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SOCIAL CONSEQUENCES OF DELAYED CHILDBEARING AND INFERTILITY

by

JOAN LIEBMANN-SMITH

A dissertation submitted to the Graduate Faculty in  
Sociology in partial fulfillment of the requirements for  
for the degree of Doctor of Philosophy, The City University  
of New York.

1995

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This manuscript has been read and accepted for the Graduate Faculty in Sociology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

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## Abstract

### SOCIAL CONSEQUENCES OF DELAYED CHILDBEARING AND INFERTILITY

by

Joan Liebmann-Smith

Advisor: Professor Samuel W. Bloom

This is a qualitative longitudinal study of delayed childbearing and infertility. The initial sample consisted of 35 women. Although they knew they might never have biological children, most did not regret postponing parenthood.

Because infertility is a socially defined illness, the doctor-patient relationship was fraught with conflict. It tended to follow a set pattern: from *dependency* to *disappointment* to *discord* to *dissociation*. The optimal doctor-patient relationship was mutual participation.

Infertility adversely affected marriages. The "medicalization of masturbation" and intercourse caused many marital problems. Couples also argued over how often and with whom to discuss infertility, when to stop treatment and whether to adopt. Those marriages that fared best were those in which the husbands were involved in infertility and its treatment. Despite marital problems, most women felt that their marriages were ultimately strengthened by

infertility.

Because of the women's hypersensitivity and the insensitivity of others, relationships with relatives and friends -- especially pregnant friends -- often suffered. Careers were also adversely affected, and often put on hold. Those who maintained active involvement in their careers fared better emotionally than those who lost interest. Most women experienced feelings of loss, guilt, and poor self-esteems, and sought different methods for coping. Some depended mainly on *intrapersonal coping mechanisms*, such as religion, philosophy and superstition. However, it was primarily the *interpersonal coping mechanisms* -- especially spousal support and support groups -- which were the most beneficial.

In the follow-up component, 10 of the original sample were re-interviewed more than a decade later. Most still did not regret delaying childbearing, and were happy with how they resolved their infertility.

Infertility did have some long-term effects on these women. It remained a permanent part of their identities. Some sex lives and marriages never recovered. Most who gave birth or adopted felt that infertility had positive effects on their parenting styles. They felt they appreciated their children more, and as older parents, they were more patient and tolerant.

Finally, this study found that while the trend toward delayed childbearing continued, the definition changed from 30 and above in the early 1980's to 35 or even 40 in the 1990's.

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relentlessly pursue pregnancy. Her patience with my long hours and short temper during the writing of this dissertation are much appreciated. And without my husband Richard's birthday present of the time, encouragement and financial support to finish this dissertation, I never would have returned to graduate school and completed it. I can never thank him enough.

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CHAPTER ONE  
DELAYED CHILDBEARING AND INFERTILITY

INTRODUCTION

The decision to become a parent is a profound one. Unlike most other choices an individual makes, parenthood is irrevocable and involves a life-time commitment (Rossi 1968). At some point in their lives, most couples choose to become parents. The timing of that decision has important ramifications for the couple and for the individual spouses as well. However, decisions about childbearing have especially significant implications for a woman -- it is the woman who becomes pregnant, gives birth, and is primarily responsible for child-care. In addition, a woman's reproductive years are limited by her "biological clock."

Over the past two decades, increasing numbers of American women have chosen to delay childbearing until they are in their 30's or even 40's (Veevers 1973; Daniels and Weingarten 1982; Frankel and Wise 1982; Mosher and Pratt 1990). In our pronatalist society, when couples marry, they are expected to have children soon afterwards (Blake 1974). Because of these normative expectations and pressures to have children, the decision to put off having children is often not an easy one to make (Rindfuss et al. 1988).

Women postpone motherhood for a myriad of reasons -- career concerns, late marriage, ambivalence, marital discord, and financial constraints among others. Some women delay because their husbands are unwilling or not ready to have children (Fox 1982; Gerson 1985; Walter 1986).

But delaying having children, like having children, is not without consequences. Veivers (1973), for example found that two-thirds of women who decided to delay childbearing wound up childless. In addition to social-psychological causes of childlessness, physiological factors play a major role. The longer a woman delays childbearing, the harder it becomes to conceive (Gray 1979; CESOS 1982; Wilcox and Mosher 1994). Since the mid 70's, doctors have been seeing increasing numbers of patients with fertility problems, and most of the increase is accounted for by older women who had delayed childbearing (Daniels and Weingarten 1979; O'Connell 1991). This means that many women who postpone motherhood ultimately discover they are infertile -- they have difficulty conceiving or carrying a pregnancy to full term.

This has significant ramifications for them. After making what they thought was a social decision -- to become a mother, these women find that they have to deal with what modern industrial society has defined as a "medical" condition -- infertility. But is infertility really a medical condition? I would argue that infertility is better conceptualized as a socially defined condition that has

medical and social implications. It is the social implications and experiences of infertility that are of sociological interest.

This dissertation is a study of the consequences of delayed childbearing and infertility. It focuses on the social impact that infertility has on women who postponed parenthood.

This study addresses the following questions:

- 1) Why do women delay childbearing and then decide to pursue motherhood?
- 2) What happens when their desire to fulfill the social role of parent is thwarted by a "medical" condition -- infertility?
- 3) What impact does infertility have on a woman's life?
- 4) What, if any, are the long-term effects of infertility?

More specifically, this dissertation investigates how infertility affects a woman's marriage and sex life, her relationships with her doctors, friends and relatives and co-workers, her career and her self-esteem. It also looks at how women cope with and ultimately resolve their infertility. The long-term impact of infertility on a woman's relationships, career, self-esteem and parenting are also addressed.

### The Trend Toward Delayed Childbearing

Delayed childbearing has been defined by demographers, social scientists and physicians as the postponement of parenthood to age 30 or older. This trend toward delaying childbearing began in the mid 1970's (Veevers 1973; Daniels and Weingarten 1982). Initially, it was women in their late 20's to early 30's who were delaying childbearing. More recently, however, women in their mid 30's through early 40's have been postponing parenthood in increasing numbers (Rindfuss et al. 1988; Mosher and Pratt 1990).

One indication of the trend toward delayed childbearing is the increase in fertility rate for women in their 30's. Since 1976, when the US fertility rate hit its all-time low, the only age group that showed significant increases in fertility rates was women between 30 and 39 (O'Connell 1991). Indeed, it was women over 30 who were primarily responsible for the fact that in 1989, the number of annual births topped the four million level for the first time in 25 years (Ibid.) This, in part, is due to the aging of the "baby boom" generation, those born between 1946 and 1964. These baby boomers account for the large increase in number of older women of childbearing age (Menken et al. 1986), as well as the large number of women who are delaying childbearing until their 30's or 40's.

Another indication of this trend is the increase in the

absolute number of older childless women. Not only has the fertility rate of women in their 30's increased significantly, but so has their rate of childlessness. Between 1975 and 1985, the childlessness rate more than doubled for married women between 30 and 34 (Bachu 1992). While some of these older childless women may have chosen to be permanently childfree, most are childless because they delayed childbearing (Chandra and Mosher 1994).

Clearly the trend toward delayed childbearing is real and persistent. Why are women delaying childbearing in record numbers? One major reason is another trend -- late marriage (Pebley 1981; O'Connell 1991). It is not surprising that women who marry later, have their children later. But couples delay childbearing for other reasons which include economic, interpersonal, psychological, and political factors. (Daniels and Weingarten 1979).

The women's movement, which encouraged women to postpone marriage and family life until their educations were complete and their careers established, has been considered a major contributing factor in both the delay in age of first marriage and the delay in childbearing (Pebley 1981; Frankel and Wise 1982; Rindfuss et al. 1988). Higher educational attainment and the resulting increased involvement and opportunities in the labor force -- which are themselves, in part, the result of the Women's Movement -- are also major contributing factors (Bloom and Trussell

1984; O'Connell 1991). In fact, college-educated women who are either continuing their education or are working in the labor force are primarily responsible for this trend toward delayed childbearing (O'Connell 1992). Daniels and Weingarten (1982) found that most women who postponed motherhood in their study did so for career reasons -- they wanted to have their careers well-established before embarking on the unknown -- the career of motherhood.

In addition to the above factors, the "contraceptive revolution" had a tremendous impact on the reproductive decisions of the baby boomers. For the first time, women were able to both effectively control fertility and have available to them, safe and legal abortions (Daniels and Weingarten 1979). In 1973 when abortion became legal, women in the United States -- theoretically at least -- had total control of their reproductive lives. It was finally possible for most American women to choose not to have children or to delay having them until they felt ready.

With the ability to control fertility, live longer, have children later and have fewer children, women can now spend considerably fewer years having and caring for small children (Ibid.). This allows them to postpone parenthood, if they choose, and to pursue education, careers or other interests both before and after childbearing and childrearing.

### Childbearing Decisions

However seriously decisions about childbearing are made, they are not written in stone. As a result of unexpected life changes and events, people often reassess their childbearing decisions (Rindfuss et al. 1988). Couples may decide to have children earlier than planned, later than planned or not have children at all. In fact, Daniels and Weingarten (1982) found that plans about the timing of fertility did not pan out for almost 40% of the women they studied. According to Rindfuss and Bumpass (1979),

The longer a woman postpones bearing a child...the greater is the probability that she will participate in other ego-involved activities that consume time and energy. These activities may take the form of a career, completion of education, volunteer work, or pursuit of avocational interests. Whatever form they take, they compete with childbearing and childrearing for the woman's time and attention (p. 226).

It is not only social factors that influence the timing of parenthood. Biological factors also play a major role. An unplanned pregnancy may interfere with any previous decisions a couple made about childbearing. Or, as happened to the women in this study, a couple may discover they have a fertility problem.

### Pursuing Pregnancy

Women decide to pursue pregnancy for as many reasons as they decide to postpone pregnancy. When a woman who delays childbearing finally decides to have a child, is her decision related to her decision to postpone pregnancy in the first place? Have career or educational goals been met, marital problems resolved, finances improved, or her husband changed his mind about having children? Or is the decision to pursue pregnancy unrelated to any previous factors -- does she feel "up against the clock" (Fabe and Winkler 1979) or pressured to have children by her relatives, spouse or peers?

Most couples who decide to try to conceive, assume it will happen almost from the first try (Liebmann-Smith 1984). While the average young couple in their 20's is likely to conceive within six months of unprotected intercourse, women over 30 not only take longer to conceive on average, but have an increased risk of infertility (Gray 1979; Wilcox and Mosher 1994).

### Infertility and Age

The optimal age for a woman to bear a child is between the ages of 22 and 26 (Behrman and Kistner 1975). The longer a woman postpones pregnancy, the more likely it is

that she will have trouble conceiving. It has long been documented in the medical literature that fertility in women declines rapidly after the age of 30 (Greene 1971; Behrman and Kistner 1975). In fact, Cutler et al. (1979) cite studies as early as 1866 that demonstrate a causal relationship between age (over 30) and infertility. More recently, a French Study in the New England Journal of Medicine caused a big stir by demonstrating that fertility decreased rapidly after 30 (CESOS 1982). Another more recent study, found that a woman's chance of conception fell by 12% each year after 31. (Van Norrd- Zaadstrom et al. 1991).

In 1988, there were approximately 5.3 million infertile women in the United States (Wilcox and Mosher 1994), and it is popularly believed that there is an epidemic of infertility. However, according to Chandra and Mosher (1994) in both 1982 and 1988, approximately 1 woman in 12 had impaired fertility. In fact, the percentage of infertility women decreased slightly from 8.5% in 1982 to 7.9% in 1988.

This myth of an epidemic in infertility is the result of an increase in the number of childless older women with fertility problems -- the baby boomers who postponed parenthood (Wilcox and Mosher 1994). Wilcox and Mosher found that the percentage of women with fertility problems increased sharply with age.

Table 1.

PERCENT OF INFERTILE WOMEN BY AGE  
(from: Wilcox and Mosher 1994)

AGE	PERCENT INFERTILE (all women, married and single)
40 - 44	35%
35 - 40	23%
30 - 34	20%
25 - 29	13%
20 - 24	9%

They found childless married women aged 30 - 44 were the most likely to have fertility problems (Wilcox and Mosher 1994, 219) with almost a third (31%) of these women being infertile. They also found infertility to be most common among women in the highest income levels. However, they believe that this is really the effect of age since women in the highest income groups tend to be older.

Why does infertility decrease with age? There are both biological and social reasons, and reasons that overlap.

#### Biological and Social Factors

After the age of about 30, a woman's reproductive hormones levels begin to decline and there is a subtle deterioration of her eggs (Stein 1985; Van Norrd-Zaadstrom

et al. 1991). Miscarriages, which are a component of infertility, also increase with age (Daniels and Weingarten 1979; Stein 1985; Gindoff and Jewelewicz, 1986).

A major socio-biological confounding factor is the frequency of intercourse. The older a couple is and the longer they are married, the less frequently they are likely to have sexual intercourse (Menken et al. 1986), and infrequent intercourse is positively correlated with infertility (Gray 1979). In fact, James (1979) considers infrequent intercourse to be a major cause of the increase in infertility with age.

On the other hand, older women tend to have had more years of sexual intercourse and often more sexual partners than younger women. Therefore, the older a woman is the greater is the likelihood that she will have had a sexually transmitted disease (STD) or pelvic inflammatory disease (PID), both of which are additional causes of infertility (Menkin et al. 1986).

Ironically, the availability of contraception -- the very factor that helped women successfully postpone childbearing in the first place -- has been blamed for the increase in infertility with age (Gindoff and Jewelewicz 1986). In fact Wilcox and Mosher (1994) found that women who had used IUD's or had a history of pelvic inflammatory disease (PID) -- which itself can result from IUD use -- were more likely to have a fertility problem. On the other

hand, they also found that the use of oral contraceptives and condoms were associated with a lowered risk of infertility.

In addition, the older a woman is, the more she is exposed to environmental toxins, radiation and smoke, all of which have been causally linked to infertility (Stein 1985). And because fertility in men also decreases with age, although not as rapidly or dramatically as it does in women (Stein 1985; Meacham and Murray 1994), if both spouses are older and delay childbearing, their chance of infertility increases.

Although age is a major factor in infertility and the focus of this study, socio-economic factors are the greatest predictors of infertility. In general, poor minority women have the highest incidence of infertility (Kunz et al. 1973; Poston 1974; Rothman 1989; Chandra and Mosher 1994).

### Infertility as Illness

Infertility is an interesting example of an illness which is both biologically and socially defined. Parsons (1951) differentiates the biological from the social definitions of health. Disease to Parsons is strictly biological, and illness is a biological state that has social consequences and implications. There is serious question as to whether infertility fits these definitions.

Infertility can better be conceptualized as a social state with a biological component.

The operational medical definition of infertility is the inability to conceive or carry a pregnancy to term after one year of unprotected intercourse. It is considered a medical condition which can be diagnosed and treated. In fact, infertility has also been conceptualized as a form of physical disability, especially by sociologists. According to Miall (1986), infertility is "a chronic condition that meets biopsychological, social role and legal criteria for disability" (p. 269). And, according to Rothman (1989), "Procreation -- sperm production and ejaculation in the male, the ability to ovulate, conceive, and gestate in female -- can certainly be considered a basic human function, and the loss of ability to perform such functions a disability" (p. 143). Defining infertility as a disability is useful since it brings it into the social realm.

Infertility is, first and foremost, a social condition which exists primarily within a social context. Regardless of a woman's biological capacity to reproduce, if she is not trying to conceive or has not tried in the past, she is unlikely to know whether or not she was infertile. In fact, I would argue that without that active desire for biological parenthood, infertility does not exist or is an irrelevant concept.

It is, therefore, the social definition of infertility -- the inability to fulfill the social and biological role of parent -- that is of primary sociological interest. And it is this social definition which is the most relevant to the women experiencing it. This has profound implications not only for the patient and her spouse, but also for the doctor-patient relationship.

### Infertility as Deviance

Using again the Parsonian construction of illness and the sick role, delayed childbearing can be conceived as a form of voluntary deviance and infertility is a form of involuntary deviance. Although men and women can choose to become sterile through surgery no one chooses to become infertile.

The majority of women of childbearing age are fertile and have children either by chance or choice. In our pronatalist society, childless women -- whether childless by chance or choice -- are violating norms and are considered deviant (Miall 1986).

Infertility is also a form of deviance because it prevents an individual from fulfilling an expected social role (Merton 1957), that of mother. As a result, an infertile woman is likely to feel stigmatized (Miall 1986). Infertile women, in fact, have been stigmatized since

ancient times (Ibid.). Unless an infertile woman tells others of her condition, she can often hide her deviance and not have to face the stigma of infertility. In fact, according to Goffman (1963) some infertile women try to "pass" as voluntarily childless since they find this to be less stigmatizing than infertility.

When a woman both delays childbearing and is infertile, she is, "doubly deviant," and therefore might feel doubly stigmatized. Older women who wish to become pregnant are often discouraged by the medical profession because of the increased potential risk to both the mother and fetus (Nortman 1979), and by friends and relatives who might consider the older woman less physically able to handle and raise a small child (Rindfuss and Bumpass 1976). As a result, many older couples may feel stigmatized and not discuss their plans to start a family with their friends and relatives for fear of their negative reactions. When they discover they have a fertility problem, it becomes even harder for them to relate this to others since infertility carries an even greater stigma than delayed childbearing.

#### Being Labeled Infertile

When couples finally reach the decision to have children, if they do not achieve a pregnancy within what they deem a reasonable period of time, they are then

confronted with the possibility that something might be physically wrong. But just because a woman suspects that she might have a fertility problem, does not mean she will see a doctor right away, or that she, in fact, has a fertility problem. A few women panic and think there is something wrong if they do not conceive the first month they try. Most women, however, tend to be reluctant to label themselves infertile and call a doctor (Liebmann-Smith 1986; Olshansky 1987).

When a woman does decide to consult a doctor, she is usually the one to make an appointment to see her regular gynecologist (Liebmann-Smith 1987; Greil et al. 1988; Becker and Nachtigall 1991). It is typically assumed by both spouses that it is the woman who has the fertility problem (Ibid.). Doctors, too, tend to assume the woman has the fertility problem even though, according to the American Fertility Society in approximately 50% of the cases, the male has an exclusive or contributing problem. It is rare, however, that husbands are the first to go for an evaluation or semen analysis even though this is the simplest and least invasive (not to mention the most pleasurable) diagnostic test for infertility. The diagnostic tests for infertility are described in Chapter Two.

The reasons why women delay childbearing and then decide to pursue pregnancy are also explored in Chapter Two. In addition, this chapter also examines when and how women

come to label themselves infertile, the stigma attached to this label, and the impact this has on their lives and relationships. The process of initiating infertility testing and treatment is also explored.

### The Doctor-Patient Relationship

Normally a patient comes to a physician because of physical or emotional symptoms. But the infertility patient comes to a doctor because of a social symptom, the inability to become a parent. Parenthood is the ultimate goal and pregnancy merely the vehicle for achieving that goal. It is therefore the frustrated desire for parenthood that leads to patienthood.

The combination of the desire for a child and the emotional discomfort of not fulfilling the role of parent are the primary motivating factors for patients to initiate and continue medical treatment. The infertility patient usually has no other medical symptoms (Becker and Nachtigall 1991). She might give up her attempt to have a biological child at any time during the diagnostic or treatment process, thus terminating her need for and relationship with her physician. Therefore, the doctor-patient relationship depends on the patient's continued social desire to become a biological parent. Except in rare cases, the patient does not need to be treated outside the context of the desired

pregnancy. Once the patient stops trying to become pregnant, infertility as a medical disorder becomes irrelevant and ceases to exist.

While some patients will try anything medically in order to have their own biological child, most have physical, financial or emotional limits. Physicians, on the other hand, make their assessments and decisions based on medical, not social-psychological criteria. According to Rothman (1989), because of all the scientific advances in reproductive medicine, "the idea began to be generated that infertility was curable, if only a couple tried hard enough, saw enough doctors, went through enough procedures" (p. 231). Physicians' incomes are dependent on continued medical treatment, and their reputations dependent on successful treatment -- the number of women they "get pregnant."

