perception. This view of the self is adequately clarified by Fisher (cited in Hays, 1998) who stated that the cultural ideal of femininity implies that a woman's failure to become a mother means her failure to become a woman. Thus the culture provides women who become mothers with the resources to embrace the treasured identity of a caring, accountable, connected human being. In other words, this is the outcome of having a child and engaging in the practices of mothering; a world from which the participants are

excluded. The impact of their exclusion from the world of the fertile had an immense impact, both emotionally and physically, on the lives of these participants that finally choices had to be made. A new and different identity had to be created with little if any guidelines as to how to create it.

4.2.2 REASONS FOR TERMINATION OF TREATMENT

Participants openly spoke about their reasons for terminating treatment for infertility. By the time the participants reached the point where the active pursuit of biological motherhood was abandoned, they had generally invested several years of their lives and considerable financial, physical and emotional resources in their attempts to become biological mothers. Their reasons varied and included aspects such as:

- Finance.
- Age.
- Physical discomfort and suffering.

FINANCE

Infertility treatment can be an expensive undertaking especially as the procedure needed to become more specialised or if failure to conceive the first time leads to multiple treatments.

Claire discussed her options and why she had to terminate the treatment: *They explained that my only option was in vitro and the cost of the treatment range from R5000 upwards and there is only a 50-50 chance of success. Financially I realized I will never be able to afford a long drawn out process.*

Des explained her reasons stating: *I don't have money number 1 or I didn't think I'll have enough money and I definitely don't want to go through any struggling.*

Beth elaborated: *After the third unsuccessful attempt I finally realized that the treatment can drain my financial resources with still no guarantee of success.*

It is important to note, that with the exception of one participant, all of these women had to fund their treatment as it is not covered by medical aid. The high cost of the different treatments had implications as to how many times the participants could go through the process. This scenario also gives the impression of hands being forced, since without the necessary funds there cannot be a pursuit of treatment for infertility.

This knowledge can be regarded as a first since it provided information about women's reasons for not pursuing treatment, which hitherto had not been a major focus in the research field. Little research has been done on the extent to which differences in social class and employment status may affect the response of people to involuntary childlessness (Miall, 1994). It is also important to note that most studies on infertility utilised white middle-class women. Recruitment for these studies were also mostly

focused on fertility treatment centres using couples or women who were at that stage undergoing fertility treatment, and therefore had the financial means at their disposal. As stated earlier the participants in the current study included women from diverse backgrounds with different financial circumstances; indicating that the length to which certain participants could pursue treatment was limited.

Also, little research has been done on the extent to which differences in social class and employment status may affect the response of couples to involuntary childlessness. Findings of a study on social factors reported higher incidence of childlessness among lower income families and attribute this to lack of money for medical procedures such as artificial insemination (Matthews & Matthews, 1986). Even in the study by Daniluk (2001) more than 70% of the participants reported a combined yearly family income of \$50 000. Only 5% reported yearly earnings between \$15 000-\$25 000. The financial implication for pursuing a biological child by lower social classes can therefore be regarded as an important area for future research.

AGE

Some of the participants stated that their age also influenced their decision not to pursue treatment.

Beth and Des explained it in this manner:

Beth: *Besides the financial burden I realized that my age is also against me. I am not in my twenties anymore, so it was time to stop ...*

Des: *I think age was a major thing. The age because I was already over 30 and I thought I'm getting older and I don't want to be 50 and my children calls me granny or something like that.*

Age was an important factor as most of the participants were not so young anymore and therefore did not have the luxury of taking time out with the intention of trying again once they had the financial resources or had sufficiently recovered from a previous unsuccessful attempt. Options for the participants were therefore also limited.

Internationally current research on age focus on what they view as a widespread lack of understanding about aging as a risk factor for infertility, for example the possibility of more Down syndrome births -and a false sense of security about what science, that is treatment for infertility can do.