Is pressure put on the patient to both continue medical treatment and to try more and more advanced and perhaps invasive procedures? What happens when the patient says "enough is enough"? According to Freidson (1961), "The professional expects patients to accept what he recommends on his terms; patients seek services on their own terms. In that each seeks to gain his own terms, there is conflict" (p. 171). Is conflict inevitable in the treatment of infertility?

Another complication of the doctor-patient relationship

is that infertility treatment of necessity involves a triad, not a dyad -- the husband must, at least to some extent, be a part of the infertility evaluation and treatment process (Hertz 1982). At some point the husband has to have a semen analysis, and this can become a major area of conflict in some relationships.

To what extent the husband is involved depends on the physician as well as the husband himself. The possibility for conflict is multiplied with the inclusion of the husband, and if his urologist enters into the equation, there is potential for even further conflict.

This study critically assesses the differing models of doctor-patient relationship in infertility treatment. Chapter Three explores the conflicts that arise because of the differing orientations, expectations and limitations of the patients, their spouses and their doctors. How conflicts are resolved is also examined in this study.

### The Marital Relationship

As mentioned above, infertility treatment requires the cooperation of both spouses. But this cooperation is not always easy to come by. As a result, couples get into arguments about everything from which doctor to see to whether or not to have surgery or stop treatment and adopt (Liebmann-Smith 1986; Greil 1986; Zoldberg 1993).

It is therefore not without good reason that infertility is considered a "couple's problem" (Menning 1980). When one partner fails, the other does as well. Regardless of who had the primary fertility problem, when a wife does not conceive, she may feel that it is her husband who failed to get her pregnant. The husband on the other hand, may blame the wife for failing to conceive. Therefore the possibilities of resentment, jealousy, anger, blame and arguments are rife within the infertile marriage (Menning 1980; Mazor 1984; Dunkel-Schetter and Lobel 1991).

The couple's sexual relationship especially is drastically affected by infertility (Menning 1980; Mazor 1984). Their sex life comes under the scrutiny and control of the doctor who dictates when, how often, and sometimes even how to have sexual intercourse. As a result, some husbands may not be able to "perform" on demand and develop "iatrogenic impotency" (Bullock 1974). Wives may lose their sexual desire and become temporarily frigid (Mazor 1984).

Infertility is a major life crisis for both spouses, although wives tend to be more physically and emotionally involved in infertility treatment. There are also major fundamental differences in the way men and women react to infertility (Greil et al. 1988; Andrews et al. 1992; Zoldbrod 1993). For example, women often want to discuss their fertility problem more frequently and openly than their husbands, and tend to feel more emotionally devastated

by infertility than their spouses (Greil et al. 1988). Do these gender differences lead to marital conflict? What affect does infertility ultimately have on a couples marriage? Does infertility pull them apart or bring them together?

Chapter Four looks at the conflicts and other problems that arise in marriages, and how couples attempt to resolve them. It also addresses gender differences in relation to infertility and how these differences affect the marriage.

#### Interpersonal Relationships

One of the most difficult interpersonal aspects of an infertile woman's life is living in the "fertile world," especially pregnant women (Menning 1977; Liebmann-Smith 1984, 1986). How do infertile women handle relationships with pregnant friends, relatives or co-workers when they cannot avoid them? Do some women try to "pass" (Goffman 1963) as voluntarily childless rather than admit to family, friends and co-workers that they are infertile? Do some embrace the role in what Ralph Turner (1972) calls "deviance avowal" and make infertility the focus of their lives and relate primarily to other infertile women?

Besides having to deal with pregnant women and new mothers, infertile women often have to put up with unsolicited advise and insensitive comments from friends,

relatives and co-workers (Liebmann-Smith 1984, 1986). How do they react when someone says the wrong thing? Are some relationships severed because of this?

The effects infertility has on interpersonal relationships are explored in Chapter Five. Special attention is paid to how infertile women deal with the "fertile world".

### Impact on Careers

As mentioned earlier, a woman's job or career goals are often major factors in the decision to postpone motherhood since pregnancy and childrearing are frequently seen as hindrances to a career. When a woman finally decides to start her family, it may not be in her best interest to let her employers know about her plans. But when a woman discovers she has a fertility problem, she may have no choice about telling their employers since she may have to miss work because of the numerous doctors' appointments required in infertility diagnosis and treatment. Does taking time off for tests and treatment or surgery adversely affect their careers?

Delayed childbearing and infertility affects careers in other ways as well. A woman who postpones motherhood may choose to stay in her present job because of maternity benefits. When a fertility problem is discovered, continued

medical benefits becomes an even more important motivating factor for staying in a current job.

Because of the commodification of procreation, babies - the "products of conception" -- often came at a high cost whether through birth or adoption (Rothman 1989). A woman with a fertility problem can easily spend \$50,000 or more becoming a mother due to the high cost of infertility treatment and maternity care if she becomes pregnant, or cost of adoption if she does not.

This commodification of childbearing and reproduction certainly has positive repercussions on the careers of many physicians and countless others involved in businesses of reproduction, adoption, surrogacy and genetics. However, what affect does it have on the careers of infertile women? Do they stay in what they may consider a dead-end job because of health insurance or because they think they may get pregnant at any moment?

Chapter Five also explores the impact that career has on the decisions to both postpone and pursue pregnancy. It also looks at what effect infertility has on job performance, relationships at work, career decisions and career advancement.

### Emotional Aspects of Infertility

Psychological stress and infertility are intricately

connected. For years, numerous psychologists and others have tried to and failed to prove that stress causes infertility (Hertz 1982; Mazor 1984; Wright et al. 1989; Andrews et al. 1992). However, psychological stress has consistently been shown to be the result, rather than the cause of infertility (Ibid.).

Infertility has been conceptualized as a life crisis (Menning 1977) because it can have adverse effects on virtually every aspect of a person's life. It affects marriages, sex, interpersonal relationships and careers, to name a few (Menning 1977; Mazor 1984; Dunkel-Schetter and Lobel 1991). Because older women who delay childbearing tend to be well-educated, professional women who have been successful in their careers and other aspects of their lives, they are used to having their expectations and goals met, and being in control over their lives (Liebmann-Smith 1986). What happens to these women when they discover they cannot control their own reproduction, something they always assumed as a given? Do they feel angry, guilty, depressed? How do they cope with these feelings and deal with the stresses of infertility? Do they turn to therapists, support groups, religion?

Chapter Six looks at the emotional impact infertility has on the lives of infertile women. It also explores the various coping mechanisms these women adopt, and the effectiveness of these coping mechanisms.

### Long-Term Impact of Infertility

All couples ultimately resolve their infertility. They either give birth, adopt, do both, or remain childfree. A few studies have looked at the short-term effects of infertility (Frankel and Wise 1982; Stein 1985; Berkowitz et al. 1990; Van Norrd-Zaadstrom et al. 1991), but most evaluate the pregnancy outcome on the mother and her child. Abbey et al. (1994) looked at the impact having children had on mothers who had been infertile in terms of feelings of well-being. However, the literature is lacking in studies of the long-term effects of infertility on women's lives.

How do women feel about their resolutions years later? Are their marriages permanently affected? Does infertility affect their attitudes about children or their childrearing practices? Chapter Seven looks at the long-term effects of infertility on a woman's life, marriage, relationships, career, self-esteem, childrearing practices.

How my respondents feel in retrospect about having delayed childbearing is addressed in Chapter Eight. This chapter also explores the changes in the definition of and attitudes toward delayed childbearing that have occurred over the past decade. Finally, this study looks at the ramifications that the recent advances in reproductive technologies might have on society and on a woman's childbearing decisions.

## RESEARCH PROCEDURES

This is an exploratory, qualitative study which consists of 35 in-depth interviews with infertile women who had previously delayed childbearing. Exploratory studies are appropriate in cases where there are no specific pre-existing hypotheses, since they are designed to generate rather than prove specific hypotheses.

Rather than imposing an a priori theoretical framework on this study, I use Glaser and Strauss's "grounded theory" (1967) -- the discovery of theory from data -- as a basis of data analysis. This technique is appropriate for exploratory research because it generates rather than tests theory. One of the major advantages using grounded theory for an exploratory, qualitative study is that "it permits maximum flexibility in the generation of hypothesis, because the hypotheses under consideration can be constantly reconsidered and redefined with each new addition of information" (Luker 1975).

### Interviews

Qualitative methods are especially suited for exploratory research (Barton and Lazarsfeld 1969). And in-depth, semi-structured interviews were chosen as the most efficient method to elicit subjective experiences from my

respondents who were in the throes of an emotional and physical crisis. According to Becker and Geer (1969), by using unstructured interviews, the interviewer "explores many facets of his interviewees, treating subjects as they come up in conversation, pursuing interesting leads, allowing his imagination and ingenuity full reign as he tries to develop new hypotheses and test them in the course of the interview." As new subjects emerged during the course of an interview, I would incorporate them into my subsequent interviews.

#### Participant-Observation

During the time I was conducting my research, I was an active member and then co-president of RESOLVE NYC, the local chapter of RESOLVE, Inc. a national self-help organization for infertile couples. At the time, there were approximately 60 active members. RESOLVE meetings were held once a month at Doctors' Hospital, a private hospital on the Upper East Side of Manhattan. The meetings were typically informal lectures by fertility specialists or mental health professionals followed by open discussions. Attendance ranged from under 10 to over 50, depending on the topic discussed. (Male infertility tended to have the smallest attendance while meetings adoption and the emotional aspects of infertility drew the largest audiences.) In addition, to

the monthly meetings, I attended a women's support-group for several months. I was also a volunteer on the RESOLVE Helpline fielding inquiries from women (and occasionally men) on every aspect of infertility including how to find a doctor, and whether or not to take fertility drugs, have surgery, or adopt.

Being a participant-observer was extremely helpful in the development of themes and categories for my interviews. In addition, my status as an "insider" was both useful and often essential to gain access to my respondents. And -- since my study was focused on women -- being a participant-observer was helpful in gaining some, albeit limited, access to the male perspective.

During the past decade, I have also continued my role as a participant-observer in the field of infertility. I have maintained contact with both National RESOLVE and RESOLVE NYC., and for the past three years I have served on the board of directors of National RESOLVE. I have continued to do telephone counseling, and the majority of calls I receive of from women who have delayed childbearing into their late 30's through mid- forties.

In addition, for the past six years I have worked part-time and as a consultant for IVF America (formerly IVF Australia) an in vitro fertilization organization. Because of my on-going work with both RESOLVE and IVF America, I have had considerable and continual personal contact with

infertile men and women, many of whom also had delayed childbearing. I have worked closely with numerous fertility specialists and counselors as well. My contacts with patients and professionals and my on-going observations have contributed to my evaluation and understanding of the social consequences of delayed childbearing and infertility.

### Respondents

While both men and women delay childbearing, and infertility affects both sexes, I chose to interview only women. Large numbers of women have either temporarily or permanently chosen careers over motherhood since the women's movement, but there is no comparable recent trend for men. But perhaps more importantly, because it is the woman who is up against the "biological clock", the decisions of how long to delay childbearing and when to have children are more crucial for her.

According to most fertility experts, in approximately half of the cases of infertility, the cause of the problem lies exclusively with the woman, while in the other half, there is an exclusive or contributing male factor. However, when a fertility problem is suspected, it is normally the wife who first consults a physician and undergoes most of the testing and treatment. Not only does the woman bear the burden of most fertility testing and treatment, she is also

the one who monitors her body looking for signs of ovulation, menstruation or pregnancy, and she is one who ultimately will or will not become pregnant.

Because of these factors and others, infertility tends to have a greater impact on a woman's life than on a man's. Also, men tend to be much more hesitant than women to discuss infertility, while women tend to be more forthcoming and even eager to discuss this problem. An example of this is the fact that RESOLVE meetings were overwhelmingly attended by women. Although some of the men who attended regularly were very active and vocal in the organization, it was -- and is to this day -- primarily a female-run organization.

For the above reasons, I chose to interview only women. I do, however, periodically refer to the infertile couple since infertility is generally considered a couple's problem (Menning 1980), and it is the couple who are, in fact, trying to start a family. I also occasionally refer to infertile men or husbands. When I do, this information comes from comments my respondents made about their husbands or from my involvement in RESOLVE or elsewhere as a participant-observer.

### Sample Selection

My respondents were obtained by a "snowball sample"

approach. The initial respondents were recruited from RESOLVE meetings and through its newsletter. I also recruited some women from a support group at a private infertility clinic, the New York Fertility Research Foundation. After each interview, I asked if the respondent knew anyone else who fit my criteria for inclusion in the study. The criteria for inclusion in this study were as follows:

1. They were woman who identified themselves as having delayed childbearing for several years or they were over 30 years old when they first started trying to conceive.
2. They were diagnosed by a physician as being infertile or they considered themselves infertile regardless of whether or not they were diagnosed as such.
3. They were actively trying to conceive or adopt, or were contemplating doing so.
4. They were married when they tried to conceive.
5. They did not have a biological child.

### Respondents

All my respondents were white women whose ages ranged from 31 to 43. Eighteen were Jewish and 17 Christian (Nine were Protestant, seven were Catholic and one was Greek-Orthodox). Out of the 35, 34 held professional or administrative jobs and one was a secretary. All of the

respondents had attended college, and only one had not received a college degree. Seven of the women had bachelor's degrees, 17 had masters degrees, two were Ph.D. candidates, two had Ph.D.'s, four were M.D.'s, and two had law degrees.

Seven women had been previously married. At the time of interview, three women had recently become separated or gotten divorced. None of the women had biological children, but nine had adopted babies as a result of their infertility.

My respondents lived predominately in the New-York metropolitan area, including Westchester, Connecticut and New Jersey. One woman lived in Ulster County.

### Data Analysis

While the general areas covered in the interviews were basically the same for all respondents, the analytic categories emerged from the content of the interviews rather than having been imposed on the data. As mentioned above, I used Glaser and Strauss's "grounded theory" (1976) -- the discovery of theory from data -- as a basis for data analysis.

The interviews were all tape recorded and transcribed. I then cut and attached them index cards which were sorted into the major categories and sub-categories that emerged

from the data. The index cards were then filed according to these categories, which became the basis for the following dissertation chapters:

- Chapter 1. Delayed Childbearing and Infertility
- Chapter 2. Delaying, Trying and Failing to Become Pregnant
- Chapter 3. The Doctor and the Infertile Patient
- Chapter 4. The Infertile Marriage
- Chapter 5. The Social and Economic Impact of Infertility
- Chapter 6. Coping With Infertility
- Chapter 7. Infertility Revisited
- Chapter 8. Delayed Childbearing and Infertility:  
Past, Present and Future.
- Chapter 9. Conclusions and Implications

## CHAPTER TWO

## DELAYING, TRYING AND FAILING TO BECOME PREGNANT

"I think, I am typical in many ways of us women with this problem now because my whole twenties, I was not involved with any one man. And I was very much into my career and myself and analysis and my friends and the women's movement and loving living in New York and just a tremendous period of growth...And then it all came together after I turned 30." (Terry\*, a 36-year-old teacher.)

What is Delayed Childbearing?

When this research project started in the 1980's, women who waited until they were 30 or older to try to conceive were normally defined as having delayed childbearing. The majority of women in my sample started trying to conceive over the age of 30, with a range from 28 to 38. However, the definition of delayed childbearing is also a subjective one, and not necessarily age related.

Five women in my sample were 29 and one was 28 when they started trying to conceive. They all, however, labeled themselves as having delayed childbearing. Most of these women had married early and had postponed pregnancy for quite a few years. For example, although she was 28 when she first tried to conceive, one woman, Hannah\*, had been

\* All respondents' names have been changed.

married since she was 18 and had wanted to start her family while in her early 20's. She had been a secretary when she first got married, but she subsequently attended medical school when she was in her mid-twenties. Although she was willing to have children while in medical school, her husband, a lawyer, wanted to wait until she finished her residency. They then agreed to wait until she was 28 and finished with her residency.

Like Hannah, many of the other women in my study made an active, conscious decision to postpone pregnancy to a later date. The average age of present marriage for my sample was 29, with a range from 18 to 38. Nineteen women married before the age of 30, and 16 over the age of 30. As expected, those who married youngest delayed childbearing the longest, with a range of five to 10 years of marriage before starting to try to conceive.

One would also expect that the older a woman was when she married, the sooner she would try to get pregnant, and this was true in the majority of cases. Of the 16 who married over 30, 13 started trying to conceive within one or two years of marriage. Some had lived with their spouses before marriage and got married with the idea of immediately starting their families. In fact, many said that having children was the major reason for having gotten married when they did.

### The Decision to Delay Childbearing

There were often multiple reasons why the women in my sample delayed childbearing. Even if they married late, some still delayed childbearing for several more years. For example, Janet, a 43-year-old editor, did not marry until she was 34, yet she waited until she was 38 to start trying to conceive. She attributed her hesitation to start sooner to "immaturity" and career involvement. She also described herself as a "late developer."

Some delayed because they felt they could not afford children. Others wanted to complete their educations, finish dissertations or postgraduate work. For others career was a primary factor. The following 38-year-old woman, Diane, had been a cooking teacher when she got married at 29. She started trying to conceive when she was 36 and happily involved in her new profession as a career counselor.

One of the reasons for getting married was because we both wanted to have children...But it was very important for me before I really was serious about it to really have my career in place. So all those years that I was in teaching, I really didn't think that I had much to offer, and I was concentrating on developing myself and making myself a healthier person. I had a lot of emotional problems that I had to get through first. So it was a question of priorities and doing things that I felt were very important before I really become serious about being a mother.

Finances played an important role for some, but since most were professional women, it was not so much an issue of

affording children as it was of maintaining their present lifestyles. As one 39-year-old marketing representative, who was married at 24 and postponed pregnancy for six years put it, "We always felt we couldn't afford it, although that was basically not really valid. You can afford a child, but we thought we couldn't." (Laura)

Another major factor in the decision to delay childbearing was the marital relationship. Some couples had marital difficulties or felt that they were not ready to turn their twosomes into threesomes. In some marriages one spouse, usually the wife, wanted to start a family, while the other did not yet feel ready to have children. However in a few cases, the wife was the one who was hesitant. Said a 34-year-old executive, "I was trying to establish my career...my husband was very, very anxious to have kids. He probably would have wanted them sooner, but deferred to my interests and my career." (Nina) This couple in fact separated after discovering that it was the husband who had the fertility problem.

### The Decision to Have Children

The women in my sample fell into three major categories: those who always wanted children, those who never wanted children and those who were ambivalent. Most of my respondents were in the first category. However,

several claimed they never wanted children or were extremely ambivalent. Despite these preexisting attitudes all the women had one thing in common -- they all ultimately decided to have children. Preexisting attitudes about motherhood and children therefore did not necessarily dictate their behavior. Their present life situations -- including financial status, marital relationship, spouse's attitude, career goals -- seemed to have had a more profound influence on their decision making process than their preexisting attitudes.

When these women finally reached the decision to pursue pregnancy, their reasons were often related to the initial reason for their delay. Matrimonial, financial, career, or educational goals had finally been met. Marital conflicts about childbearing had been resolved, and having children became a priority. For example, those who delayed because they were not married in their 20's, were ready to settle down and start their families when they got married in their 30's. Those who delayed because of financial reasons, started trying to conceive when they felt more financially stable or did not feel they would be making a major financial sacrifice to have a child. Those who delayed for educational reasons tended to start trying as soon as they completed their graduate degrees, or residencies. And those who postponed because of their careers, started trying when they felt their careers were where they wanted them to be.

Said Diane, the career counselor quoted above,

When I started trying, I felt my business was well on its way. I could see myself making the sacrifices necessary to be a mother. And I could see working a child into my life. And I saw myself developing an entire lifestyle that included parenting, career, family, marriage. And I could see the total picture very clearly about how to combine all those roles. I guess that's when I really started saying, "Hey this is for me."