However, Baram et al, (1988) mentioned that 30% of respondents in their study indicated they would not re-enter an IVF program. Respondents cited various reasons for their decision. These included cost (41%), low success rate (23%), advanced age (14%), unwillingness to undergo more surgery or physical pain (14%) and emotional distress (16%).

As stated earlier, most of the studies on infertility used respondents/participants with a particular social background; that is white, middle to upper class individuals. These individuals were recruited mostly from fertility centres and therefore bias in the sense that these people had the means to pursue parenthood (Baram et al, 1988, Daniluk, 2001, Miall, 1986). These are also mostly international studies. The above mentioned themes in this section can therefore be regarded as fresh views as the women in this study varied in most aspects from previous studies.

PHYSICAL DISCOMFORT AND SUFFERING



In the hope of fulfilling the desire to have children participants relayed stories of the physical pain and discomfort they endured.

Ella clearly stated her dissatisfaction with what happened to her after losing her daughter:

It was a very difficult process, because the instruments that they used really hurt me.

Beth commented on her experience of infertility treatment: *The procedure is so invasive, cold and clinically conducted and so painful the only thing that kept me on that bed was my desire to have my own child.*

Claire daily has to endure physical discomfort after having both tubes removed due to an Ectopic pregnancy. She said: *I constantly have pain, I have infection and most days don't know whether I'm climbing on or off the bed.*

Amy summarised her experience in the following manner: *um apart from the emotional impacts um because um doctors wait for menstrual cycles which happens monthly, you have to undergo treatments month by month by month and what I couldn't handle was that I would always build myself up that this month was gonna be the month and then the next month ... nothing happens. So every month I went through this emotional roller coaster it just impacted on me so much um I went through a depression and so on. I just couldn't I couldn't go on anymore. I decided to stop the treatment and apart from... the side-effects it also became worse um I just felt I needed I needed to stop.*



In spite of their desire to have their dreams of being mothers fulfilled, it became a matter of how much physical discomfort any woman can endure before calling a halt to the treatment. The participants unmistakably found it exceedingly difficult to deal with the invasive treatment although the decision to stop was only made after enduring all the pain and trauma numerous times.

According to Hays (1998) choices about motherhood are highly conditioned by family histories, by financial and material resources, by the cultural groupings to which we belong, by our place in the marriage market, by the political and legal conditions of the

period, by our own physical and mental health and the health of those close to us. As circumstances change, choices may also change.

In identifying their motivations for abandoning their procreative efforts participants in Daniluk's (2001) study indicated the following: emotional exhaustion was by far the most frequently cited reason (50%), followed by health concerns (20%), successful adoption (15%), lack of financial resources (15%), and relationship strain (10%).

According to Daniluk (2001) women are left to make sense of their medical experiences and their infertility and have to construct a new life course for which there are few guidelines. Years of trying to conceive and of medical testing, a passage through surprise, denial, anger, isolation, guilt, depression, and grief ultimately culminate either in a negative verdict or a decision by the couple to end the investigation and treatment process.

Previous researchers suggest that infertile couples actually experience relief at being finally able to get on with their lives (Matthews & Matthews, 1986). A sense of closure develops as it seems they can continue with their lives after years of dashed hopes. However, my findings indicate that events occur throughout the lives of the infertile persons which serve to open wounds and renew old longings; which leads to the next major theme.

4.2.3 THE TRANSITIONAL PHASE

Participants expressed the view that they have been through a very challenging life experience and that they were fundamentally changed as a result of that experience.

One of the sub-themes that were identified is the following:

- The issue of God's will.

THE ISSUE OF GOD'S WILL

Having had to deal with all the futile attempts to conceive and having come face-to-face with the reality of their childlessness, the women found the strength to continue in the following areas. At the crossroads of their lives they found their faith sustaining them.



Des so very eloquently spoke about this aspect and her views: *I just decided I'm just gonna actually leave it in God's hands. So eventually it was uh it was just it was sort of a faith it was a lot of it was based on faith and I thought if I don't get married (which I actually still want to do) um and I don't have children then it's in God's hands. So if it doesn't include whatever I don't have whatever isn't in God's plan (laughing) but then you must know what is in God's plan for your life ja so um then I am happy ja. I wasn't always you know that I know that I wasn't always it took me all this time twenty years ...*

Ella said: *When my husband came to fetch me at the hospital the last time I was so sad again but then I realized I must accept and move on because it is the will of God.*

Amy: *I also believe that things happen for a reason. I believe that things are set out and things will happen in time if it's meant for you. Um and I also believe that sometimes*

things shouldn't be challenged. You should accept and move on and make the best of things. So at the moment though I'm still young enough I feel that I'll leave it in the Lord's hands. I am not gonna spend anymore money and go through anymore medication and suffer from side effects and from emotional impact. I'm rather gonna put it in God's hands ...

Beth: I could only let go of all my negative emotions once I truly understood what my purpose was. God was guiding my part and the future that I had so neatly planned for myself was definitely not in line with His will for me. Once I understood the concept let go and let God... things fell into place for me.



The participants' inability to have children was regarded, like Jesus, as their cross that they must carry. The women accepted the view that this was a burden; although they will live with it and deal with it because it is the will of God. They have put their faith in God and thus are able to deal with their fate. These views reported by the participants directly linked with the discussion earlier about the role of religion in child loss as well as the women's views that they must have done something wrong; leading to blame and feelings of guilt. As stated earlier, immersing themselves in religious doctrine is one way of dealing with the feelings of guilt and self blame.

According to Layne (1997) for many people, Christianity provides a useful framework for thinking about the meaning of their loss. To many would-be-parents and grieving

parents, Christianity provides the much-needed moral support and reason for pregnancy losses; depicting babies as angels in heaven where they are taken care of. The image of the baby in heaven acts as a key symbol for thinking about their loss and for sorting out complex and undifferentiated feelings and ideas, making them understandable to oneself, and communicable to others. For women who could not conceive at all, their grief is just as real and painful. According to Menning (1988) possibly more painful than if a real loss had occurred. Where real losses have various related rites which help overcome grief, infertility has no such rites. It should be recognized that the grief expressed is real, and no attempt should be made to prevent the women from expressing it.

It was therefore not really surprising to see the extent to which religious discourse was employed especially since all the participants in this study belongs to the Christian faith. The women indicated that they have found various ways to live with their childless status such as focusing on their god children, family's children, etc. However, the women seemed to experience a lot of mixed feelings regarding the choices they have made and that they sometimes question their decisions and wondered if they should have given it one more chance; which leads to a discussion of the following sub-themes, namely.

- Coping strategies.
- Ambivalence

COPING STRATEGIES

Participants indicated that there are days when the reality of life without children just becomes too much to handle, but that they have found ways to deal with it.

Des explained: *I don't I don't create a space to be morbid or whatever I don't really do that. I try to move away from that as quickly as possible maybe three days or so if something upsets me for three days or whatever if I become broody it's just doesn't have it won't be longer than about three days it will still be at the back of my mind but I'll try to do something else. Occupy my mind with something else. Because I think if you want something and you can't have it you are going to... somehow pieces of you parts of you are gonna die inside.*



Ella indicated: *I have evolved. During this time my emotions and how to handle it. I think I grew up and I also have a very good support structure.*

Beth stated: *Looking at this experience from the view point that it was not meant to be changed the way I saw my future. I spend a lot of time on self enrichment. I read a lot and hope to travel extensively in the near future. Also the fact that I have an understanding husband and a supportive family help when those bad moments creep up on me.*

Participants reported that having a coping strategy was important in order for them to continue their lives without children. Participants indicated various methods of coping that included depending on internal resources such as inner strength, self confidence, and

true acceptance of their fate; being able to rely on a support structure or trying to move on by focusing on the future.

Previous research had focused on coping skills indicating that some of these skills include the tendency to reframe problems so that they can become more manageable, accompanied by a low degree of denial and avoidance of issues. Apparently people using these coping skills, tend to be among those who cope better with infertility. Baram et al., (1988) stated in their findings that most women and men cited their ability to cope primarily because of their spouses as a source of support. Close friends and family members were also regarded as important sources.