Having a stable marital relationship played a key role in some decisions. According to Janet, the editor mentioned earlier who finally decided to start trying when she was 38, "We'd been married for four years and we'd had our good time, saved our money, done all sorts of things. We felt we were pretty sure we were going to stay married." And Laura, a marketing representative, said they decided to have children after nine years of marriage because, "...we'd gotten over the seven-year itch with some very high hurdles, and we both felt very good about that ... we felt really comfortable with each other. But more often than not, it was a combination of factors that induced the couple to start trying. Said Irene, a 36-year-old woman who married at 24 but postponed trying to get pregnant until she was 30,

My career was relatively established. I had been on the job about six years, and my husband's career was relatively established. And we were planning to make a major life change which was to go out of the city...What we were really thinking of was where we wanted to spend the next ten years? And with that I think we thought, well, where do we want to raise children? And I think it was a combination of both of our careers being settled in and being financially stable, and the idea of thinking, "Well, what do we want to do in our thirties?"

## The Biological Clock

Age was a primary or contributing factor in the decision to start trying to conceive for most women in my sample. For some, having children was one of the main reason for marrying. For them, concern about their age -- feeling their biological clocks ticking -- was a factor in their decision to start trying soon after marriage. Just turning 30 was enough to motivate some to start their families.

It was right at my 30th birthday. I turned 30 in September ...and within those few days all of a sudden the maternal instinct just sort of arose. I think it was turning 30, and I also think prior to that, I simply wasn't ready for it intellectually or emotionally. And it was just one of those things that one day I woke up and the idea seemed appealing and not repugnant. (Bonnie)

All the women in my sample were aware of the link between age and genetic problems in offspring, especially Down Syndrome. However, only a few were aware of the link between age and infertility. This was especially surprising given the educational level of my respondents. Said a 35-year-old pediatrician who started trying when she was 30,

I was 30 and I thought I better hurry up and try, because I knew, as a doctor, that...35, that's it, and then you have Mongoloids. I know that's not true, but that's what I thought being a medical person. (Yvonne)

The other physicians in my sample also were unaware of the correlation between age and infertility although it was well documented in many medical textbooks.

## Pressure From Others

Pressure from their spouses played a major role for those women in my sample who were either ambivalent or opposed to the idea of having children. Said Jane, a 34-year-old college instructor, "I just knew I didn't want any kids...it never crossed my mind...If my husband didn't have a dying desire to have a kid, I probably wouldn't have a kid." When asked why she decided to try to get pregnant, she answered, "Oh, well, we'd gotten married. We had a house and we were settling in...It was just one of the next steps in nesting." And Karen, a 40-year-old copywriter married to a 33-year-old lawyer, admitted the following:

I never wanted to have children. I never had that desire. In fact I was very negative about having children most of my grown up life...I started getting older. I started getting more mature and being able to face some of my anxieties. I was in a marriage that made me very happy. I began to see that I wouldn't have my options forever. And (my husband) desperately wanted a child. In fact, it became clear early on in our relationship that unless there was eventually a child, if I was not willing to have a child, then he was not willing to stay in the relationship. And we broke up a number of times before we were married, before I was ready to say yes, I will have a child. So I was very motivated to examine some of my feelings about having a child because I loved him very much. I was very happy in our relationship...and I was getting older. I began seeing having child as a positive, interesting experience. I worked on some of my anxieties about pregnancy and childbirth in therapy very hard...and I finally got to the point where I started to feel some of my positive feelings about having a child, and then started getting excited about it. It never really occurred to us that we might agree to have a child and then not be able to.

This was another case, like Nina mentioned earlier, in which the couple separated while undergoing infertility treatment. In both these cases the husbands were more interested in having children than the wives. However, ironically, in both cases, the husbands were the ones with the primary fertility problems, and also the ones who wanted to end the marriages. Both these cases will be discussed further in Chapter Four.

In some cases, the pressure to have children came from family members. My respondents tended to find family pressure to be more annoying than coercive. One woman's mother periodically bought her bed jackets that she could wear in the hospital after she gave birth. (Laura) Another subject was annoyed by her mother-in-law who was constantly knitting a baby quilt in her presence. (Beth)

Pressure from friends, although not as common as family pressure, was equally annoying as the following woman, Amy, discovered:

We went through several years of real extreme feeling of not wanting to have a child at all, and a lot of anger at people who told me, "But you have to have a child" or who intruded upon me in saying, "But your over thirty and you really don't have much time", or "It's immoral not to have children", or "You never truly give of yourself until you raise a child". And various lectures of that sort which I still get angry thinking about.

While some of my respondents gave in to pressure from their spouses, none were swayed by pressure from family and friends. The women in my sample ultimately decided to start

their families when they wanted and felt ready to. For many, what they thought to be the hardest part -- the decision of when to start -- was over. Now came the fun part, or so they thought.

### Trying to Conceive

Most of my respondents felt that once they made up their minds to get pregnant, they would succeed right away. "I figured when I wanted to have a baby, I would just have a baby. I really was just about that Pollyannish about it," confessed one woman. (Michelle) Most were even convinced that they would conceive the first month they tried. A few, in fact, planned to start trying nine months before a month they found convenient or astrologically favorable.

Since most respondents had spent so many years using birth control and concentrating on not getting pregnant, it never occurred to them that there might be a problem. A few had had abortions and this only reinforced the notion that they were very fertile indeed. Others felt confident about conceiving easily because their past medical histories and exams gave them a false sense of security.

[Infertility] was one health problem that I just never dreamed of having...I'm physically very voluptuous and I got my period when I was eleven. I never skipped a period. Everything about my biological system seemed to work according to the textbook. So that the concept of it not obeying me at that particular junction just really never entered my mind...I had no particular history of any kind of quote female complaints. No

infections, no previous abortion, no miscarriages. I went to the gynecologist's office to get a pap smear and get my breasts examined every year. (Bonnie)

A few women however, because of a personal or family history or medical problems, worried that they might have problems conceiving. Several were concerned because they had had irregular periods. One woman worried that she might have trouble because she had had an IUD, and news about the link between IUD and pelvic inflammatory disease was just coming out. And several women feared that they might have trouble conceiving because they had gone for periods of time without using birth control at various times in their lives and had not gotten pregnant.

For the most part, however, even those women who were warned that they may have some trouble conceiving thought that they would conceive easily. Said Janet -- one of the oldest women in my sample -- who was 38 when she first tried to conceive,

One woman once said to me. "When are you going to have children?" And I said I don't know ...there's time. And she said very casually, "Well you know, it might not be so easy. You might have problems." And I just flicked it off in my mind. I thought, "I'm just positive that the minute I put my mind to it, it will happen."

And Hannah, a physician, was so confident that she would not have a fertility problem, that she felt scorn for those who did.

I didn't have the slightest thought it could happen to me. As a matter of fact, when I was in medical school we had a panel discussion once on infertility and I

remember thinking, "Why is this a problem? These women are healthy. There's nothing wrong with them. What are they carrying on about?" And I had absolutely no sympathy, and no thought that it could ever happen to me.

Those few who were concerned about their fertility tended to see their gynecologists even before they started trying to conceive. For the most part, their gynecologists reassured them that they would have no trouble getting pregnant. A few doctors did, however, tell the women that it might take up to a year for them to conceive. It is understandable, then, that given their lack of knowledge about age and infertility, and the fact that they were healthy, my respondents were confident that they would soon become mothers.

### Being Infertile

There was tremendous variation in my respondents' responses to not conceiving right away. Most were surprised and disappointed when they did not become instantly pregnant. Some felt that there was something wrong after only one or two months of trying. Others were disappointed but did not give it much thought at first.

The hardest step for most people having difficulty conceiving is to admit that their might be a problem and consult a doctor about it. This means labeling themselves "infertile". Infertility is sometimes confused in people's

minds with impotency in men and sexual dysfunction in women. Because of the stigma surrounding infertility, some women put off seeking help because to them, "it was like admitting failure," as one woman put it. (Ruth) Even some of the women who had seen doctors for several years about getting pregnant, refused to consider themselves infertile.

It was often a specific event or moment that enabled my respondents to come to accept the label "infertile." For one woman it happened when she was well into the treatment process. She had an appointment for artificial insemination with her husband's sperm and the doctor never showed up. She was both furious and traumatized by this experience because she was at the mercy of her doctor -- that her ability to become a mother was in his, not hers or her husband's hands. When she realized that she had relinquished control over her reproduction, she finally admitted to herself that she was infertile. (Janet)

Said one 38-year-old woman, Diane, after several years of treatment,

It just hit me now, two-and-a-half years later that I really have a problem. I think I spent so much time really denying the reality that until I really saw this group at RESOLVE and saw that..and even then I felt very uncomfortable about admitting it. So I don't like to even say "infertility" I like to just say I have a fertility problem.

Most of the women admitted to feeling embarrassed by the word "infertility", and tended to avoid using it. Like the woman above, they preferred the term "fertility

problem." Even those who accepted the label "infertile" tend to do so hesitantly. This prevented some women from joining to infertility support groups such as RESOLVE. While no one overtly talked about the stigma attached to the word, it was clear by their discomfort using the word or their avoidance of it, that they felt very stigmatized indeed.

Having a specific diagnosis often helped the women accept the fact that they were infertile, and not having a diagnosis made it more difficult for them to acknowledge it. One woman did not think she was infertile even though she had been trying and failing to conceive for two years. She finally had a laparoscopy (a diagnostic surgical procedure) which showed that she had large fibroids. Until then, she said, "nobody told me that there was anything wrong, so how could I... be infertile?" (Sara)

Some women confused infertility with sterility (the absolute inability to conceive) which carries an even greater stigma than infertility because, by definition, sterility is incurable and therefore a permanent state. If there was a chance of a pregnancy, these women refused to consider themselves infertile. Said a physician after failing to conceive for over a year, "I now was defined as infertile by a medical definition...(but) I wasn't so convinced. I knew that there was going to be a miracle around the corner."

## Conclusion

My respondents delayed childbearing and then pursued parenthood for a myriad of both related and unrelated reasons. Their preexisting attitudes about having children were not necessarily related to their childbearing decisions. Rather, their decisions to pursue pregnancy were primarily based on their present situations -- their marital relationships, their careers, their financial situations, and the ticking of their biological clocks.

When the women in my study finally reached the decision to start trying to conceive, most felt that it would happen almost instantly. Infertility was not something they anticipated. When they failed to conceive, some women panicked and assumed there was something wrong. Others had more difficulty accepting the idea they might have a fertility problem -- they felt stigmatized and many delayed consulting a doctor for months or even years.

In the next chapter, we look at when and how women go about consulting doctors about their infertility. We also explore the doctor-patient relationship and its impact on the infertile couple.

CHAPTER THREE  
THE DOCTOR AND THE INFERTILE PATIENT

In the previous chapter, it was shown that there was tremendous variation in both how and how long it took a woman to come to the realization that she had a fertility problem. But it is one thing for a woman to realize that she might have a problem and quite another thing to actually do something about it by consulting a doctor and becoming an infertility patient. In my sample, the time from the initial realization of a problem to the initial consultation with a physician varied from a few months to two years.

Consulting A Physician

Why would a woman who is already in her thirties and suspects that she might have a fertility problem wait to consult a doctor? When a woman who is trying to conceive does consult a doctor, it is an admission that something is or might be seriously wrong with her reproductive system. She is then faced with potentially painful diagnostic tests and treatment as well as, and perhaps more importantly, the painful possibility of never being able to have her own biological child. Also by consulting a doctor, a woman puts

herself in the role of patient, when all she wants is to be in the role of mother.

Most people go to a doctor and become patients because they have physical pain or discomfort. This is not the case with infertility. Although infertility is a physical condition, most patients do not suffer physically. Rather, they are suffering emotionally from being deprived of having children. Because they have no pressing need for physical symptom relief, they can postpone going to the doctor indefinitely. It is only when their social symptom -- the inability to fulfill the role of parent -- becomes unbearable that they seek medical treatment.

Some women may postpone consulting a doctor because they are discouraged from doing so by their spouses. Many men are embarrassed by their inability to impregnate their wives -- they see this as a failure, an inadequacy and ultimately as a reflection on their masculinity. In fact, some men tend to identify infertility with impotency and fertility with virility (Miall 1986; Liebmann-Smith 1987). For them, consulting a doctor is especially threatening since it forces them to discuss their sexual frequency, timing and position with a stranger, usually another man (Hertz 1982).

When a woman finally makes the decision to go to a doctor, she is faced with two possible problems 1) finding a competent doctor and 2) being taken seriously by that

doctor. However, neither of these issues were considered a *prior* problems by my respondents. Indeed, most never gave them a thought until after the fact -- when they had already become dissatisfied infertility patients.

### Choosing a Doctor

When the women in my sample finally decided it was time to see a physician about a possible fertility problem, the overwhelming majority went to their regular gynecologists. OB-GYN's seem the logical choice since they deal primarily with the female reproductive system. However because infertility is a couple's problem, it requires specialized knowledge of both the male and female reproductive systems. This is especially true since at least half the time, male-factor infertility is a primary or secondary factor. Just because a doctor advertises himself as a fertility specialist, does not mean he is. In fact, regardless of postgraduate or specialized training, any OB-GYN can claim to be a fertility specialist and many do.

Most of the women in my study had no idea that there was a subspecialty called "reproductive endocrinology." Whether or not their OB-GYN was competent in the field of infertility was never initially addressed. My respondents assumed that if their doctor was not knowledgeable about infertility, he or she would refer them elsewhere.

Even those few women who thought they should see a specialist often had difficulty finding one. Amy, a doctoral candidate called her university's women's center for a referral and was sent to a so-called "fertility specialist." However, she discovered that his interest and training in reproduction was limited to performing abortions. On top of that, Amy found him to be cold and condescending.

I hated him... (but) I didn't have any alternatives. I hadn't met anybody else who was infertile and I really didn't know what alternatives existed. And after all, he'd been recommended by the Women's Center. I didn't realize at that time that the reason they recommended him was that he was a good abortionist. I thought, you know, these people are really together about women's health care services.

The center subsequently removed his name from their referral list for infertility. But as we have just seen, the confusion about who is qualified to treat infertility is quite widespread. If health referral centers do not know how to find an appropriate infertility specialists, it is not surprising that individual women do not know who the appropriate doctors are.

According to the Society of Reproductive Endocrinologists (SART), in order for a physician to be a certified reproductive endocrinologist, she or he must first be certified as a general OB-GYN. In addition, she or he must successfully complete an approved two-to-three-year fellowship, pass a written examination, an oral examination

and publish a thesis. In 1983, when SART was formed, there were under 100 certified reproductive endocrinologists. In 1995, the number had risen to over 500.

None of the doctors my respondents first consulted were certified reproductive endocrinologists and most did not have any special postgraduate training or interest in infertility. Yet all these doctors initiated infertility testing and treatment. They did not refer their patients to specialists or let them know about their lack of specialized training in this area. Yvonne, a pediatrician, described the situation with her first doctor, her regular OB-GYN:

He was a very kind sensitive, wonderful dedicated person. (But) infertility was not his field of expertise and after a while I thought he was futzing around. And I wondered why he didn't say, you should go to a specialist.

It is interesting to note that, considering her medical training, she did not go directly to a fertility specialist.

When the women in my study went consulted a doctor about a possible fertility problem, they expected the doctor to do something about it. They were ready to begin their infertility workups in order for their problems to be diagnosed and subsequently treated.

### The Infertility Workup

A typical infertility workup consists of the following diagnostic tests:

Semen Analysis - This should be the first test conducted. A man's sperm is evaluated for the 1) number of sperm 2) morphology (shape) and 3) motility (movement)

Post-Coital Test - Sperm are removed from the woman's vagina several hours after she has intercourse to see if they survive in her cervical mucus. This test should be done at the time of ovulation and can indicate problems with the sperm, cervical mucus or their interaction.

Tests for Sperm Antibodies and Infections - Blood and/or cervical mucus should be tested for antibodies which can kill sperm, and infections such as T-Myco-plasma and Chlamydia, which can cause fertility problems. Both men and women should be tested.

Blood Hormone Levels - Women, and men if they have a fertility problem, should have their blood tested to see if they have normal levels of hormones either necessary for reproduction or that can interfere with reproduction.

Ovulation Tests - Ovulation can be determined by a woman's temperature (BBT), her cervical mucus and the her hormone levels in her blood or urine.

Endometrial Biopsy - This is a more invasive but accurate test to determine ovulation and the levels of reproductive hormones. Many women find this test very painful.

Hysterosalpingogram - This is an X-ray procedure in which dye is injected through the cervix into the fallopian tubes and uterus. This test can determine if a woman's tubes are blocked as well as the shape of her uterus. Some women, especially those with blocked tubes, find this test quite painful.

Laparoscopy - This is a diagnostic surgical procedure that should only be done after all other tests are negative, or if a woman repeatedly fails to conceive after many treatment cycles for no apparent reason. The doctor inserts a thin instrument through the woman's naval which allows him to visually inspect her ovaries, uterus and fallopian tubes for adhesions, scars and other structural problems. Because it is a surgical procedure that requires general anesthesia, it carries the normal risks of surgery including infection and death.

In order for a workup to be done correctly and safely, a person who suspects they have a fertility problem should be seeing a qualified fertility specialist, something most of my respondents did not do, at least initially.

### Not Being Taken Seriously

When many of the women in my sample finally consulted a doctor, they were confronted with the second unanticipated problem -- they were not taken seriously by their doctors. This was especially true of the women who sought treatment within a year of trying, even though they might have been well into their 30's.

At the time of my initial research, the link between infertility and age -- while not widely publicized in the lay community -- should have been common knowledge in the medical community. According to one of the leading textbooks on infertility at the time, "Fertility is maximal in the female around the age of 24 years, after which it gradually tapers down to the age of 30 and rapidly declines thereafter. (Behrman and Kistner 1975).

Yet many OB-GYN's either were unaware or chose to disregard the evidence that infertility increased after the age of thirty. They tended to treat their older patients in much the same way they treated their younger patients. They followed the general rule that you wait one full year before

initiating an infertility work-up or treatment. Although the standard medical definition of infertility does say that a woman is infertile after one year of failing to conceive or having a viable pregnancy, most fertility specialists believe that a woman over the age of 30 who has not conceived in 6 months should start an infertility workup.

Those doctors who did not take their patients concerns seriously tended to be patronizing or condescending towards them. They tried to reassure their patients that nothing was wrong and that they should wait another six months or year before considering they might have a problem. In the meantime, they should just relax and "it" would happen. One woman who did not start trying to conceive until she was 38 went to a doctor after the first six months of trying.

The doctor was very relaxed and his whole attitude was very relaxed. He never gave me the feeling that it was a terribly urgent thing that I must immediately check out. And he kept saying, well, wait a few more months and see. He knew that I worked under a lot of stress and he said, maybe you should -- the typical things, take a vacation, etc. etc. (Janet)

While some of these women were happy to be reassured and very relieved by their doctor's attitude, others were angered and decided to find a doctor who would take them more seriously.

Terry, a 36-year-old woman, was 32 when she started trying to conceive. After failing to conceive for six months, she went to her regular OB-GYN who started doing some basic tests. She took fertility drugs for four months

still did not conceive. "I had started reading as much as possible," said Terry. "So I now knew that I needed a specialist and I was wondering when this doctor was going to suggest it, and I was feeling guilty about leaving him and branching out on my own."

Terry finally made an appointment with a "fertility specialist" a friend said helped her friend get pregnant. The following month the doctor she had been seeing finally told her she should see a fertility specialist. The second doctor she consulted, the so-called "fertility specialist", asked her how long she had been married, and when she told him a year, he was indignant.

He said, "A year! It's much too early! Your other doctor has already set things off on the wrong foot by doing any tests. That just delays the process of getting pregnant. Take a vacation and go away on weekends when it's your fertile time." And he said, "I'm sorry if I sound so hard-hearted or unsupportive, but this is really what I think is best." And by that time I already knew something was not right, and I also knew that I was older and he wasn't validating that I might need special attention. And so we didn't go back to him.

### Miscarriages

Women who consult doctors because of miscarriages also commonly find that their concerns are not validated. Miscarriages are a sign of something medically wrong with the patient, the fetus, or both. Miscarriages are also experienced by most women as an actual death (Berg 1981; Borg 1981). Yet while miscarriages are often emotionally

devastating for the women who experience them, and proof that there is or was something physically wrong with the pregnant woman, the fetus, or both, they are considered normal by the medical profession since an estimated one-third of pregnancies end in a miscarriage. (Many of these miscarriages happen very early in the pregnancy before a woman even realizes that she is pregnant.)

As common as miscarriages are, recurrent miscarriages are considered a medical problem and fall under the definition of infertility. However, many of the doctors the women in my sample consulted saw even recurrent miscarriages as normal, as "nature's way of getting rid of a mistake", and not as an aspect of infertility. One woman, Fran, had two miscarriages was told by her doctor that she had blighted ova, that it was something that commonly occurs in nature. The doctor then told her that there was nothing wrong with her and that he would only run tests on her after she had ten miscarriages. Contrary to what this doctor told Fran, recurrent miscarriages are not always, in fact, "nature's way of getting rid of mistakes". While genetic problems are responsible for many miscarriages, other causes -- such as cervical problems and hormonal insufficiencies -- can often be found and treatment can be successful.

Miscarriages are also usually considered a sign of fertility rather than infertility; a woman is able to conceive but she cannot carry a pregnancy to term. One woman

who had just had a miscarriage was brushed off by a "fertility specialist" she saw for a second opinion. "He was very nice but very condescending ...'We really are being silly about coming. You're perfectly all right. I guarantee...by March you will be pregnant.'" (Anna) She never conceived again.

What the above doctors did not understand was that their opinions are irrelevant to the women who label themselves infertile. These women have already made up their mind to pursue infertility diagnosis and treatment as a means of achieving or maintaining a pregnancy. It is the patient's subjective evaluation of her situation and desire for parenthood not the doctor's evaluation of her medical condition that counts.

Infertility is an interesting example of a disease where self-diagnosis is more important than diagnosis by a physician. It only exists as a disease if the patient says it is. She may have totally blocked tubes, but if she is not interested in becoming pregnant, the diagnosis of infertility is meaningless and irrelevant to her. The doctor might deem her infertile, while she might deem herself lucky.

On the other hand, most infertility patients appear healthy and symptom-free, and doctors are not trained to treat apparently healthy patients. The doctor has to believe there is a real problem and a physiological cause of

this problem. The symptom -- the failure to achieve a pregnancy after a reasonable period of time -- is one the doctor has to verify in order for him to acknowledge its importance or even existence. If the doctor thinks his patient has not tried to get pregnant long enough to be concerned about her fertility, then he will not consider her infertile, regardless of how she feels. When a seemingly healthy patient determines she has a problem the doctor does not see, the doctor is likely to see her as overly anxious at best or as a hypochondriac at worst.

The only way for a doctor to know if the infertility patient indeed has something physically wrong with her is to initiate an infertility work-up, which can take several months. If the doctor chooses to disregard the patient's concern, he will not initiate diagnosis or treatment, thus negating the patients concerns, at least from his perspective. From the patient's perspective, however, he is denying the reality of her concerns.

When a patient believes she has a medical problem and her beliefs are not validated by her doctor, that becomes a potential area of conflict. This is why it is especially important for a woman to have the support of her husband when initiating infertility treatment. If both spouses determine that there is indeed a problem and approach a doctor as a couple, they are more likely to be taken seriously or persist in finding a physician who will take

them seriously.

### Husband Involvement

Getting a husband involved in infertility treatment can be a real challenge, since many husbands are hesitant to consult doctors about their fertility problems. However, infertility treatment requires the involvement and cooperation of the husband, and it is desirable and often necessary that he become an integral part of the treatment process. At the very least, the husband has to produce a sperm sample for a semen analysis.

Infertility treatment, therefore, is not comprised of the normal dyad, the doctor and his patient, but it is really a triad, the doctor, his patient and his patient's husband. Even if the husband has a fertility problem himself and is seeing a urologist or andrologist (a specialist in male reproduction), it is the wife who ultimately will or will not become pregnant. The wife therefore, is normally thought of as the primary patient, and it is typically the wife's doctor who takes charge of helping a couple conceive.

Most of the women in my study wanted their husbands to be involved in the diagnostic and treatment process and to accompany them to the doctor's office whenever possible. When their husbands were involved, they said it helped make

things emotionally and sometimes physically more tolerable. However, many of the women were disappointed that their husbands either were not involved, or their doctors did not encourage their husband's involvement.

I was disappointed that there was not more interaction between the two of them...My husband isn't very comfortable with it and he went to please me...he kind of handled it like a businessman. He said he was concerned about the finances...So he discussed the finances and the doctor said, "Well do you have any other questions?" And he said, "No, I'll just pay for this visit." So it was kind of like two businessmen getting together and negotiating. (Irene)

Because of the treatment triad, the potential for conflict is multiplied. Wives often reported, for example, that their husbands were annoyed at having to take time off from work, especially since they were not the ones being treated. Said one woman,

After my last miscarriage the two of us had an appointment together to see Dr. \_\_\_\_\_ and [he] canceled the appointment at the last minute. And both of us had rearranged our schedules, but he was really annoyed. And so he called up the office and had a big fight with the secretary and then had an argument with [the doctor] the next day when we kept the appointment...Dr. \_\_\_\_\_ apologized but was also a little bit distant... (My husband) hasn't seen him since...It was a big deal because I was always wanting him to go to my appointments with me and he never did. And now that he starts going, he gets very headstrong. And so after this I just decided it's easier for me to go by myself. (Elaine)

Several women reported that their husbands found dealing with physicians very threatening, especially when the husband himself had a fertility problem. The following

woman describes what happened when, in the initial consultation, her doctor reported that in addition to her fertility problem, her husband had a low sperm count.

Tom hated Dr. \_\_\_\_\_ from the first moment he sat down...He started talking to us about donor inseminations, which I thought was very strange and [my husband] was completely put off by. And I thought it was not the kind of thing to do when you're telling people for the first time that basically both of them are infertile. He made statements like well, I don't know if you'll ever conceive. I don't think your husband will ever be able to impregnate you. Things like that. (Jane)

They never returned to that doctor.

### Control and Conflict

The differing role-expectations in the doctor-patient relationship often leads to conflicts. The infertility patient becomes a patient not because she is sick in the traditional sense but because she wants to fulfill the social role of parent. Yet she finds herself in the midst of traditional medical care where the doctor expects to be fully in charge and the patient is expected to follow the doctor's orders.

If the doctor thinks there is nothing wrong with his patient he will dismiss her concerns as unfounded as in the cases above. But if he takes her seriously, he is likely to use all the technology available to him to find a cause and then cure for her "disease". The patient is then expected to play the role of passive patient and follow the doctor's

orders.

Most of the women in my sample were professional women who were used to making important decisions for themselves and being in control or at least an equal participant. Although many of the women were told to just relax and take vacations, others went to doctors who were more aggressive and wanted to very quickly do some of the more invasive aspects of the infertility work-up. One woman, herself a physician, went to her doctor after a few months of not conceiving. Her doctor suggested that she have a hysterosalpingogram, a fairly invasive and often painful diagnostic x-ray procedure. She felt that it was not the appropriate next step in the work up and switched doctors. (Hannah)

Doctors are not usually trained to have their patients be equal participants in their health care. Conflict often resulted when the doctor felt that his authority was being challenged or undermined or when the patient felt she was not respected or treated as an equal participant in her health care decisions.

In the beginning, I rejected the drugs. He really bristled. And the second time I went back he said, 'Well, you're against drugs and everything.' He really seemed to be offended by that, that I wasn't just jumping at the word of a great doctor or something. (Janet)

The following woman, Amy, also clashed with her doctor because of fertility drugs. She was a fraternal twin and was very concerned that fertility drugs would cause her to

have a multiple birth. Amy was hesitant to take Clomid, a fertility drug in pill form that is used to induce ovulation.

(The doctor) gave me statistics and told me that in all the time that he'd been using Clomid, which was eight years, that he'd only had two sets of triplets, and that it was highly unlikely that I would have more than twins. And at that point twins seemed to me like, you know, I could get my two kids over with at once...And I said, "Well, Okay, Clomid, but never Pergonal (a more potent injectable fertility drug that often causes multiple births). And after the first month of Clomid, he said that he wanted to amplify it. And I said with what? He said with a hormone. And I said what hormone? And I know sort of from the tone of his voice that it was Pergonal. But he wasn't saying it to me. And he really did try to slide it by on me. And I said, "You know, I'm going to decide whether or not to take it, but don't slide it in on me." And he kind of looked chastised, but he didn't really take the confrontation.

On the other hand, some patients want and expect their doctors to be in control and make all the medical decisions. Fran, the woman mentioned earlier whose first doctor ignored her recurrent miscarriages, switched doctors and found one who took her concerns seriously. Her new doctor diagnosed a hormonal deficiency and gave her the choice of treating her with hormones or doing more diagnostic tests in order to rule out other problems. However, she was not happy with being put in the position of making medical decisions. "He wouldn't make that decision for me and I felt that that's not a decisions that should've been left up to a patient. I just wasn't a doctor."

Even though a patient might feel that the doctor should be in control, the reality is that it is the patient who

must primarily be responsible for her own health care. Several other women talked about ultimately being pleased that they were able to make medical decisions for themselves. Not surprisingly, the patients that were the most in control and outspoken were the ones that had the most conflict with their doctors. The following woman, Paula, was the daughter of an OB-GYN. She was scheduled to have a diagnostic laparoscopy. Paula had two cysts on her ovaries and was concerned that they might be cancerous because her mother had had ovarian cancer. She became upset when she was asked to sign a consent form.

(You) start thinking about all this stuff you've read, that you're under anesthesia and they take everything out and you wake up and you've had a hysterectomy...And it seemed to me that the informed consent allowed them to do that...The resident who was on staff said to me, "The only reason for this is because there is a slight risk that with the laparoscope they can burn your intestines and they have to have your consent to go in and repair it." Which is understandable. That really didn't bother me. I had faith in this doctor that he knew what he was doing...still I was very uptight about the whole thing...and the consent was really bothering me. And I kept telling the resident..."I really want to speak to Dr. \_\_\_\_\_. I just want to make sure I understand this." And I tried to call him and of course his answering service answered and he was nowhere to be found...And so I took the consent and I just crossed that out and I said I consent to any repair, any emergency surgery that has to be done, repair any damage, but consent for any other surgical procedure is being withheld at this time... Well she, the resident, took a hold of this thing and she left. She was furious. And she came back and said Dr. \_\_\_\_\_ is not going to operate on you unless you sign this consent form...It was horrible...I called my mother, and she said, "Oh go ahead and sign it. Don't be such a stickler..."The next time I saw him I was half asleep. They had medicated me and I was wheeled into the operating room and he started to be sarcastic... "Don't worry, I'm not

going to take out any organs."...It was really awful. And then after the surgery too he said the same thing. "I didn't take out any organs."...He was sarcastic and he was obviously threatened by the whole thing. Instead of just calling me up and saying, "Well, the hospital requires this, but I give you my word that I'm not going to." That's all I wanted to hear. (Paula)

Paula, like most patients, wanted and expected to be treated as an adult who was capable of asking intelligent questions and making informed decisions for herself. However, because her doctor and the hospital staff were not used to dealing with patients who questioned routine procedures, conflict was the inevitable result.

#### The Medically Knowledgeable Patient

Paula was medically well-informed in part because both her parents were physicians. She said that she had always read a lot of medical textbooks, especially OB-GYN books. Several other women, especially the four physicians, were also extremely well-read and well-informed medically.

The more medical knowledge my respondents had the more likelihood there was for conflict or difficulties in the doctor-patient relationship. My physician respondents all had overt conflicts or problems with their doctors. In some cases their doctors seemed to resent and/or be threatened by their medical knowledge.

One doctor, a psychiatrist who had recurrent miscarriages, got into an argument with her doctor because

he had lost one of her hormone tests. She was then billed for a test her doctor said he had not preformed. Finally when the test results came back from two different labs, one was normal and the other high. They started to argue what to about the differing test results and what course of treatment to follow.

We were arguing about that, and then he sort of threw up his hands and said, "Well, I don't know what to do. Take bromocryptine (an antiprolactin drug) if you want." And he sort of threw a prescription at me. So I got really upset... (my husband) said I was somewhat abrasive with him. (He) thought we were going to come to blows ...I didn't go back to him. (Elaine)

While some doctors were threatened by their physician patients, others seemed to expect more from them than they might from their lay patients. Said one doctor, a pediatrician, "He did an endometrial biopsy which they say hurts a little. It was the worst pain I ever had in my life. And he yelled at me because I said it hurt. And then I cried." (Yvonne)

Others doctors also seemed to treat their physician patients with less respect and formality than they probably would have treated their lay patients. Ruth, an internist, had the an experience she described as one of the worst experiences she ever had.

I walked in and...he was extremely brusque. I said good morning and he barely grunted and he pointed to the chair. I sat down and behind me on the sofa there was a blonde -- a sweet young blonde thing sitting on the sofa and he said, "This is my resident, Dr. such and such." He didn't say, do you mind if she sits in or anything.

She was just there. And he said to me, "So, what can I do for you today?" And I said, "Well, I think my husband and I have an infertility problem." So he said, "Okay, go inside. We'll examine you. I'm sure we can help you. Most of my patients get pregnant within a year." So I go in. I get undressed. I get on the table and I cover myself up with the sheet. And he walks in with her and they're giggling between each other as they walk in. And one of the basic things you learn in medical school is that when you go to examine a patient, you don't lunge at their body. You first hold their hand or feel their pulse or touch their forehead, or do something that is not sort of physically invasive. He takes the sheet off me and starts palpating my breasts. Doesn't say, "I'm going to examine you now." Doesn't even make a pretense of looking at the color of my eyes or whatever. And while he's doing that, he's flirting with her. And he says to her, "Do you have a stethoscope?" And she says no. And he says, "What kind of doctor doesn't have a stethoscope!" And it's all this flirtatious sexual banter...He's Israeli and has a real macho manner and she was a blonde. She was dippy and she was really unprofessional.

Ruth then showed the doctor her temperature charts she had been keeping for three months. (Temperature charts give some indication as to whether or not a woman is ovulating.) The doctor then showed it to his resident.

And he says, "I don't even know if she ovulates." to her, ignoring me. And meanwhile it's clear that I'm a physician...So he examined me. And he was brusque the entire while. And then while he's feeling my abdomen, he says to me, "Why would you want to work at a place like Elmhurst?" I said, "I like it very much"...And he said. "Oh but it's a city hospital. The patients are disgusting." I couldn't believe it...so I get dressed...He says, "Well, you need to do BBT and QRS and TUV." And I said, "What do all those things stand for?" And he told me. He said basal body temperature...and hysterosalpingogram and something else...I had an idea but I wanted to know if it hurt. When would it be done. How long did it take? Did I have to be admitted to the hospital? Like I'm a physician. Can you imagine if I didn't speak English well or if I weren't a physician. He was so abusive. It was so terrible. I felt intimidated. I tell you that I felt intimidated and that really is amazing because I'm not that easily

intimidated...I walked out of there and actually felt grateful because I thought this guy was going to help me.

The intimidation that this Ruth felt is typical of how many patients, infertility or otherwise, feel in the doctor-patient relationship. Infertility patients, however, might feel more intimidated by and grateful towards their doctors because their doctors help them achieve a major life goal -- becoming a parent. Fertility patients often say the doctor *got them pregnant*. This is an enormous amount of power for a doctor to have over a patient.

The rudeness and abruptness with which the woman above was treated was, unfortunately, not that unusual. Practically all the women had fertility doctor horror stories. But possibly because they are acutely aware of how doctors should treat their patients, the physicians in my sample expected more from their own doctors and seemed to be more upset by the treatment they received than my non-medical respondents. On the other hand, several of them were remarkably passive patients even though they were extremely upset with their doctors.

In addition to dealing with physicians, infertility patients often have to deal with other medical professionals. Many reproductive scientists, in fact, are Ph.D's not MD's, yet they may conduct medical exams and procedures. Nurses and physician's assistants also frequently perform medical procedures.

Normally infertility patients have no trouble with being seen for diagnosis or even treatment by non-physicians. But when the patient is a physician, the relationship becomes especially complex because you have a non-physician treating a physician. The non-physicians might be threatened by their MD patients while the MD's might be less tolerant of non-MD's than of MD's. The following woman, another internist, and the PhD reproductive scientist she consulted had tremendous difficulties relating to each other:

First of all he insisted on calling me Mrs. rather than Dr. And he is a PhD and I am an MD. And I think I even said it to him, "If you're going to call me Mrs., you're a Mr." But that wasn't the last final run in ... Everybody there was just nasty. I had to wait for an hour and a half to see him, when I had made a 9:00, and I didn't understand it, because obviously he's not a doctor. He didn't have an emergency delivery or something like that. He was in the hospital, quote unquote. "The doctor can't be reached. He's in the hospital." And I said boy, this guy has a lot of nerve. He's in the hospital and I wanted to talk to him and ask him a few questions. (She was then given a pelvic exam by one of his nurses or technician.) I had the most painful pelvic exam I've ever had. And I'm not squeamish about pelvic exams...So when I came in to see him after...I was waiting for an hour and a half, I had this extremely painful pelvic exam and everybody in the office insisted I was Mrs., couldn't be Dr. And they also insisted that I couldn't get a copy of my own report. It had to be sent to my doctor. I said but I am a doctor. That's why this whole Mrs. Dr. came in. And I don't ordinarily make a big fight about Mrs. and Dr., but I wanted to get my report and they wouldn't send it to me. Then he said, "That's not why you're upset." He said, "You're upset because you're infertile." And I said, "Oh God," I said, "You're not going to play psychiatrist on top of all this." So anyhow that was the beginning of my run in with\_\_\_\_\_. He was just entirely obnoxious. And he never gave me any professional courtesy, by the way. His fees were outrageous. (Hannah)

Conflicts and power struggles were common occurrences among my sample even in cases where the patients liked their doctors. Sometimes the conflicts were overt, as in the cases where the doctor and patient got into arguments, and sometimes more subtle, as in the cases where the patients found their doctors distant, insensitive or unresponsive to their needs.

Almost all my respondents had had fertility doctors whose personalities they did not like. While some of these women switched doctors because of this, others decided to stick it out believing that personality and bedside manner were not as important as technical expertise. Said one woman about her doctor, "(His personality) leaves a lot to be desired. But at that point, I'd been with a personality. So I didn't care if he was a real cold fish, he'd gotten this girl pregnant."

#### Confronting the Doctor

When patients have conflicts with their doctors, they have three choices: they can stay with that doctor and say nothing, they can confront him or her and hope the situation is resolved, or they can switch doctors. Most of the women were either too intimidated by their doctors to confront them, or felt that confronting would get them nowhere. However, some did try to talk to their doctors about what

was bothering them in an effort to resolve their conflicts.

It is usually quite difficult for a patient to predict the results of a confrontation with their doctor. However, those women who had good relationships with their doctors and felt they were treated as equals tended to report that their doctors took suggestions and criticisms quite well. The following woman had a very good relationship with her doctor and was generally extremely pleased with him medically and personally. However, she became very upset with him because he had not warned her about the side effects of a fertility drug he gave her. The drug, HCG, caused her breasts, thighs and abdomen to swell and she misinterpreted this as a sign of pregnancy. Because of her basically positive and equal relationship with her doctor, she felt comfortable confronting him.

I was very angry about the lack of information that had been given to me...I said that I really thought that if I was going to have these physical changes, he might have at least mentioned them to me because, under the circumstances, I thought other things were happening... And he said, "You're absolutely right and you have a right to be angry about it," and I said, "Well, don't let it happen again...don't let it happen again to your other patients." And he said, "You're right. You caught me on it. You're absolutely right." (Gail)

Some of the women who confronted their doctors found that although the doctor respectfully listened, it made very little difference in the doctors behavior. The following woman, Karen, expected a more equitable relationship with her doctor than he seemed interested in. She tried to discuss this with him.

A couple of times we made a feeble attempt to work out a relationship that would work for both of us. I said to him once, I said, "Listen, ...when I ask you questions, it's not that I don't trust you. Can we talk about this a little bit so that you understand where I'm coming from?" And we had like a little confrontation and an attempt to work something out. He listened and he tried a little bit. And then I'd go for another visit and we'd end up right back in the same thing. And I just realized it was hopeless. His style was his style. I wasn't going to change him. That it was really nothing to be angry about. He just wasn't the doctor for me. I know some very intelligent women who go to him because there are a lot of women who don't want to know. All they want to know is that they're seeing a good doctor. "Doc, tell me what to do, I'll do it."