AMBIVALENCE

As it is clearly stated in the previous chapter the decision to discontinue treatment is no guarantee that a complete mind-shift is possible. The decision made by these women is still questioned.

Amy: Um no I always wonder what if I had continued. What if I tried more alternatives. What if I could have endured the side-effects and the emotional impact and just bite through and go on? Um there is always a question that that things could have been different have I given it a chance and perhaps follow it through. So I find myself constantly thinking maybe even blaming myself some days. You know some days, I have

good days that where I tell myself I tried I went through it I experienced it and another I could not succeed but there are other days where I blame myself by saying you gave up. Why you were weak you couldn't handle it. So I am really torn between the two. Sometimes I have good days sometimes I have bad days and ...

Beth: Living with the decision not to pursue treatment has not been easy. I still sometimes wonder what would have happened if I just gave it one more try... but I realize that emotional rollercoaster that I was on would have eventually destroyed me. But still ... the maybes are there maybe if I tried something else, maybe if I tried a different facility and so it goes on and on...



Claire stated: This is reality this thing is in your face. There is one of two things you can do in this situation. You can either regress or go into a depression or you can work on those things that cause such pain.

As stated earlier in this discussion the women developed coping strategies to deal with their infertility, however these findings clearly indicate that for these women there is no such thing as closing this chapter of their lives by simply making a choice. These findings differ totally from those of Daniluk (2001) where participants regarded their decision to not pursue parenthood as closure thus allowing them to move on with their lives. A reason for this ambivalence might be that in Daniluk's longitudinal study some of the participants' midway decided on pursuing other options, such as adoption and

surrogacy. The women in the current study did not consider any other options and therefore do not have the hope of potential motherhood.

Baram et al. (1988) argued that after many unsuccessful treatments and the infertile going through stages of grief reaction, that is anger, despair, detachment, reorganization and finally acceptance, it is important for the infertile to discuss their feelings and concerns about their experience. In comparison most of the women in the current study indicated that being part of this study provided them with the opportunity to speak about their experiences for the first time. The findings also undoubtedly indicate that the women also went through the different emotional stages. These researchers then clearly state that the infertile should be aware that they are at risk for experiencing an anniversary reaction. This reawakening of anger and grief could occur a year or more later. If this is a possible explanation for the current findings around acceptance, it is a definite research question for a follow up study.

In conclusion, much has been written about the stressors inherent in dealing with failure with infertility treatment. However, it became quite clear that women do not only experience the emotional upheaval during treatments but rather the knowledge of never being able to conceive catapults the infertile on a never ending emotional rollercoaster.

4.2.4 ACCEPTANCE OF STATUS AS INVOLUNTARILY

CHILDLESS

The women in this study invested such a lot of energy in pursuing biological parenthood that it seemed when they had to let go and move on they felt they were ill prepared for living with their choice. They expressed the following view points.

SENSE OF MARGINALISATION

In dealing with the reality of the infertility the women in this study had to accept that they would forever be excluded from the club of biological motherhood of which most women are a part.



Amy: Um it's something that I've given over yes um but there will always be that little want you know when I see family members with children or I go to parties or I walk in a supermarket and I see a mother pushing a pram there is always a little gap inside of you that that wants , like I want my own child you know. I don't think it will ever go away. I think if I I reach the age where I can no longer reproduce um not that I can now but um normal biological age um I think I will have to accept it and live with it but I don't think I will ever over come it and to um to say it's over there will always be that little gap in my life.

Des: I'll feel sad for a moment or two when I see mothers with babies. I will like I said but it doesn't it's not going to go on for long when I leave here a day or two later it will be over.