Karen finally left him and switched to a doctor who was more open to a more equitable doctor-patient relationship.

Confronting a doctor is another way a patient can have or regain some control in the doctor-patient relationship. The following woman, Fran, found her doctor too sarcastic and insensitive, and felt intimidated by him. Fran became extremely angry when her doctor billed her \$1200 for a (dilation and curettage (D&C) after her second miscarriage. This was \$850 more than he billed her for a D&C after her first miscarriage. Fran phoned him up to complain.

The funny thing was that my husband told me that when I was calling him about my problems when I was pregnant he said I sounded like a little girl... But he said when I called him about the money, he said I sounded very grown up and very, you know, 'What do you mean by this?'

Fran said that when she was pregnant and afraid of having a miscarriage, she acted like a little girl with her doctor because she did not know what was happening to her and felt out of control. She said she was able to confront him about

money because she felt more in control over financial issues than medical issues. Although they came to a financial compromise, Fran continued to find him very insensitive to her emotionally and decided to switch doctors.

### Switching Doctors

Infertility patients -- perhaps because there is so much room for conflict in the relationship between fertility patients and their doctors -- are notorious among doctors for doctor shopping and doctor hopping. This was true of my sample. When conflicts cannot be resolved, or the patient believes that the doctor can not help her conceive, or the patient realizes that the doctor will never change, the patient usually switches doctors.

Patients switch doctors for a variety of other reasons besides unresolved conflicts. Sometimes there might be a precipitating event, or the patient might just feel that she cannot continue working with a doctor because of his or her personality as in the case above. Quite a few women who switched complained about their doctor's insensitivity, and others complained that their doctors and did not seem to know who they were. "I was annoyed with him that he thought I had only been coming a couple of months when I really had been coming like nine months," said one woman. "I was enough annoyed that it caused me not to go back." (Sara)

Becker and Nachtigall (1991) found that most of the infertility patients in their study changed doctors because of the physician's emotional detachment. Although a factor in some cases, this was not the primary reason most of my respondents switched doctors. In fact, some women who were very unhappy with their doctors did not consider switching. The following woman felt that she could not change doctors because she thought she had no alternatives. Then a woman from an adoption support group she contacted asked her about her doctor.

I started describing him and she said, 'I don't mean to intrude, but...' And she not only completely validated my feelings that this was a miserable way to be treated by a doctor, but the fact that I was infertile didn't mean that I should have such a bastard for a doctor.

(Amy)

Some patients who switched had liked their doctors but felt that they had done everything possible for them, and that they can go no further with him or her. Said one woman about her doctor,

I really like him. And I don't think he treats me in a paternalistic manner either. I think he treats me as an intelligent individual, not a dumb female...I hope I'm not going to have too much difficulty when I tell him that for my own peace of mind, I think it's going to be better for me to go to a fertility expert, and that I would love to come back to him after I get pregnant.

(Nell)

Most of the women had difficulty telling their doctors that they were switching, and many never bothered to tell the doctor. They just wrote or called the office requesting that their records be forwarded. Confronting the doctor

about his personality had been fairly easy for the following woman, a clinical psychologist. However, telling him they were leaving was quite another matter. She "never got up the nerve" to tell him directly that she was switching doctors.

What I did actually I guess is kind of a sneakier way out. I simply stopped going, which I think is probably what most people do. So what are you going to? I mean, if you tell him his personality doesn't jibe with yours, what difference is that going to make? (Alice)

Some women found it very difficult to switch doctors even though they were extremely dissatisfied with them.

Said one woman,

Towards the end...he would snap at me. "Don't you trust me? Why are you asking all these questions?" And I finally decided to leave. It was very hard leaving him too because at least I had built up some confidence in him as a doctor, and I was afraid to cut loose. (Karen)

Several other women wanted to switch doctors but their husbands were against the idea of going from doctor to doctor. One 39-year-old woman, Isabelle, wanted to change doctors because she had been on Clomid for many months, had tried artificial insemination twice and still was not pregnant. She felt that her present doctor did not have anything else to offer her and she felt "time was running out." Isabelle's father had read about a fertility clinic in an Ann Landers column and made an appointment. Her doctor, however, would not send her records and persuaded her to cancel the appointment, stick with him and keep taking Clomid. The same fertility clinic was subsequently

mentioned to her by her priest, so she decided to definitely go there. However, her husband did not want to change because he wanted to give their doctor a chance. He had read in a popular book on infertility that switching doctors can be a disadvantage because the doctor never gets to medically know the patient well.

Other women as well said that their husbands felt that they should stick with their current doctor because they already established a relationship with him. Some couples stayed with their doctors for many months or even years because they had never considered switching, were afraid to, or did not know how to find another doctor.

### Finding New Doctors

Once a woman decides to switch doctors, she still is confronted with the same problem she faced before, how to find a good doctor. Said one woman, a clinical psychologist, "I wasn't happy with my medical experiences," said Alice, a clinical psychologist. "I ran clinics so I have a very good idea of what's considered proper medical care and what's slipshod. And I was having trouble finding what I considered to be a decent doctor."

Another woman left her regular gynecologist because he prescribed estrogen cream while ignoring her husband's sperm motility problem. Finding a new doctor turned out to be

more difficult than she thought it would be.

I had no idea how to go about finding someone, but I presumed there were people who had this specialty...so I called places like Planned Parenthood whom I'm sure found it very amusing. But they were very helpful. They didn't know of anyone, but they gave me the name of a gynecologist in the Larchmont area...So I opened up the Yellow Pages and there was Dr.\_\_\_\_\_ 's name. (Gail)

Several other women mentioned looking in the Yellow Pages for a fertility specialist. Others used the lay referral system, and got recommendations from other women with fertility problems. The following woman who started trying to conceive when she was 38, decided to find a specialist after having seen her regular gynecologist:

I didn't mess around... I was getting older already. I said I wanted to be in the best hands from the start. So I started shopping around for a doctor and found Dr. \_\_\_\_\_... I asked everybody I knew. And the some people I gave more credibility than others. I asked the questions I was interested in. I wanted personal recommendations. And I ended with a list of probably half a dozen fertility specialists, and I started calling them.. A couple of them I ruled out because their secretaries were so rude to me on the phone. A couple of them I didn't like the answers to some of the questions I asked. (Karen)

The doctor she wound up with was, in fact, a certified reproductive endocrinologist with an excellent reputation both in the medical and lay communities.

A recommendation by a friend, however, was not always an indication of a doctor's qualification as a fertility specialist or even good non-specialist. A "good" doctor was often defined by my respondents as a doctor who helped a friend or acquaintance become pregnant. But this definition

of "good" actually had very little to do with that doctor's level of training, competence or ability to treat infertility in some cases.

One woman, Laura, after having spent over three years with a doctor who operated on her twice and gave her fertility drugs, was told by him doctor that there was nothing left for him to do. She was 38 at the time. Laura's doctor did not refer her to anyone else so she got the name of a doctor who helped a friend of her sister's become pregnant. She called but had to wait four months for an appointment. The day of her appointment the doctor cancelled to deliver a baby and she had to wait another two months. When she finally saw him, he diagnosed her problem as hormonal and said that was not his area of expertise. Laura then had to wait another few months to get an appointment with a qualified fertility specialist.

Those women with a large network of friends with fertility problems and those who joined RESOLVE or other self-help groups tended to be the most knowledgeable about infertility and who the qualified fertility specialists were. These women often had a chance to meet different doctors first hand and hear them speak at meetings. They frequently would wind up consulting or switching to those doctors.

However, like Laura, those women who did not know others who had fertility problems were often no more

successful at choosing a good second or third doctor than they were with their first.

It's really embarrassing to say for an intelligent woman what I did. But...I really didn't know where to find a doctor. And I happened to get a copy of Savvy Magazine which had a write-up on this guy ... who supposedly specialized in older women...He was number two, and he was a horror show. (Janet)

### Conclusion

When infertile couples decide to seek medical attention for their infertility, they are initially faced with two problems, finding a qualified physician and getting that physician to take them seriously. While ultimately they all find doctors to take them seriously, finding a competent, qualified physician was an on-going problem for most of the women in my study.

The doctor-patient relationship tended to follow a set pattern for most of my respondents: from dependency to disappointment to discord to disassociation.

Dependency: When an infertility patient consults a doctor, she depends on that doctor tell her if he or she is qualified to treat her. She also depends on the doctor to take her seriously, perform the appropriate diagnostic tests and follow the best course of treatment for her.

Disappointment: The patient may be disappointed if she discovers her doctor is not, in fact, qualified to treat her. Whether or not the doctor is qualified, the patient may become disappointed if he does not take her seriously or if he pushes her into following a course of treatment for which she is not ready. In addition, many patients become disappointed that their doctors fail to meet their expectations about the optimal doctor-patient relationship. The ultimate disappointment, however, is disappointment that the doctor has not helped her achieve a pregnancy.

Discord: Once the infertility patient becomes disappointed in her doctor, she is less likely to feel so dependent on him or her. She may disagree with the doctor's medical and personal treatment of her, and either keep her feelings to herself or verbalize her needs and dissatisfactions. If she does the latter, it may lead to disagreements, arguments or conflicts with the doctor.

Disassociation: Whether or not there is overt discord, by now the patient is ready to disassociate herself from the doctor and find a new doctor. She then has to go through the process of finding a new, hopefully more appropriate or qualified fertility specialist. Once she establishes a relationship with that new doctor, the process tends to repeat itself until a pregnancy is achieved or the patient

terminates medical treatment altogether and chooses to adopt or remain childfree.

In this chapter we have seen how the doctor-patient relationship is especially complex in infertility treatment, and that conflict is almost an inevitability. Not only is the patient and her doctor involved, but the husband is also an integral part of the treatment process. The doctor not only becomes responsible for helping the couple become parents, he, of necessity gets involved in the couple's sex life.

We also saw that the patient must take control of her own health care in order to maximize her chance of good medical and personal treatment as well as her chances of success. As one woman put it,

As an informed patient, I think I was able to add to my treatment. I think that we had quicker success because I was participating, and I was keeping track of things and I was able to remind him. I mean, I had some good ideas about my own treatment and he would say, "Hey, that's a good idea." But he was never threatened by it. He was always receptive to those suggestions. (Karen)

This is an example of "mutual participation" in the Szasz-Hollender typology of the doctor-patient relationship (Szasz and Hollender 1956). It is an optimal model of the doctor-patient relationship especially for infertility patients, one that they and their physicians should strive for.

In the next chapter we will explore the marital relationship. We will especially examine the impact that infertility treatment has on a couple's sex life, as well as other aspects of their relationship.

## CHAPTER FOUR

### THE INFERTILE MARRIAGE

In the last chapter we saw that the doctor-patient relationship in infertility treatment is not the usual dyadic one. Rather it is a triadic relationship involving the doctor, patient and patient's spouse. While the husband's involvement in some aspects of treatment is essential, it is also commonly a source of conflict in the doctor-patient relationship. But what about the interaction between the spouses themselves?

#### Husband's Involvement in Treatment

It was very important to the women in my study that their husbands be involved in their infertility treatment. Most wanted their husbands to accompany them to the doctor's office whenever possible. Although the husband's presence was not always necessary for medical reasons, the wives felt they needed their husbands presence for emotional and sometimes physical support. This was especially true when they underwent treatment or tests that were invasive, potentially painful, anxiety provoking, or when the test or treatment results were crucial in determining the wife's chances of conceiving.

The extent to which a wife perceived her husband to be involved in the medical aspects of infertility had an impact on the marital relationship. Most of the women in my sample reported that their spouses were fairly cooperative about going to the doctor when it was absolutely necessary. However, many said that their husbands resented having to accompany them to the doctor if their husbands felt it was not essential that they be there. This became a major source of conflict for some couples. Some men, in addition, were resistant to going to the doctor's office even when their presence was essential.

Each time I needed him to come to the doctor with me, I'd have to fight for it. I'd have to say I have an appointment Wednesday morning. And then Tuesday I'd say remember, tomorrow we're going to (the doctor). And he'd say, "Oh shit, I have a meeting." And he'd do that thing. And I'd say I'd really like you to come with me. And he's say "Oh, okay, all right, I'll cancel the meeting." And this whole big martyr schtick. (Ruth)

Even when the husband was the one with the fertility problem, the wife was the one who usually went for treatment since there is very little that can be done for male infertility. Some husbands with varicoceles (varicose veins in the testicles) underwent a minor surgical procedure, and a few husbands were given hormone supplements. But even in those cases, the wife was usually treated in order to compensate for her husband's subfertile condition. To enhance their fertility, some wives of infertile men were given fertility drugs and/or underwent artificial

insemination with either their husband's or a donor's sperm. If the husband's sperm were used, the only medical requirement for the husband was masturbation -- either at home in the doctor's office -- in order to produce a sperm sample.

### The Medicalization of Masturbation

Masturbation is probably the single most stigmatized normal sexual activity in our society. Many myths exist about the evils of masturbation -- it has been blamed for everything from causing blindness and insanity to causing sterility. It is ironic then that men who are trying to impregnate their wives are told that they have to masturbate as part of the infertility work-up or even treatment in the case of artificial insemination.

Many of my respondents reported that their husbands very much resented having to masturbate to produce sperm for tests or inseminations. Some of the husbands balked at or had trouble producing sperm samples for semen analyses. Their wives were furious at their hesitancy or lack of cooperation since semen analyses are an absolute necessity for every infertility workup.

The big deal is this jerking off into a jar in the morning when you have to go to work. And I'm late too and I have to sit there pleading with him ...he gets angry sometimes about it... he resented showing up late to work in the morning because of the masturbation in the morning. He said that it made him feel tenser at

work...he said he feels tense enough without having this creating more tension. (Hannah)

A husband's refusal to cooperate in producing a semen sample for artificial insemination is likely to significantly lower that couple's chance of a pregnancy. When the husband refused or was unable to "perform", it usually became a major area of conflict for the couples. "When he can't masturbate I absolutely flip out. Especially if it's a month that I've taken Clomid (a fertility drug)," said one woman. "It just drives me up the wall." (Sara)

Many of my respondents said their husbands hated having to masturbate at certain times, that it made them feel angry and humiliated. It was probably for the first time in their lives they were not only told that they had to masturbate, but when and even where to do it. Many of the men who attended RESOLVE meetings also talked about how humiliating and embarrassing it was, especially to be asked by a female receptionist or nurse to go into the bathroom and produce semen. Some found it very difficult to "perform" and were grateful when the bathrooms had Playboy or other "incentives". (Some IVF clinics have recently begun to provide, or suggest the men bring, X-rated videos for use in what some programs call the "mastabatorium.")

Men who go to a fertility doctor's office because they have to produce a sperm sample are in a situation where they are likely to feel doubly stigmatized. Every one in the

waiting room -- the receptionists, the nurses, the other patients -- would know that they are infertile and that they were there to masturbate. Although most wives were somewhat understanding about their husband's embarrassment, they were not too sympathetic. They felt that compared with the painful, invasive and potentially dangerous procedures they had to go through, having to masturbate was an innocuous, if pleasurable experience.

#### The Medicalization of Marital Sex

When sex -- normally a private, personal matter -- becomes medicalized and open to scrutiny, the results can be disastrous for both the individuals and the couple. Prior to infertility, most of the couples in my sample said they had very normal, happy sex lives. However, because infertility treatment medicalizes sexuality, my respondent's sex lives changed as a result.

In order to achieve a pregnancy, couples have to have intercourse within 24 to 48 hours of ovulation. At the time of my research, the most routinely used method to estimate when ovulation would occur was the Basal Body Temperature (BBT). This required that a woman take her temperature every morning before getting out of bed, and then chart the results. Most doctors required this at least for a few months, but many women continued doing BBT on their own so

they would be aware of when they were ovulating.

Based on the fluctuations of the temperature chart, doctors would tell couples on which days they should "schedule" intercourse. Doctors also required the women to circle or check the days on their charts when they had sexual intercourse and the doctor would try to discern if they had sex at the "right" time or frequently enough to make conception possible. Therefore, a couple's sex life literally became an open book. It was no longer dictated by their love, affection, sexual desire or hormones, but by the doctor and thermometer. As one woman succinctly put it, "There was very little making love. It was mostly making babies." (Kay)

For most of the couples, scheduled sex drastically changed their sexual relationship, at least temporarily. "Sex became very routine and almost dreaded," said one woman (Sally). Scheduled sex became a serious problem for some couples and significantly interfered with their sex lives.

When I was on the Pergonal I would call (the doctor) when my temperature was about to go down, and she would say, "Okay, have intercourse tonight, tomorrow and the next day." Well, you can't perform that way. It's horrendous. You feel like animals, not human being. So it made us the best of friends and for a long time very lousy sex partners. (Wendy)

In addition to telling their patients when to have sex, some women were told by their doctors what position they should use, how often to have sexual relations, and how long they should remain in bed after intercourse. But it was not

just their doctors who dictated sex. Most of the woman were aware of their fertile days and would try to control when they should have sex. This wrecked havoc with many couples sex lives.

Sex for a couple of years was horrible. Just horrible. I thought well, I really love this guy. But it really makes you question -- you know you love him but you really wonder because you're not getting anything out of sex...I felt such pressure to make sure we were having intercourse every other night for a few nights in a row, that there just wasn't any enjoyment. (Mary)

In some cases, like the following, trying to have sex at the right time of the month got carried to the extreme.

I'd tell him two or three times in a cycle, this is it, I'm going to ovulate. We have to screw. And then I'd end up wanting to screw every six hours or something. And I mean it did get really crazy...After my second miscarriage ...we decided we were just going to do it every two days no matter what. And then as soon as I'd get my period, I'd start immediately obsessing about when we were going to be fucking. And it was a problem for us too because of our schedules. There were some times when I'd leave in the morning and he'd be in bed and he'd get home and I'd be in bed at night. (Elaine)

This couple, both psychotherapists, were ultimately able to work things out to their mutual satisfaction and have a more normal "scheduled" sex life. Many women, however, reported that their spouses very much resented scheduled sex.

Because of the resentment about scheduled sex and/or the pressure to have sex, quite a few husbands had bouts of impotency or trouble maintaining erections. Said one woman, "From [my husband's] point of view, the closer it seems to be to baby-making as opposed to sex, the more difficult time

he had and the more he refused to be involved, and the more upset he became, and unable to perform." (Beth)

As a result, some of the women were forced to become more subtle or secretive about when they were ovulating and when the doctor required them to have sex. Some women said they wore sexy negligee or were very seductive during ovulation in the hope that their husbands would not be aware of their real motives and feel pressured to perform.

Impotence was not the only sexual problem that resulted from scheduled sex. Many of the women said they became unable to achieve orgasms or had even totally lost interest in sex. This, in turn, also affected their husband's enjoyment in sex as the following woman, Bonnie, graphically described:

He really doesn't have any problems functioning as such [but] he doesn't seem to reach orgasm very quickly. So I think he's probably really working at it. I feel really bad about that, but I figure what else can you expect when you're demanding something that isn't coming spontaneously. And I think he probably knows that I'm lying there thinking, just deposit the sperm and leave. Which is all I'm interested in. I'm not interested in sex anymore. I'm interested in conception...If I could take a little pill in the morning instead of having sex, I would rather do that--that would be wonderful.

#### Babymaking vs. Lovemaking

The function of sexual intercourse for virtually all infertile couples becomes procreation rather than recreation. Therefore, when conception fails to occur, sex

is often seen as the cause of that failure. So not only did sex become a routine and sometimes difficult chore for many of the women in my study, it also became associated with failure rather than pleasure. "You're going through the motions of something that time and again has been proven clinically to be unsuccessful," said Bonnie. "Unless you have absolutely no brains and no sensibilities and no sensitivities, you've got be affected by all that negative reinforcement."