Ella spoke about the way she feels when confronted with the current baby boom in her family: *Oh, you feel so bad, so excluded. It is so difficult to accept.*

Beth elaborated: *I hate nothing more than having to listen to mothers or mothers-to-be going on and on about babies. I feel so excluded that I consciously avoid these kinds of gatherings especially if it is a particularly low time in my life.*

Claire stated: *I still don't go visit my friends in the first few days after they have been discharged from hospital. I know I must put up a bright face so I try to avoid going as long as possible.*

All the participants reflected on the negative feelings they have to deal with when faced with a situation in which mothers and future mother's discussions led to them feeling excluded and isolated. This unmistakably indicates that the decision to remain childless does not mean the infertile miraculously overcome all the emotions they experienced during the pursuit of parenthood; instead when confronted with the situation all the old feelings of loss and feelings of exclusion and isolation returns.

Societal attitudes towards childlessness reinforce the marginal status of the infertile in a child-oriented society and their sense of isolation is heightened. Previous research indicated that the different experiences of the infertile separated them from their friends (Miall, 1986). According to Walker (1995) women who are mothers themselves feel and think about motherhood in a specific way and they develop a personal and individualised

self-image that is grounded in a social context. This indicates mother's recognition of themselves as part of a distinct social group; which is that of mothers. What infertile women have to deal with is the remarkable tenacity of the importance that continues to be attached to women's fertility; and this ensconce certain continuity in feelings of self-worth, celebration and power in many women's social identity as mothers, again a world in which the infertile women have no claims. Therefore, fertility continues to be highly valued by women and to inform their choices around motherhood (Walker, 1995).

ANGER AT INJUSTICE

Many of the women mentioned their difficulty in witnessing or hearing about children being battered and abused by their parents. They confessed that they have great difficulty reconciling why they, women who so desperately wanted children and have so much unconditional love to offer, were being denied the chance to produce and parent a child.

Ella: How can I express myself? When you witness these days how some people treat their children then you think why they have children. Why not me I would have taken better care of those children.

Claire: I look at my sister-in-law and think you are not married, you live in a shack and you have five children at the age of 29. What I would have been able to do in your shoes

...

Amy argued: *And it makes me so angry to the pit of my stomach when I see or read about these youngsters leaving children on the doorsteps because here I am who can provide a good home for the child.*

Participants reflected on the unfairness of their situation as they have the means or the desire to have a child but are denied this prerogative, whilst other women who in their opinion should not have children are fortunate enough to be blessed with children. They freely admit being envious, but also sometimes filled with anger especially when hearing or seeing a child being mistreated. As stated earlier in this discussion, research indicated that the involuntary childless experience strong feelings towards people who appear to reproduce at will and those who mistreat children (Matthews & Matthews, 1986, Menning, 1988).



SUPPORT

Whilst having to accept their fate and future as biologically childless individuals these women experienced a strong desire for support from their partners, family and friends.

Des stated: *People don't really ask. They leave me alone I think. I don't know, the family never asks. My mom and dad just encourage me to go out and find men (laughing).*

Ella experienced the following: *My whole family is very supportive and understanding. When I miscarried they took such good care of me and still do. My husband tells*

everybody I am his baby and he is my baby. This experience had brought us so much closer than before.

Beth: I am blessed with a supportive family who won't ask sensitive questions but just encourage me to do what makes me happy.

However, one respondent indicated the opposite happened to her where she had to constantly deal with people's preconceived ideas.

Claire explained: *The community in which I grew up taught me that when you get married, you must have a child otherwise there is something wrong with you.*

Her experience was made worse by the fact that her husband was not ready to give up the pursuit for children.



Claire said: *My husband really wants a baby. He has a son but he wants a baby.*

Throughout this chapter the importance of having a good support structure was mentioned repeatedly by the participants. This section is really confirmation of what a good support structure can mean for a woman who has to deal with such a major decision, that is to remain childless after years of this dream just being out of reach and now having to live a life they did not originally plan.

Earlier findings suggest that involuntarily childless women feel excluded from certain groups in society. Respondents referred to feeling left out in conversations with family,

friends and strangers. They also stated that it is rare for any discussion to take place in which parents don't mention their children and thus parenthood develops into the major theme. One respondent referred to this as the club to which I don't belong (Letherby, 1991). Thus it seems likely that events occur throughout the lives of infertile persons, which serve to open old wounds and renew old longings. However, infertile couples are expected to continue to live normal lives including being pleased for others who become pregnant, commiserating with those who find themselves pregnant and don't want to be, and going to baby showers.

4.3 OBSERVATION OF THE FINDINGS



Participants agreed that during the period of dealing with treatments and still living in hope of a solution to their infertility, they experienced tremendous negative emotions and their perceptions of themselves were also very negative and self-blame seemed to dominate. They found it difficult to negotiate their identities as women. They therefore found it extremely difficult to live in the world of the fertile. Participants constantly emphasized the emotional toll taken by infertility on their lives.

The process of dealing with the medical treatments and of having their lives *on hold* while awaiting the outcome of what sometimes seems to be an endless onslaught of treatments are painful and challenging. They spoke of the pain and humiliation of some

of the medical investigations and treatments. They reiterated their feelings of profound grief over these failed treatments.

Although reasons for terminating the treatment varied within this study, the decision was only made after years of attempting to enter the world of the fertile. The women had to deal with physical pain and discomfort, costly financial procedures, whilst all the while growing older each year. Indications are that conceiving the first time after treatment does not happen very often (Phipps, 1993).

Most participants acknowledged that there was little in their lives left untouched by this experience, and spoke of the difficulties of living on the social margins as infertile individuals in the world of the fertile. Progressively these women are faced with the difficult task of constructing identities, i.e. new plans, different expectations, a fulfilling world without a child as infertile women during the transitional phase. Their way of dealing with this process was to acknowledge that this was the will of God and that they have to accept it. However, these women buy into the dominant discourse within society of the mother as the emotional centre of the family and motherhood as women's destiny and the source of their deepest fulfillment and are left with questioning their decision every time they are face to face with the "picture perfect mother".

The prevailing feeling expressed by the participants is that closure is difficult. There are always too many reminders around emphasising what is lacking in their lives. It is interesting to note that only one participant spoke about being pressured to have a biological child, whilst the rest of the group experienced understanding and support from their partners, family and friends. This had a positive impact on the women regarding the choice that they made.

A summary of the dominant themes that emerged include the following.

- Participants agreed that infertility had a negative impact on their lives. The main areas in which this negativity was felt included the emotional domain, leading to self-blame and eventually feelings of not being feminine.
- Each of the women reached a point when it became apparent that she could not continue with the process of actively pursuing biological motherhood. Particularly in the light of the physical discomfort, the financial burden and their age counting against them.
- Living with this decision was seen to be difficult as the women came in contact with women who are mothers. They were left with a sense of envy, and feeling marginalised.
- The transitional phase highlighted the participants attempt at establishing coping strategies and focusing on self enhancing activities. A general perception was the belief that it was God's will that they should remain childless.

The results, as well as the literature reviewed, showed a great tendency amongst infertile individuals to regard their infertility as the will of God. It seems as if the desire to have a child is among the strongest emotions that people experience. Therefore, it is not surprising that infertility has been considered to be life's worst experience by those who suffer from it (Dyer et al, 2002). For many women infertility is as much an emotional and spiritual crisis as it is a physical challenge. This study indicates that religious beliefs play an important role in how infertile women make sense of their infertility as well as how they deal with the reality of their childlessness. The literature clearly indicates that ambivalence does seem to exist around the will of God. On the one hand, infertile women expressed the belief that a righteous God will provide, that whatever happens their faith will sustain them. However, views of a more vengeful God were also expressed. Some women thought their infertility is punishment by God for some misdemeanor such as sexual promiscuity or premarital sex, (Dyer et al, 2002; Walker, 1995). The question that needs answering is where does these views originate? Is it based on societal views, deeply ingrained by how we are raised, etc? Possibilities seem endless. Answers to these questions are not clear in the literature, although I should mention that infertility has existed since biblical times. The bible also clearly expresses different views; that is that Sarah was blessed with a child at a very advanced age, whilst Rebecca was punished with infertility. Can the possible reason for this belief originate from the affirmation of these thoughts within biblical doctrines? The results of this study clearly provide opportunities for further investigation.