Many women came to view sex as an unappealing and unpleasurable required chore. In spite of this, some of these women were still able to view intercourse as a hopeful event. "It's much easier to lie there and just be a piece of meat," admitted one woman. "But I'm very glad to have sex, because sex means to me a chance to get pregnant. So I will have as much sex as I can. However, it's not for lovemaking, it's for babymaking. (Beth)

The majority of women reported that they had sex less frequently than they did before they discovered that they had a fertility problem. Because of scheduled sex, many said that they had intercourse primarily during the first part of their cycle, prior to and during ovulation, and much less frequently after ovulation. "After ovulations I didn't have any interest in sex at all," admitted one woman. "And then when I got my period ...it was like, oh, it was too messy, why bother?" (Terry)

Sex just for pleasure was a thing of the past for most of the women. Sexual intercourse was almost considered a form of medical treatment. Therefore, for most, any form of sex that could not result in a pregnancy -- such as oral sex -- was considered a waste of time.

We started to have oral sex, and I was all prepared to stop so that he could come inside me. And he came faster than I thought. So I was really upset that we wasted the semen...I felt selfish in stopping and he was enjoying himself, and I didn't want to make everything very clinical. But I went into the bathroom and I was crying, and I didn't tell him because I felt bad."  
(Helen)

Several women admitted that sex with their spouses, even before discovering they had a fertility problem, had never been particularly good. For them, infertility and scheduled sex did not help matters. Said Bonnie,

Sex was never a really strong suit. We get along in so many other ways and [infertility] has attacked the weakest part of the marriage, which is the sexual part...it has really wreaked havoc. My husband is extremely loving and extremely affectionate and extremely supportive. He's not a particularly sexual man.

The possibility of having an affair occurred to some of the women in my sample, although none admitted carrying out the fantasy. Bonnie felt that if her husband was more sexually interested, she would be able to get pregnant. Therefore sex with another man, at least in her fantasies, was the solution.

I have thought in my real dark moments that maybe it's just my chemistry with him that's not working out. Maybe I should contact an old boyfriend or something. I mean, horrible thoughts that I wouldn't even have under

any other circumstances. Not for an affair, not for kicks. But just for this right sperm, in my search for this master sperm that can find its way to this very obviously elusive egg.

While scheduled sex had a disastrous effect for some, others did not seem to mind. A few women said that even though they no longer had sex drives, their husbands enjoyed the fact that they had to have sex more frequently. Also several women mentioned that not having to use contraception was wonderful and enhanced their sex lives.

#### Scheduled Abstinence

Scheduled sex was not the only problem for the couples in my sample. There were times throughout a cycle when a doctor would tell a couple to abstain from sex at certain times, such as a few days prior to ovulation, in order to build up the husband's sperm count. Also, some women were diagnosed as having sperm antibodies, a condition in which a woman's antibodies kill her partner's sperm. Couples with sperm antibodies were often told to abstain from sex or to use condoms for several months. Neither of these prescribed treatments were welcomed by either my respondents or their spouses. As one woman put it, "you don't get pregnant with condoms!" (Hannah)

Many of the women in my study decided on their own to abstain from sex for certain periods of time because they wanted to "save up sperm" for when they were ovulating.

Others abstained when a pregnancy was achieved or even suspected because they were afraid that having intercourse might cause them to have a miscarriage. In fact, some couples were told by their doctors to refrain from intercourse for up to three months because of concerns about possible infection and subsequent miscarriages. One 43-year-old woman, Janet, had become pregnant when she was 40 and was told to abstain from sex. She miscarried and the doctor told her not to have sex for six months. "Then things were slightly normal," she said, "but then we started the inseminations and you've got to abstain to build up the sperm." Janet also had negative side effects from the fertility drugs so did not feel like having sex. "It's really practically been a platonic relationship," she admitted. In fact, she felt so badly about the situation that she suggested to her husband that he have an affair.

As we can see from the above examples, it's virtually impossible to have a normal sexual relationship, and therefore a normal marital relationship during infertility treatment. As one woman put it, "For the past three years [sex] has been a constant preoccupation. Either we were trying to get pregnant, or I'm pregnant and we can't screw. Or I just miscarried and we can't screw." (Elaine)

Sexual intercourse -- a once spontaneous act of love and sexual desire -- became a chore, a duty, a medical prescription often devoid of any feelings of sexuality or

even love. Scheduled sex combined with the mood changes caused by both fertility drugs and continued failure to conceive could not help but adversely affect a marriage as the Bonnie discovered:

What kind of relationship can stand up to "Today we have sex, tomorrow we don't have sex"? What relationship can stand up to the fact that two weeks before I get my period I start to get depressed because I start getting pre-menstrual symptoms?...Then I get my period and then five days before my period I take all the estrogen or progesterone drops and start getting crazy and tense. And then you not only have the misery of having your period, which is always a drag for 24 hours anyway, but the combined drag of not producing what you want....How much can a relationship tolerate of that? And in such a sensitive area as sex? How much can you bang sex around before it just sort of completely eats away at the rest, the good part of the marriage, the trust and the love and the sexual feelings and the attraction and all those things that really hold a marriage together? How soon will it be before some part of me does blame him...for not getting me pregnant?

### Resentment, Blame and Guilt

With all the physical, sexual and emotional turmoil caused by infertility, it was common for spouses to resent and blame each other as well as themselves for their predicament. Some women blamed their infertility on the fact that their husbands made them wait too long to start trying to conceive, while others blamed it on the fact that their husbands were not sexual enough. A few blamed their husbands for having the primary fertility problem, but they tended to feel guilty about having these feelings.

I must confess that when I felt that I was fine and that it was his problem, I felt very resentful towards him --

that if I had married somebody else I would have three children, and what did I do to deserve this...but then it became apparent that I had a problem, and he's a better person than I am because he doesn't have these resentful feelings. (Janet)

In several cases, the husband's fertility problem was diagnosed until after the wife had already been through infertility treatment, and this caused considerable resentment. "I was going through all that shit and taking the blame, and having people tell me to relax, that kind of thing, including him, said one woman about discovering that her husband had the primary fertility problem. "I was furious at him." (Paula)

However, some women whose husbands had the primary problem still managed to blame themselves, especially if they were the ones who were more interested in having children. The following woman was married to a man who had children from a previous marriage and had initially refused to have more children:

The thing that really bothered me was that my husband had a problem and he was possibly going to have an operation, and that was the worst type of infertility that I could imagine because I was the one that wanted the children and he was going to have to have an operation. There was a lot of guilt involved in that. (Helen)

When the wives were the ones with the primary fertility problem, they often felt guilty and blamed themselves for their situation. "I feel guilty because it's me, and there's nothing I can do about it. And then I feel guilty because I'm older and that there isn't that many years for me to

work it out," said a 39 year-old woman married to a 35-year-old man. (Isabelle)

### Husband's Emotional Involvement

Regardless of who had the primary fertility problem, my respondents invariably felt that they were more emotionally involved in infertility than their spouses. This often resulted in considerable problems and conflicts for the couples. Some of the women got into arguments with their spouses because of their lack of involvement. When husbands refused to discuss infertility and their feelings about it, my respondents often interpreted this to mean that they did not really care about having children.

Many of these women, in fact, did admit that their husbands were not as interested in having children as they were. For most of these women, the fact that their husbands were not as emotionally involved as they were meant that they had to carry the full psychological as well as physical burden themselves.

I felt he wasn't as concerned about it, about the whole infertility, as I was. That I was doing most of the work, because I was the one who had to go to the doctor and I was the one who had to get the injections, and I was the one who had to make the appointments, and call her and get follow up and get the lab tests, and schlep him to go there. And I was the one who kept bringing it up for discussion, like when should we think about adoption? Or when should I change doctors? Or should I have the laparoscopy? (Ruth)

On the other hand, when husbands were more open about discussing infertility and their feelings, it tended to bring the relationships closer together. Ruth, the woman above who had accused her husband of being uninvolved, described what happened when her husband returned home from a business trip and discovered his wife had not conceived that month:

He said, "You know last night when you told me that you'd gotten your period, I felt like you stabbed me. And I realized that even though you accuse me of not being concerned about it, I really am. In fact I'm so concerned about it I can't even deal with it. And it's really hard for me." And then we both started crying.

#### Gender Differences

Husbands and wives react differently to infertility as the above example poignantly shows. While most of the women in my study were aware of these differences, they were not particularly happy about it. The overwhelming majority of my respondents felt that infertility was harder on them than their husbands. "I do feel like the whole thing has had much more of an impact on me, and that he's physically been removed from it," said one woman. "He's like the stereotype of a man who is able to suppress it all, and goes to work. And it just doesn't have the same meaning and terror."

(Michelle)

The women in my study tended to obsess a lot about infertility -- it was an integral part of their everyday

lives. Because women are ultimately the ones who will or will not become pregnant and give birth, infertility does indeed have more meaning for them in a very personal as well as biological sense. This is one reason why women have a much more difficult time emotionally dealing with infertility.

It is, in fact, virtually impossible for women not to obsess about infertility. As we have seen, infertility treatment for women often requires frequent doctor's appointments and hormonal regulation both of which require close monitoring of a woman's menstrual cycle. The monitoring of the menstrual cycle requires daily temperature taking and charting, and for some women, the monitoring of her cervical mucous for signs of ovulation. So even if a woman tries to forget about her infertility, she has constant reminders: every morning when the first thing she does is put a thermometer in her mouth, every time she goes to the bathroom and looks for menstrual blood or checks the quality of her cervical mucous, and every time she and her husband make love and she wonders if this time it worked or were they wasting time and sperm because she was not ovulating. As one woman graphically put it, "It's with me every single day. I wake up with it, I go to sleep with it, and I think about it literally fifty times a day. It is always with me. I dream about it. It's night and day, and day and night, seven days a week, ever since this began." (Bonnie)

Unlike women, men -- even those who are diagnosed as having a fertility problem -- do not have these constant reminders of their infertility. Many women resented the fact that their husbands could easily avoid thinking about infertility. "I've been the one that's living with it. He can distance himself from it and forget about it," said another woman. "For three years it's been like a constant, like my heartbeat." (Elaine)

Most of the women admitted that they not only obsessed about infertility, they frequently wanted to discuss their infertility treatment and options with their husbands. None of their husbands, however, wanted to discuss it as often as they did. This frequently caused misunderstandings and conflicts in the marriage. One woman, for example, said that her husband resented the fact that she sometimes called him at work to discuss an infertility or adoption issue. (Hannah)

From the women's perspectives, discussing infertility with their spouses was not just an obsession, it was a necessity. As we saw in the previous chapter, many important medical decisions had to be made during the course of infertility treatment. Ideally, these decisions would be made with the consent and agreement of both spouses.

Making informed medical decisions requires a certain base of knowledge. Many women in my sample read a lot of books and popular articles about infertility or obtained

information from support groups. When their husbands did not have the same base of knowledge, the decision-making process became even more difficult. One woman was upset because her husband not only was hesitant to discuss infertility, he was also hesitant to read about it. "I've practically had to threaten to kill him if he didn't read the fertility book," she said. "I got really pissed off that he wouldn't sit down and get totally absorbed in the fertility book." (Nell)

Most of the women said that their husbands also were reluctant to discuss infertility with friends or relatives, and this too often became an area of marital conflict. Several women said their spouses did not even want them to discuss it with their own friends and relatives. Said one woman about her husband's reaction to her discussing their infertility problem,

In the beginning, he couldn't stand it. He would just absolutely get furious. I think he found it very embarrassing, and I guess [felt] demasculinized. He didn't want anyone to think it was his fault or his problem or anything like that...I guess he would rather have people assume that if we didn't have any children, it was because we didn't want children. (Hannah)

It was not unusual for the husbands to try to "pass" as fertile and voluntarily childfree. Some husbands went as far as forbidding their wives to talk about infertility with anyone. In fact, several said they had to ask for their husband's permission to be interviewed for this study. One woman, Paula, had to resort to discussing their fertility

problem "on the sly" because of her husband's rather paranoid attitude. "It wasn't that he wanted people to think it was my problem," she explained. "He didn't want anyone to know that we were even trying to conceive." She went into group therapy and in one of the first sessions told the group that she had been trying to get pregnant:

I came back and I told (my husband) about it. And he got upset about it. I said, "Why do you care? They don't even know my last name." He said, "Yeah but they can figure it out." I said, "We don't even use the same last name." He said, "But yeah, you know, Paula at \_\_\_\_\_." Twelve thousand people work there!

Subsequently, when it was discovered that Paula's husband also had a fertility problem, they started communicating about it better. "It was impossible to avoid the issue, especially in marital therapy...it's not a taboo subject in there," she explained.

The stigma of infertility appeared to be much greater for the husbands than for their wives. Once the women accepted the fact that they or their spouses had a fertility problem, infertility became part of their identity, even if they only selectively revealed their infertile status. Some even engaged in "deviance avowal" and made infertility the focus of their lives. These women tended to freely reveal their infertile status to virtually all their acquaintances. Some become very active in self-help organizations for infertile people such as RESOLVE. Infertility became an integral part of their identities.

Many husbands, on the other hand, were more likely to engage in "deviance disavowal", either ignoring or denying their infertility. They wanted nothing to do with infertility or support groups. They especially did not like discussing it with anyone including, their wives. Their wives, found this very distressing since they much wanted and often needed their husbands to be emotionally involved in infertility and it's treatment.

#### Considering Stopping Treatment

Gender differences also played a role in decisions about infertility treatment. Decisions about initiating, continuing or stopping treatment tended to be more complex and difficult for the women because they were usually the ones who had to undergo the medical interventions. Many women, like the following, found that their spouses were sympathetic to their decisions about treatment and other options.

He accepted my unwillingness to have the surgery. We talked very frankly early on about what it might have meant for him to have his own child...he said everything bad that was on his mind to me, and yet he still said that he cared for me and would respect any opinion that I came up with. And he could definitely consider adoption. (Lynn)

However, not all husbands were so understanding about what their wives were going through, or the difficulties they had in making decisions.

He started getting depressed about the fact that the news was getting worse and worse. And he was also starting to see that my patience and psychic energy to continue was being used up...I really wasn't sure that I was going to go back to trying at all. At that point I was letting myself consider all the options, and by that I meant everything from continuing trying...to never having children...I had more or less said to him, it ain't my problem anymore...he was very angry that I was no longer so committed, that there was the possibility of my quitting...And he was very hostile to me in a kind of general sense. He went through a period where he criticized everything that I did. He was on top of me. My showers were too hot. My hair was parted in the wrong place. I served too much soup or too little soup...He was just constantly criticizing me. And I was real aware that he was real angry at me. I don't think I was aware at that point how angry I was at him...When we finally sat down and talked about it, all those complaints translated into, "You're not doing this the way I would do it." And that's what he was feeling about the infertility. "You're not dealing with this the way I would go about dealing with this." (Amy)

Whether or not to stop treatment was a major area of conflict for many couples. The wives tended to be the ones who were ready to stop medical treatment and look into other options, especially adoption. They would decide that "enough is enough" while their husbands wanted them to do anything possible that might result in a pregnancy. In the following case, the wife's decision to stop treatment led to misunderstanding and almost a divorce:

At one point...I stopped taking the medication. I just freaked out completely and I said I can't do it anymore! And that in turn affected David. He couldn't understand what I was doing. And we were very very close to breaking up at that point...I couldn't get him to go to a therapist at that point. But I felt something had to give...And we called our friends in Chicago... and we flew out there. Both of them are social workers and both of them are family therapists. It didn't resolve too much other than it took some of the pressure off. I still wasn't sure that I wanted to continue, but when we

got back I started taking Clomid again...It wasn't so much that I didn't want to continue, it's that I was so ambivalent about it. And I, until recently, didn't understand that was really what was upsetting him.  
(Jane)

In both examples above, the husband's anger was, at least in part, due to a lack of control over both their reproductive lives and over their wives whose decisions and actions could affect their chances of having a biological child.

#### Considering Adoption

Practically all the women said their husbands had a more difficult time than they did in accepting the fact that they might never be able have their own biological child, and that adoption might be their only option. The issue of whether or not to adopt or even consider adoption was extremely emotionally charged for most couples and one which precipitated many marital arguments.

As mentioned above, when spouses were not in agreement about adoption, it was usually the woman who wanted to adopt before her husband felt ready or would even consider it as an option. Because women undergoing infertility treatment usually go through more both physically and emotionally than men, it might be somewhat easier for them to stop medical treatment and give up the idea of having a biological child. Those women who were considering stopping treatment and

pursuing adoption said they realized that having a baby was more important than achieving a pregnancy.

In addition, since men are so far removed from pregnancy, and childbirth to begin with, the ability to impregnate their wives takes on a very important physical and emotional role for them. Some men might see their genetic contribution and biological connection to a child as the only thing that makes them a father. Therefore getting their wife pregnant has an important symbolic meaning for them as well. If they cannot "father" a child, they may feel that they have no other major contribution to make and even fear that they will have no interest in the child. In fact, the term "to father a child" means to get a woman pregnant, while "to mother a child" means to nurture it. Women, therefore, may have an easier time looking beyond the biological connection and seek parenthood rather than pregnancy as their primary goal.

Some of my respondents' husbands hesitantly agreed to consider adoption, but with certain stipulations that made things difficult for their wives. One woman, Dinah, had been told by her doctor after he performed a diagnostic laparoscopy that she had no chance of conceiving. Her husband then told her that since she could not conceive, he did not want to adopt for two years. This was a double blow to her. As Dinah put it, "I'm now getting punished. I can't conceive and therefore I don't get to get what I want,

which is a baby."

Quite a few women said their husbands were totally opposed to adoption. One woman said when she brought up the subject, her husband was so against it, he would refuse to even discuss it. She recalled him saying, "If we can't have our own children, I don't want anybody else's children. And besides, there are no healthy normal intellectually curious Caucasian babies up for adoption anyway." (Bonnie) Others reported that their husbands said they were opposed to adoption because they could not be guaranteed a normal, healthy child. One woman said her husband told her he did not want to adopt because he did not want "anyone else's trash." (Diane)

It was not just concern about the adopted children that prevented some men from wanting to adopt. My observations at RESOLVE meetings as well as my interviews made it very clear that, for many men, adoption was extremely stigmatizing. If they adopted, they could no longer hide the fact that they are infertile or try to "pass" as fertile by claiming that they were childless by choice.

Adoption is proof positive that a man could not "get his wife pregnant". Some of the men at RESOLVE meetings as well as some of the husbands of my respondents confused infertility with impotency and fertility with virility. These men therefore tended to believe adoption would be a reflection on their masculinity, and that people would think

they were impotent if they adopted. An example of this is the woman whose husband did not want "anybody else's trash." She excused his insensitive, hostile remark by saying, "He's feeling terribly impotent and feels that, quote, his cock doesn't work." (Diane)

Not all husbands, however, were opposed to adoption, and some were even more open to it than their wives. Because adoption involves a lot red tape, it is virtually impossible to pursue unless both spouses are in agreement. Those women who were actively trying to adopt tended to have the full cooperation of their husbands.

Nine couples had already adopted babies at the time of interview. Although coming to the decision to adopt was not easy for any of them, once the baby arrived, their concerns were dispelled. They all reported that they and their spouses were extremely happy about their decision to adopt. Most were still in the process of pursuing a pregnancy because they wanted more than one child. However, they all said that they would adopt another child if they did not become pregnant.

#### Positive and Negative Effects

Virtually all the women reported having some marital problems related to infertility. However, most felt that their marriages were strong enough to overcome these problems. Some had the help of therapists or support

groups, but many were able to resolve many of their problems on their own. The majority of women felt that, in spite of, or perhaps because of these problems, they had gained something positive from infertility. They talked about how they and their spouses were forced work together to confront their fertility problems, overcome them, and find mutually satisfying solutions. Many gained a new respect for their spouses and their marriages, and talked about how infertility actually strengthened their relationships. Infertility also forced many of the couples to discuss, often for the first time, the meaning of parenthood and the importance of children in their lives. Most decided that having children was essential to their marriages, and that they would do anything to have children. A few, however, decided that their marriages were the most important thing to them, and that they could be happy without having children.

While most women felt that their relationships became strengthened or closer, several were concerned that their marriages might not be strong enough to survive the problems caused by infertility.