The advantage of using a feminist epistemology in this study is firstly that it provided the opportunity for individuals to be personally empowered through their participation in the research project. For some of the women their participation allowed them the freedom to openly express their feelings and thoughts about their infertility for the first time, without having to worry about not being understood, judged or pitied. Secondly, through their contribution to making visible a social issue, that is infertility, participants experienced the therapeutic effect of being able to reflect on and re-evaluate their experiences. It also provided the setting for the researcher to experience these results and be empowered as well. Feminist research includes the researcher as a person and frequently attempts to develop special relationships with the people studied (Sarantakos, 1998). In my opinion, applying the Feminist Standpoint Theory was an appropriate approach as it allowed for the opportunity to pursue answers to an event so personal and filled with so much emotion, with the necessary sensitivity and awareness of the roles of both the researcher and the researched. It was therefore the applicable approach to use.

CHAPTER 5

LIMITATIONS AND RECOMMENDATIONS

5.1 LIMITATIONS OF THE STUDY

In an attempt to understand the implications of these findings it is necessary to firstly address the limitations of the participants. Despite my best intentions and considerable effort to recruit participants from more diverse backgrounds, there was no ethnic/racial variation in this sample. Those who agreed to participate in the study were all from the 'coloured' community, of the Christian faith and relatively well educated.



It is nonetheless important to realize that the transition to biological childlessness may not be the same for those from different ethnic or cultural backgrounds in which fertility is even more highly valued. Secondly, it might also be different for those for which few other possible parenting options, for example adoption are available.

Being limited to all heterosexual individuals which included only one single woman also means that the study does not provide information about the adaptation of single or lesbian women who unsuccessfully pursue treatment for infertility.

Using a quantitative approach in this study might more clearly have shown the extent and the severity of involuntary childlessness amongst South African women, as the size of the sample would have been much bigger, although that was not the aim of the current study.

In retrospect, maybe arguing for the use of both quantitative and qualitative approaches in this study should have been an option. The use of both quantitative and qualitative methods within feminist research had been debated for years, seeming to encompass recognition of the need for breadth as well as depth of information (Maynard & Purvis, 1994; Sarantakos, 1998). Maynard and Purvis (1994), state that the division of quantitative versus qualitative impoverishes research and that there have been calls for the use of multiple methods to be used in a complimentary rather than a competitive way.

Oleson (2000) in her critique of Standpoint theory questioned the degree to which women's experiences can be equated with knowledge, without detailed interpretations of how these experiences have emerged based on the material, historical and social circumstances of this experience. Although some of the context in which these women's experiences occurred was explored in this study, the researcher made no attempt to give a richer and more detailed understanding of all the circumstances. In spite of the limitations it is hoped that the study gave a voice to infertile women and highlighted the women's continuous plight in living with biological childlessness.

Oleson (2000) also states that it must be remembered that within the context of feminist research knowledge is an ongoing, dynamic process. Therefore, the researcher is aware that the knowledge gained in this study is only partial knowledge and can only be

regarded as a transitory platform for action and reform as new topics and new issues of concern in women's lives emerge.

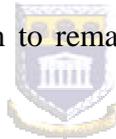
5.2 RECOMMENDATIONS OF THE STUDY

As stated in earlier chapters of this study, there is a lack of information regarding the personal experience of infertile women. Therefore, there is a definite need for research focusing on the effect of infertility on South African women who decide to remain childless. As clearly stated by some participants and underwritten by the literature reviewed in this study, it appears that to be infertile and the decision to remain childless, still marginalises women. Pressured by what is apparently the norm, infertile women are prone to blame themselves and find it difficult to live with their decision. More in-depth research into this area must be conducted to give a voice to these women.

Using the feminist standpoint epistemology provided the opportunity to break down taken-for-granted concepts and rebuilding them into new entities. The idea is to lay bare the essential concepts of the research and use this as a basis for revealing what is going on. From the perspective of feminists and as women it is important that we take cognisance of our own beliefs regarding advanced reproductive technologies, the pervasive reinforcement of patriarchal control over women's bodies and their reproductive capacity. Numerous research studies praise the value and success of these treatments, never focusing on the negative impact that it has on the women undergoing the treatment. The idea of the end justifying the means in this regard is totally

unacceptable. More studies should focus on the trauma and discomfort that infertile women suffer during these highly technical treatment processes.

This study is an initial attempt to examine South African women's experience of the transition from potential motherhood to non-motherhood and how they deal with their involuntary childlessness, and therefore, far from conclusive. Yet the research also points out many of the difficulties that future researchers interested in the study of infertility will encounter. In addition, the research directs the attention of researchers and other interested parties to the impact of infertility on individuals as well as the difficulty of living with the decision to remain childless. As outlined by this study and based on how these five women regard their decision to remain childless, future research in this area needs to be undertaken.



5.3 CONCLUSION

As stated in an earlier chapter of this study the main aim was to highlight some of the complexities underpinning infertility and its impact on the lives of South African women. The main objective was to give a voice to the experiences of women in South Africa whose attempts to conceive were unsuccessful.

Findings indicated that infertility had a negative impact on the lives of the women. The main areas in which this negativity was felt included the emotional domain, leading to self-blame and eventually feelings of not being feminine. Each of the women had to deal

with the fact that the pursuit of biological motherhood has ended, particularly in the light of the physical discomfort, the financial burden and their age counting against them. The women attempted to establish coping strategies and focused on self enhancing activities during the period of transition. A general perception was the belief that it was God's will that they should remain childless. Last but not least it seems that the decision was difficult as the women came in contact with women who are mothers. They were left with a sense of envy, and feeling marginalised.

It is apparent from this study that the decision to abandon treatment and accept that they will never be admitted to the club of biological motherhood presents a difficult task for the infertile women. A task influenced by a number of individual, situational and relationship factors as discussed in the previous chapter. For most of the women in this study acceptance and living with the idea of childlessness is difficult.

Further research in this area is needed to fully comprehend the impact of infertility on individuals who want to have children but are unable to conceive. It would be helpful to do the present study with more participants, especially persons of different ethnic backgrounds and sexual orientation.

Daniluk (2001) argues in her study on transition that we need to remain cognisant of the relative absence of socially sanctioned role alternatives for adult women, and of the

implicit cultural assumption that motherhood is intrinsic and essential to adult female identity and a meaningful life.

In the final analysis, the complex and as yet unresolved issue confronting researchers is to find ways of empowering infertile women caught within the entrenched patriarchal expectations of motherhood.



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APPENDIX 1

Interview schedule

1. Explain how you felt when you first realized that you have fertility problems?
2. Tell me about your experience with fertility treatment.
3. What impact, if any, did this experience have on your life.
4. What was the reaction of your family on your childlessness?
5. Did family/community pressure have anything to do with your desire to have a child?
6. Explain how you dealt with situations in which others (family members/friends) have their children along. 
6. Why did you decide not to pursue treatment anymore?
7. How did you accomplish the mind shift to non-motherhood?
8. How do you approach your childlessness at this stage?

APPENDIX 2

Confidential

Complete the following questions by either writing in the answer *or* making a cross (X) in the appropriate column.

Home Language	
----------------------	--

Age	
------------	--

Religion	
-----------------	--

Marital status	
-----------------------	--

Qualifications	
-----------------------	--

Occupation	
-------------------	--



Years at current address	
---------------------------------	--

Type of fertility treatment explored:

Artificial Insemination	
In-vitro Fertilization	
IUCC	
Donor Insemination	
Surrogacy	
Other (specify)	

Duration of treatment:

Date of last treatment:

Where treatment was done:

Treatment success:

Never	Once	Other (specify)
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Support Structure:.....

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