I think we both have been concerned because it has created such enormous pressures on the marriage. More so than money or in-law problems or even personal trouble that you run into from time to time in the relationship. It is an underlying crisis that's with you all the time, and yes, I would have to be concerned with the future of the marriage if it continued like this. (Bonnie)

Some women admitted to coming close to separating at times during infertility treatment. One woman had been very ambivalent about having children, and at one point, her husband talked about leaving her because of her it. She told him she would understand it if he divorced her. But ultimately they decided that whatever the fate was, they would face it together. "I'm glad that we've gotten to that point," she said. "I guess it's part of being closer now than we've ever been." (Jane)

Not all the couples, however, fared so well. Three of the relationships, if fact, did not survive the crisis of infertility. In the following case, the couple started trying to conceive after two years of marriage when the wife, Carrie, was 34. Her husband, Nick, had two teenaged children from a previous marriage and had had a vasectomy. Carrie conceived twice with donor sperm and miscarried both times. She was in the process of leaving Nick after seven years of marriage when I interviewed her.

[Infertility] has caused stress in the marriage. After five-and-a-half years of temperature charts and trying and anticipation and so on, it really has caused problems. The marriage is breaking up. Not because of this, this had just been one problem area, not the thing that's causing the marriage to end...I don't think the marriage would have been successful anyway. But it definitely contributed. Because at a point where the marriage was in a lot of difficulty, my husband felt that we should really stop trying to get me to conceive because the marriage was in trouble. But because of my age, I had to continue. So that in itself caused problems.

In spite the impending break-up of her marriage, Carrie was

seriously considering continuing to try to conceive on her own with donor sperm.

Another woman, Nina, had recently separated from her husband, Sam, of 15 years when I interviewed her. Sam was from an Israeli (Yemenite) family of 11 children. (His father had two wives when bigamy was still legal). According to Nina, in Sam's culture, "the only thing is life is your children. If you don't have children, you're basically a cast-off." Sam, however, had a very low sperm count. In fact, because his sperm count was so low, the first doctor he went to thought he had had a vasectomy! He was diagnosed, however, as having a varicocele, which was subsequently operated on. But his sperm count remained low and the doctor recommended they use donor sperm. According to Nina, Sam seemed to have no trouble accepting the idea of using donor sperm. Nina conceived after four months of inseminations, but had an early miscarriage. As the months went by with no success, Sam became less involved in their infertility, and Nina became more depressed.

[The marriage] got really worse over the infertility issues because it brought out a lot of other things. I mean, it brought out the roles and what people were supposed to be doing in marriage. And I can't attribute the failure of our marriage entirely to it, but I think that it was a contributing factor because it opened up such a Pandora's box...the last three years we lived in New York and I was pursuing the AID, it was deteriorating...I almost stayed in the marriage because I was very desperate to have a child, and it seemed to me like the only way I could do it at this stage...I'm 36, if I get divorced..I won't be able to have one at all.

Nina said, in retrospect, that she should have discussed his feelings about using donor sperm more, even though Sam seemed to have no problems with the concept. While she looked at donor insemination as "an injection", she never really knew how Sam felt because he would never discuss it. In fact, she was in a RESOLVE support group and tried to get him to go to a therapist, or at least RESOLVE meetings, but he refused.

Both of the marriages above ended more or less by mutual consent and on fairly friendly terms. In the following case, however, when Bob walked out on Karen, it came as a total shock to her:

We had such a terrific attitude about [infertility]. We were the picture of mental health. I mean, if you saw us during that year you would say, boy, aren't they handling this wonderfully? Look at them. They're so wonderful. They're doing everything. They're together on it. They're supportive.

Karen and Bob had been living together for over six years before they decided to get married. Karen had never wanted to have children, be pregnant or go through childbirth. But Bob, who was seven years younger than she was, had desperately wanted to have children. In fact they broke up several times before they got married because she would not commit to having a child. Except for their conflict over having children, Karen was very happy with their relationship, and decided to go into therapy to deal with her negative feelings about having children. She

ultimately worked out these negative feelings, and because she was 38, decided to try to conceive even before they got married. It turned out, however, that Karen was not ovulating, and Bob's sperm were of very poor quality, and they both wound up taking fertility drugs.

Bob never came to terms with their fertility problems, Karen claimed. "He always said, 'I refuse to face the prospect that this might not work out. It's going to work out. That's all.'"

They continued treatment and artificial insemination with her Bob's sperm for six months, at which point the doctor recommended using donor sperm (AID). Bob reacted "very very badly" but agreed to work on it in therapy. (He was also opposed to adoption.) Karen's doctor in the meantime had recommended that she have a laparoscopy which she did not want to have because she was terrified of anesthesia. In addition, because they already had a diagnosis, she did not believe they would find anything else wrong. However, she told Bob that she would agree to surgery if he made a commitment to try three to six months of donor sperm. Bob agreed, Karen had the surgery, and was given a clean bill of health.

I think that's what did it. I think that's when Bob freaked out a little, because it now became clear that it really was him with the problem. We did one month of donor sperm. It was the most horrible month I ever lived through in my life. He was unbearable and mean to me...he confessed to me...that he didn't think he could go through with it any more, and it had been such an awful experience for him. So I said, 'What do you

mean?' He said, 'I don't think I can continue - I don't think I can give up having my own baby, and it's clear to me that we can't have one. I think it's time to think about ending the relationship.'

Karen had a pregnancy test and the results were negative.

That night Bob had a session with his therapist.

He told me it was all over when he came home. He agreed to have one joint therapy session in which it became apparent that he wasn't even open to working on it in therapy. And he was gone. Never looked back...I just sort of assumed that the issue for Bob was having a child, and that he couldn't see living his life without having a child as part of his life. And I could accept that. The part that I couldn't accept and still cannot accept to this day was that it had to be his own biological child. To me that's not coming to grips with reality...I think that is a sickness to be so compelled to have your own biological child that you will walk out of a loving, wonderful... I thought it was a loving wonderful marriage.

It is interesting to note that in all three cases of failed marriages, the husband had a primary fertility problem, and all three couples resorted to using donor sperm. Even though a woman who has artificial insemination with donor sperm does not actually have intercourse with the donor, she is trying to conceive with another man's sperm. As a result, some men tend to think of donor insemination as adultery. In fact, some religions, such as Orthodox Judaism, actually do consider it adultery, and other religions including Catholicism and Lutherism are opposed to the practice (Andrews 1984).

The problems some men have with donor sperm have been well-documented (Menning 1980; Cooper and Glazer 1994). The

secretness surrounding the use of donor sperm -- not to mention male infertility itself -- is a major problem for many couples. As I mentioned earlier, many men do not want or allow their wives to discuss their fertility problems much less the fact they had to use another man's sperm to achieve a pregnancy. In addition, couples are often counseled -- especially by physicians -- not to tell anyone they are using donor sperm. Some doctors, in fact, either mix the husband's sperm with the donor sperm or tell the couple to have intercourse the same day as the insemination so that there is a chance, however remote, that the child will be the husband's. While many couples are comfortable with this, for some, the secretness surrounding donor sperm only adds to the stigma of male infertility. It is no wonder then that some relationships do not survive.

On the other hand, when husbands and wives are open about their feelings about using donor sperm, the results can be very positive. In fact, according to Andrews, "Ninety-eight percent of those couples who bear a child via AID feel their decision was the right one and a majority of those who have AID children decide to have another child in the same manner" (1984, 186). And Sherman Silber, a urologist and specialist in male infertility, found that couples who use donor sperm have a lower divorce rate than the general population (Liebmann-Smith 1986).

In order for a marriage to survive infertility, each

couple has to find the options and solutions that work best for them, whether it be adoption, donor sperm or childfree living. Most of the women in my study were grappling with the process of finding the best resolutions for both their infertility and their marriages.

### Conclusion

As we have seen in this chapter, infertility affects every aspect of a marriage. Because infertility medicalizes sexuality, a couple's sex life invariably changes, usually for the worse. Husbands and wives react differently to infertility, and that in turn affects their relationship with each other.

In general, the wives were much more involved in infertility than husbands. The extent to which the husband was involved -- or at least the wife felt he was involved -- in the emotional and physical aspects of infertility often determined how the marital relationship fared. The women whose marriages seemed to be doing the best were the ones married to men who were involved in many aspects of their infertility and it's treatment.

The process of overcoming the crisis of infertility ultimately forced couples to confront areas within themselves and their relationships that most other couples never have to deal with. Some relationships could not

survive the crisis of infertility and the couples split up. Others relationships were in jeopardy. However the majority of women felt that going through infertility helped strengthen their relationships with their husbands. Their marriages were thriving in spite of, and perhaps partially because of this crisis.

The following woman, Gail, in summing up her marital relationship, articulates what many others felt about their marriages:

I think probably our relationship is stronger, our mutual respect for one another is greater, our love is certainly deeper, and it's a whole different relationship than when we started. And probably a much better one...I think going through this process put a real strain on the marriage...I think if you survive it...I can't imagine another thing happening in our marriage that we wouldn't be able to deal with having survived and experience this together.

## CHAPTER FIVE

## THE SOCIAL AND ECONOMIC IMPACT OF INFERTILITY

In the previous chapter we saw both the negative and positive impact that infertility has on the marital relationship. This chapter explores the impact infertility has on other interpersonal relationships and on careers.

## THE IMPACT OF INFERTILITY ON INTERPERSONAL RELATIONSHIPS

Relationships with Family and Friends

It is not only the nuclear family that is affected by infertility. Relationships with extended family members as well as ones friends, peers, and co-workers are also affected. Because infertile couples are often faced with pressure from others to have (or not to have) children, infertility can become an extremely emotionally-charged interpersonal issue. Therefore, the decision of when and how they tell others about a fertility problem is a very personal, and sometimes difficult one. The stigma of infertility makes the decision about discussing infertility even more difficult. The reaction of others to this information and their subsequent behavior toward the infertile couple can have long-term consequences for the

relationship.

When infertile individuals or couples do decide to discuss their fertility problems with others, the reactions can vary tremendously -- some people respond with sympathy, some with indifference, and some with embarrassment. Many of the women in my study themselves were embarrassed by their own infertility. This combined with not knowing what response to expect from others, often made many of them hesitant to tell their friends and relatives what they are going through.

Because they felt stigmatized and dreaded the reactions of others, some of the women went years without telling friends or relatives about their infertility. They preferred to "pass" as either temporarily or permanently childfree by choice. Some only told others when they felt they absolutely had to, such as when they were hospitalized after a miscarriage or for a surgical procedure.

It was not only concern about friends' or family members' responses that made the women hesitant to discuss their infertility. Several of the women were concerned with the impact the news would have on their parents -- they felt it was important to protect them from negative news they felt they could not handle. One woman, Irene, had not yet told her mother.

I guess I'm waiting until it's absolutely definitive that I cannot have my own children and then I will discuss that with [my mother]...she's a very fragile kind of guilt-ridden woman, and very unaware of her

feelings. And she's got a lot to deal with the last couple of years. She retired...Her health is going downhill and I don't want to introduce an additional stress for her to ruminate about...and I don't want to deal with her reaction until I'm sure that I'm going to have to deal with her reaction. I think she will react guiltily about it. In some way I think she will ultimately feel that she is to blame.

Although Irene had not told her mother, she -- to her regret -- had told her mother-in-law about her infertility. Her mother-in-law subsequently told her that she had read that although Napoleon was very much in love with Josephine, he left her because she could not have children. This comment both offended and upset Irene.

As in the above example, when a woman finally does discuss her infertility, it can often be difficult to predict the results. "I went so slowly telling people," said Sally, a psychiatric social worker. "I did total psychosocials on everyone before I told them, and I only told people that I knew I would get a very supportive response. And it didn't always happen."

### Strained Relations

While many of my respondents reported that their friends and relatives were very sympathetic and supportive, others complained about insensitive and unsupportive responses. Several women were upset because some people they told refused to believe that there was a problem. Said

one woman, "As far as my parents are concerned there's nothing wrong with me, so there's nothing to discuss. 'Why have a laparoscopy? Why put yourself through that? You're an idiot.'" (Wendy)

Even comments that may have been well-intended were often misinterpreted. There was, in fact, very little anyone could say that my respondents found comforting. If the listener was too sympathetic, my respondents tended to feel patronized. If, on the other hand, the listeners made light of their problems and said, "Don't worry, things will work out," my respondents tended to see this as unsupportive and insensitive. Sally, the psychiatric social worker mentioned above, admitted that all comments sounded unsupportive to her because she started telling people at a time when she was very vulnerable.

Most of my respondents were especially annoyed at receiving unsolicited advice from friends and relatives. They were often told that a certain doctor was the "best one" because he got so and so pregnant. Others were given advice on everything from what sexual position to use to where they should go on vacation in order to conceive.

The advice and comments my respondents universally mentioned as being the most annoying and upsetting were those that implied that the infertility was somehow their own fault. These comments were also the ones most frequently made and included, "Just relax and you'll get

pregnant", "Take a vacation and you'll get pregnant" or "Adopt and you'll get pregnant". While there is no scientific evidence for supporting the notion that stress causes infertility, this belief is one of the most persistent -- and annoying -- myths about infertility. These types of comments were made to virtually all the women in my study many times by many different people.

One woman, Paula, had been forbidden by her husband, Larry, to tell her family or friends that he was the one with the primary fertility problem. When she told her physician mother (who also happened to be her gynecologist) that she had a fertility problem, her mother kept telling her to relax. Finally Paula blew up at her mother and told her that Larry was the one with the problem and she did not want to hear anymore about relaxing. Her mother was very embarrassed and apologetic, and stopped telling her to relax. Instead, she told Paula that if she got pregnant, she would probably have trouble carrying the baby.

While Paula found her mother too intrusive, others found them too uninvolved or unresponsive. The women themselves often did not know what type of response would be comforting to them and what would be annoying. The following woman, Terry, described what happened when she finally -- after two years of treatment -- told her mother:

When I said to her, "I'm not getting pregnant, I've been going to different specialists, I'm unhappy and I don't know what's going to happen," she didn't get emotionally involved. First I wondered why she didn't care more.

Then I realized that it probably would have felt harder to me if she had started to say, oh, you must feel terrible, and on and on. What she just said was, "Oh, I'm glad that you're going to the best doctors, and it sounds like you're doing what you can do." And just sort of supportive but very low key. And she never asks me anything. I volunteer information to her like an update.

The women in my study would also get extremely upset when people made negative comments about having children in general. They hated it when friends said such things as, "You're crazy to want children. Kids are awful." What they found particularly disturbing was that these comments were usually made by women who had several children rather than women who themselves were childfree.

All my respondents had stories to tell of insensitive remarks made by friends and relatives. These comments -- while they were probably meant to comfort -- tended to have the opposite effect. Many of the women ultimately learned to either anticipate them and prepare retorts, or just ignore them. But when friends or relatives continually made insensitive comments, the relationships did suffer. The hypersensitivity of women with fertility problems combined with the insensitivity of their friends or relatives often resulted in overt conflicts as in this case:

My father was and remains horrible about it... he was kind of laughing and joking with [my husband], and said something about, you know, "Let me give you some tips on how to knock her up." And I told [my husband] that if he ever had a conversation like that in front of me again that I would divorce him, that I was not to be discussed as some kind of breeding cow. And my father was crazy about it. He would make nasty comments like,

"If and when you ever decide to have children"...and finally we had a blow up where he made...some stupid comment, and I said, "You know I know that you're joking, but I really wish you wouldn't." And then he just started screaming at me about how he could say whatever he pleased in his own damn house. (Amy)

Because relationships often became strained, many women began seeing their friends and relatives, especially those with children, less frequently. Large gatherings were especially difficult for them. They tried to avoid family gatherings where nosey relatives were bound to make them feel uncomfortable by asking such questions as, "Any news yet?" or "When are you going to stop being selfish and make your parents grandparents?". Another reason infertile couples like to avoid family gatherings is that pregnant relatives and new mothers are likely to turn up on these occasions.

### The Fertile World

Many of the women found that it became increasingly difficult for them to relate to "fertile women" because they felt fertile women could not empathize with their fertility problems. The following woman felt that her mother did not fully understand the impact infertility had on her:

I think the thing that hurt me the most was that my mother never really understood what I was talking about at all, and it's really hurt our relationship tremendously. I became very close to my mother-in-law who is now on a campaign to round up all the adoptable children in the United States for me. And my mother later went on to tell my sister ... that I was having

trouble getting pregnant, and my sister's response to that was ...to see if she could become pregnant. And of course she instantly became pregnant, and I sort of blew up my whole family relationship... I don't think [my mother] has treated me properly. I used to spend a lot of time with my parents...But now my parents spend Sundays with my sister and the baby. My sister and the baby are always there...my mother would rather spend her days with the wonderful grandchild than to listen to her daughter feel miserable about herself. (Hannah)

Because of their strained relationships with the "fertile world", many women tended to pursue friendships with other infertile couples. Many joined infertility or adoption support groups where they would be with others they could relate to, others who were unlikely to show up visibly pregnant.

While insensitive, glib remarks often caused a volatile reaction, the pregnancy of a friend or relative was the most disturbing situation and led to the most intense conflicts for virtually all the women. Pregnancy in others provoked feelings of jealousy, rage, inadequacy, guilt, and even hatred. Many reported violent fantasies towards pregnant women such as stabbing them in their bellies. For the most part they kept these feelings to themselves and the pregnant person was either unaware of these intense feelings, or if aware, could not understand them.

My respondents were often embarrassed and baffled by their violent fantasies and feelings of jealousy. One woman, Sara, described her feeling towards pregnant women as, "tremendous jealousy and actual hatred sometimes, and

envy" and was upset by these hostile feelings. "I feel that it's a personality flaw, that my misfortune shouldn't color the way I related to other people, and it does," she said. "I just can't stand being near pregnant women. It does me in."

Because they tended to feel badly about their feelings about pregnant women, most women tried to avoid being around pregnant women whenever possible. One woman said that because so many women in her long-standing women's group were becoming pregnant, she felt overwhelmed and had to leave the group. (Lynn) Being among pregnant women just made most of the women feel even more like outsiders and failures -- they could not succeed at something all their friends were all doing quite easily, something that most women in the world are able to accomplish with no problems.

It was not just the knowledge of another woman's pregnancy that these women found upsetting. How this news was conveyed was often problematic. One woman was awakened at night by a phone call from an older cousin who had two children:

She said, "I just wanted to let you know before you heard from your mom, I'm pregnant"...and I said, "Oh, congratulations. You must be really excited. That's really wonderful, I didn't know you wanted to have another kid." I was totally appropriate. But it was really hard for me. When I got off the phone there was sweat dripping down my arms. And then this week or last week I realized how angry I was at her. She didn't have to phone me up at night. She could have written me a letter three days before she told the family...it would have been much better for me to read it so I didn't have to react. Because what am I going to say to her? "You

bitch! Don't you have enough already?" I have to be appropriate. (Ruth)

But for many of the women, not being told about a pregnancy was just as bad as being told. Not being told made them feel patronized and even more inadequate and vulnerable than they already felt. The thought that their friends felt that they had to protect them from the truth because they were incapable of handling it made these women furious.

There were people in the family who became pregnant and I wouldn't be told about it. And that really started driving me crazy, because even though it upsets me, I felt that people shouldn't make the decision for me. That if I didn't want to be told about people's pregnancies, I would tell people "Don't tell me if people are pregnant anymore." (Wendy)

The worst social situations for most of the women were baby showers, christenings, brises and other celebrations of babies and motherhood. Having to observe, much less participate, in the celebration of a pregnancy or new baby was emotionally traumatic for most of the women. It was a no-win situation -- some felt they had to attend and then regretted it because of the pain it caused them. Others avoided going and then felt guilty about that decision.

Many of the women talked about observing mothers with their small children and getting upset because they felt that they would be better mothers. It was especially difficult for these women to observe mothers yell at or hit their children. While being around babies or small children

was difficult for some women, it was mostly seeing the pregnant women themselves that was the most disturbing.

It was not only the pregnancy of friends and relatives that evoked negative feelings, seeing pregnant strangers was also difficult for the women in my sample. They tended, however, to find it easier to express their hostility towards anonymous pregnant women rather than pregnant women they knew. One woman, Elaine, said she would never give a pregnant woman her seat on a bus even if she was in labor, and another woman, Sara, worked across the street from a maternity store, and admitted taking delight in beating pregnant women to taxis. These women certainly could not behave this way with friends.

A few of the women in my sample who had adopted but were still trying to conceive noticed that they did not have these same hostile feelings about pregnant women. Said one about adoption, "It brought an immediate and instantaneous relief to all these feelings [of] wanting to kill, take out a knife and stab every pregnant woman. And wondering what about her made her capable of - what does she have?" (Fran) Another woman described how she and her husband were flying home with their newly adopted baby, when a pregnant woman got on the plane: "I turned to Dave and I said, 'She's still pregnant and we've got ours!' It was really a nice feeling." (Wendy) A few women, however, still admitted they felt the same intense feelings of jealousy and/or hostility in spite

of having adopted a child.

### Pregnant Co-Workers

As we have seen, infertile women are often very upset and angered by being around pregnant friends, relatives and even strangers. The situation becomes even more complicated when the pregnant woman is a co-worker. The infertile woman has to act professionally regardless of whatever feelings she may have of jealousy or hostility. Also, there is little opportunity to avoid the pregnant women on the work site as this doctor found out:

Right now my infectious disease fellow is pregnant, one of my closest friends is pregnant...my infection control nurse is pregnant, the pulmonary technologist at our hospital with whom I was friendly, just left to go have her baby. And around me I see these women who look like me and then get pregnant and grow and grow and grow and grow, and get rosy and happy, and every time I walk by Jill's fucking desk she's reading a book on natural childbirth with the baby's head coming out of the pelvis. (Ruth)

Working with pregnant women can put a tremendous strain on work relationships that normally require objective professionalism. Another doctor, Hannah, was upset because a fellow physician who was pregnant asked her whether or not she was pregnant. When she said she was not, the pregnant doctor asked if she would be willing to see a patient who had just been treated with radioactive iodine. She did not want to examine the patient herself and risk contaminating

her fetus. Hannah got extremely upset. "I just didn't want to be the sterile one in the group that you call up when you don't want to be near radiation," she explained. She also very much resented being asked at work whether or not she was pregnant.

At the work site -- as in social situations -- some people think it is best not to tell infertile women about co-workers who are pregnant. This, however, usually backfires since a pregnancy cannot be hidden for long. Mary, an assistant manager of a boutique, was extremely upset because she was not told that her manager was pregnant, even though all the other employees -- even the part-time ones -- were told. "I was the last person at work she told," she explained. "And I was so angry with her. I said, 'If for no other reason, I was at least your assistant manager. I really think you should have told me, even knowing that I would be upset.'" Mary had a particularly difficult time because she was the assistant manager of a dress boutique that was very popular among pregnant women and young mothers.

Women undergoing infertility treatment have many other work-related issues to deal with besides interpersonal relationships. Job performance is often adversely affected and careers are frequently put on hold, making career advancement -- and satisfaction -- extremely difficult. In the remainder of this chapter, we will explore the impact

infertility has on working women.

#### THE IMPACT OF INFERTILITY ON WORK AND CAREERS

The majority of my respondents (27 out of 35) had advanced degrees, and all except one had professional or administrative jobs. For the most part, these women described themselves as being very involved in their careers -- at least before they started trying to conceive. But many found that infertility dampened their enthusiasm for their work or careers. As a result, some women found that their job performances or careers were negatively affected, as in the case of this 43-year-old editor:

I've done very bad work in the last six months. I've barely been functioning. And it's become not very important to me in terms of doing a good job or being committed to it. And I don't know what's going to happen....The work has gotten sloppy and the kind of work I do, it's creative and it comes out of me. And when I'm depressed and I'm burnt out and I don't care, nothing happens...nothing is generated. (Janet)

#### Job Interference

Infertility treatment often requires that a woman take time off from work for a doctor's appointment. Many of the women complained that juggling work schedules and doctor's appointments was very disruptive and stressful. Because most did not want employers and co-workers to know about their fertility problems, getting away from work --

especially when it involved leaving or missing important meetings -- often presented additional difficulties. "I had to lie all the time," said a 37-year-old executive. "It was tremendous pressure...And I always felt guilty about it."

(Nina) Admitting to being infertile is an admission of planning a pregnancy and many women were concerned that this would adversely affect their careers.

Those women who were doctors and therapists often had to change their own patients' appointments, and this sometimes created problems for them and their patients. The therapists, especially, did not want their patients to know about their fertility problems because of countertransference issues. For example, Elaine, a psychiatrist who had had multiple miscarriages, had to cancel a lot of appointments in order to recover. She said that several of her patients had psychotic episodes when she cancelled their appointments because they were afraid that she was going to die.

Women who traveled had the added difficulty of not only fitting in doctors' appointments, but scheduled sex as well. Paula, a 37-year-old publisher, turned down one job in favor of a less desirable one because in the first job she would have to travel during ovulation. But Bonnie, a 31-year-old public relations executive, was lucky enough to work for a company that would fly spouses in for "conjugal relations", which she carefully planned to coincide with her ovulation.

While flexible work schedules and part-time positions made it easier for some to get away for doctors' appointments, many still found it disruptive as did Amy, a 33-year-old educational planner.

God knows that going to doctor at all hours of the day...with no control over the schedule of your doctor's appointments, was disrupting and made it hard to work. I didn't have a full-time job at that point, I was doing mainly consulting so I was able to fit it in without too much difficulty...But it made it very hard at one point when I decided I had to go back to work. I had to do something that would make me feel good about myself. And at that point I was having regular doctor's appointments and it made full-time work difficult.

Some women were fortunate to find doctors who tried to be accommodating to working patients and had early morning, evening or weekend hours. But it was not only the challenge of fitting in doctors' appointments during working hours that a problem for the women, they found other aspects of infertility treatment disruptive as well. There were often times when a women would have to phone her doctor for test results or for specific instructions about medications, and she would try to find a private phone so her conversation would not be overheard.

Several women described getting negative pregnancy test results or other bad news from doctors while at work. Not only did this make it difficult for them to concentrate on their work and carry on as usual, but it made it hard for them to hide their distress. Anna, a 32-year-old special education teacher, finally had to tell her co-workers about her infertility because she "fell apart" during a meeting:

I began to cry. I got so upset and felt so alone and so miserable, and it never happened [before]. Now it happened and I hated it to happen because that's of course what people remember....I went up later and they said, "Oh, just forget about it." At that point I said, "You know, there are times when I'm in my office and I'm crying or I have my head down and I'm hysterical."

Talking to women at work about their fertility problems was helpful for some other women as well, but many felt strongly about the importance of keeping their infertility a secret and protecting their privacy at all costs.

### Postponed Careers

Infertility can affect more than a woman's performance on the job. Many of the women put their careers on hold while they tried and failed to conceive month after month. Some talked about "biding their time" until a pregnancy or baby materialized. Others postponed major career moves, passed up job opportunities or stayed in jobs they hated because they thought that any month now they would become pregnant. "I thought about switching jobs, but then I was trying to get pregnant," said Laura, a 39-year-old marketing representative who was not happy with her job. "And so I thought, well, with my luck, I'll get something I really like and I'll become pregnant. What a fool!"

Nell, a 31-year-old lawyer, also stayed in a job that she did not like.

I kept expecting to get pregnant. I mean, that's why I've kept the job, this federal job. I keep saying I don't like what I do, and I need to go job hunting. I need to get a new job. On the other hand, if I get pregnant, I'm in a wonderful position because I can take time off. I walk to work. I would be four blocks away from my baby..If I'm going to have children, I'm working at the perfect place. And I keep delaying doing anything.

Other women postponed important career moves such as going into private practice or pursuing postgraduate training because they too thought would be getting pregnant any minute. For example, Gail, a speech scientist, did not apply for a post-doctoral fellowship because it would require full-time work and a three-year commitment. "I thought I'm going to start this and in a year I'm going to have to stop or at least reduce my work load to part time in order to have this child," she explained. "And, of course, I'm now more than three years beyond my dissertation."

(Gail) She and several other women said that -- in anticipation of a pregnancy and children -- they took several part-time jobs instead of a full-time job.

Part-time jobs with flexible schedules turn out to be particularly advantageous to women undergoing infertility treatment. However, there are some drawbacks to part-time work, as Sara, a 37-year-old urban planner discovered:

I haven't been able to work full-time ever since the beginning of this. Because how can you, when you're taking off for this and that and the other thing and going three times a month for AIH [artificial inseminations with husband's sperm] and then this time for blood tests and that time for post-coital tests? I mean, you can't. I don't know how anyone can work full

time and actually do all this and then take off for a lap[aroscopy] here and surgery there. So I didn't look for full-time work. And working part time is working full time for part-time pay.

Even though part-time jobs make it easier to fit in doctors' appointments, they also tend to be less secure and less prestigious than full-time jobs.

While many non-infertile women postpone career advances based on a planned pregnancy, they are unlikely to regret those decisions if they succeed having children. Infertile women, on the other hand, can wind up without either the job or child of their dreams. Ruth, a 31 year-old physician, described herself as "a very high-powered person" who had worked 80 hours a week. Because she was trying to conceive, she took a non-prestigious, 40-hours-per-week job at a "very non-challenging" city hospital. "I thought that if I had a child that it would be a really good job for me," she explained...And the job sucks. And I don't have a family. So now I'm angry at myself because I never should have made a decision based on something I had no control over."

For Claire, a 37-year-old lawyer, the frustration of being in a job she did not like coupled with the emotional devastation of not getting pregnant, prompted her to quit.

Part of my thinking when I took the job was this would be a good job to have a baby in...because it wasn't very demanding, and I had given a two-year commitment--which apart from the baby issue--I shouldn't have given, and didn't understand when I gave it that it would be as hard as it was. I mean, the first year, the job was fine. The second year was terrible...If I had had the baby when I had that job, it would have worked

out fine....The fact that I didn't aggravated the sense of being there....That was the point I was most depressed and I gave up at that point... If I could mobilize myself to be interviewing, I would blow the interviews because I just was in a terrible state. And I ended up quitting and taking a year off, which I loved.

Several women talked about staying in their jobs because of the medical benefits, especially maternity benefits. Although they were not reaping those benefits, some were able to use their medical benefits to cover the costs of infertility treatment. Because of the high costs of treatment and some fertility drugs, these women could not afford to lose their medical benefits. However, some found that their health insurance policies did not cover the cost of infertility treatment, and this was particularly frustrating and disappointing for them.

Although these women and others who remained in jobs they did not especially like felt frustrated, they had no way of knowing if they really could have gotten a job with better medical or other benefits. However, those women who actively turned down job offers or opportunities knew exactly what they passed up, and were now particularly angry about their decisions. One woman, Bonnie, described what happened when she was offered her ideal job -- sportswriter at a major television network:

If I had taken the job and two months later, while we were on the road I turn up in a maternity dress, it would have just destroyed my credibility in the business after portraying myself as a career women...the long and short of it is I turned it down. What a mistake! Obviously afterwards as the months rolled on and I didn't get pregnant, I had to think about that it was a

super opportunity...career wise it was the right move to make. And staying in my present job was the wrong move to make. And it was exacerbated by the fact that...the pregnancy hadn't panned out. So in that sense it was a disaster.

Although many women were upset about the effect of infertility on their career, most did nothing about it. They were still waiting for a pregnancy or adoption to happen. A few, however, did make some changes to help their flagging careers. Alice, a 42-year-old psychologist, who had just decided to stop infertility treatments, had been very involved in her career before pursuing pregnancy. However, as a result of going through infertility, her career "went on the back burner." She decided to stop trying to conceive because she, did not like fact that her career was not going anywhere. "Since I've made the decision," she said, "my career has moved forward." Getting involved in her career helped Alice both cope with her infertility and stick with her decision not to continue pursuing pregnancy.

#### The Impact of Work and Careers on Infertility

While infertility often had a negative effect on work and careers, many women like Alice, the psychologist mentioned above, found their jobs and careers helped them deal with their infertility problems. They talked about the important role their careers played in their lives and said

they felt best about themselves when actively involved in them.

Those women who were able to throw themselves into their work and careers seemed better able to cope with infertility problems than those who were uninvolved in their careers. Not only was work a distraction for them, it gave them a feeling of accomplishment and a sense of control over their lives. For some women, it was infertility that pushed them into more involvement in their careers. "Since I haven't been able to get pregnant, I have channeled a tremendous amount of energy into business," admitted Diane, a 38-year-old career counselor. "And I've done things that I didn't even really want to do, but did them in order to compensate for the fact that I didn't have a child... So it's made me focus more on my career.

Many of the women talked about how their jobs helped keep them sane while going through the process of infertility treatment -- that being able to throw themselves into their work and careers helped them forget about infertility, at least during working hours. "One of the things that really has surprised me about me is how much my work meant to me in going through this process," said Gail, a 34 year-old speech scientist, "how much a support and a lifeline it really became."

For some work was not only a diversion, their careers actually compensated for what they were missing in their

lives -- a child. As Michelle, a 37-year-old fund raiser explained:

I think ultimately the result of all the frustration and disappointment was that I got more involved in my job. It was just a way to try to forget. I worked longer hours. I wanted to be productive. I wanted to produce a baby. I couldn't produce a baby, so I decided to produce a body of work. And I just worked harder and harder. And I was very successful, so it was nice. It paid off. But I think ultimately it was mostly a substitute.

Even though involvement in her career might have been a substitute for a child for Michelle, she clearly benefited from it both financially and emotionally. Those women who were stuck in dead-end jobs had neither a baby nor the feeling of success that involvement in their careers might have given them.

### Conclusion

In this chapter, we saw that interpersonal relationships can become quite complicated as a result of infertility. It is difficult for infertile women to divulge information about their fertility problems and to anticipate and accept the reactions of others. Partly because of their own sensitivity, and partly because of the insensitivity of others, many women experiencing infertility find themselves involved in conflicts with friends, relatives and co-workers. Relations with the "fertile world", especially pregnant women, frequently become strained.

We also explored the impact infertility had on careers. Infertility treatment often required time away from work and interfered with a woman's job performance. Some women put their careers on hold or postponed making positive career moves because they anticipated becoming pregnant. Some lost their interest in and commitment to their careers. Those women who maintained involvement in their careers -- regardless of their reasons or motives -- fared better emotionally, and sometimes financially, than those who let infertility dictate their career choices and commitment.

The next chapter will explore the emotional impact of infertility and the various coping mechanisms employed by women experiencing infertility.

## CHAPTER SIX

### COPING WITH INFERTILITY

In the previous chapters we have explored how infertility can negatively affect marriages, sexuality, interpersonal relationships and careers. It is therefore understandable that Barbara Eck Menning (1977), founder of RESOLVE, said that infertility represented a "major life crisis."

#### EMOTIONAL REACTIONS

As we have seen, there are a multitude of interpersonal ramifications of infertility. But as with other life crises, infertility also has serious emotional consequences for the individuals involved. When asked what the most difficult aspect of infertility had been for them, practically all the women talked about its emotional impact and the toll that it took on their lives. As one woman put it, "You can deal with the physical thing, you know it's going to end. With the emotional pain you can't say, 'Well, in a week I'll be able to do this'...It's a different ball game." (Sara)

These emotional consequences can be viewed from a social as well as psychological perspective. They are the

result of a condition that is both socially and medically defined, and that exists primarily within a social context. According to Menning (Ibid.), there are predictable emotional responses to infertility: surprise, denial, isolation, anger, guilt and unworthiness, depression, and grief. While the women in my study experienced all these emotional responses, I will concentrate on those emotional reactions that I found most prevalent: feelings of loss, and feelings of guilt. I will also explore how my respondents coped with the crisis of infertility.

The emotional pain the women experienced varied from woman to woman, but most of them talked about their pain in terms of loss. Infertility involves many losses -- the loss of control over one's life, the loss of a normal sexual relationship with one's spouse, and perhaps most importantly, the loss of the dream of having a child of one's own. These feelings of loss stem from the failure to fulfill a basic role, that of motherhood.

### The Loss of Control

Many women talked about feeling a loss of control, both emotionally and physically. For some it was more of a general feeling of their lives being out of control, while for others it was a more specific feeling of the physical loss of control over their reproduction. For others, it was

a combination of both. As Helen, a sales representative put it, "I can't control my customers and I can't control my sperm and egg."

Most had previously always felt in control over their biological lives. They took care of themselves and their bodies. They were careful about birth control. They had regular check-ups with their doctors. Their bodies now betrayed them and they found this very disconcerting. To compensate for this feeling of being out of control, many tried taking control in other ways.

I felt very unhealthy, that my body was not healthy like it should be. And it wasn't doing what it was supposed to do. And I joined exercise programs and I joined weight reducing program. This was all because I wanted to control my body which was out of control. (Elyse)

Many talked about how, until they experienced infertility, they had always felt in control over their lives. Most were successful professional women who felt proud of their ability to control their lives and reach whatever goals they set up for themselves. Their lives had been proof that if they worked hard enough they could succeed. They were not used to failure.

I always accomplished what I wanted. I wanted my own apartment, I had it. I wanted my own life, I got it. I wanted to support myself in a style to which I had become accustomed, I had it. I wanted boyfriends, I had them. I wanted to get married, I got married. I always got whatever I wanted. All of a sudden, a major thing, I'm not getting it. I cannot believe it...it never occurred to me that I wouldn't get what I wanted. (Fran)

This feeling out of being out of control of one's life also

had a profound effect on many of my respondents feelings of self-worth and self-esteem.

### The Loss of Self-Esteem

Whether infertility primarily involves failure to conceive, or failure to carry a pregnancy to term, infertility is ultimately the failure to become a mother, and as a result, is a tremendous blow to a woman's self-esteem. "It's an ego-battering experience. I don't feel as pretty. I certainly don't feel as fertile or as feminine," said one woman. (Bonnie)

Many of the women, in spite of their previous accomplishments, now felt that they themselves were failures or that there was something terribly wrong with them. They referred to themselves as "inadequate," "incomplete," "not a whole female," "flawed," "defective" or even as "damaged goods". As one woman put it:

You've lived your life for so many years and you've accomplished whatever your goals have been...and one goal that you have is to get pregnant and have a family. And to think that you can't do it, I think that's been the hardest thing. It makes you feel like there's something wrong with you. I mean physically there might be something, but it makes you feel that mentally.  
(Mary)

The diagnosis of infertility itself often contributed to the feelings of low self-esteem. During the infertility workup, some of the women discovered they had missing

ovaries or misshapen uteri, and knowledge of these conditions contributed to their feelings of low self-esteem. One woman was found to be a carrier of a rare genetic condition that was causing her to have repeated miscarriages. "It made me feel really weird," she said. "I kept looking in the mirror to see if I looked normal, because I felt like I was so weird. And I kept feeling like I was walking around with this lethal gene that was killing off all my progeny." (Elaine)

Many said they felt they were less feminine than other women because of their infertility.

I think for me it's more a reflection on my womanhood, and maybe that encompasses sexuality. I don't feel very womanly because my image of being a woman is to be a parent, be a mother...I measure myself a lot against other women whom I see with children and with careers, and with family life. And somehow I feel not as good as they are. (Diane)

Some even said they did not feel like a complete woman since they could not do something every other normal woman could do -- conceive and give birth to their own baby. As one woman put it, "Sometimes I feel like I have a caricature of a woman's body. That it's sort of too ripely feminine on the outside and it's no good on the inside." (Amy) She and others admitted that they tried to compensate for not feeling feminine by changing their external appearances. "For a long time I really did feel less a woman," the woman above admitted, "and I went through a period of wanting to look very very feminine and not wearing pants and letting my

hair grow and wearing quite feminine clothing." (Amy)

One woman, however, explained that while she found it disturbing that her reproductive system was not functioning the way she always assumed it was functioning, she felt that infertility actually made her feel "more a woman because I really have had to come to grips with what it means to be a woman." (Gail) She was able to come to the realization that the physical processes of pregnancy and childbirth were not what defined womanhood or motherhood, and as a result her self-image was not adversely affected. Although a few others felt the same way, many of the women in my sample equated being a woman with being a biological mother. And they were the ones whose self-esteem suffered the most.

#### The Loss of a Genetic Connection

The loss of the chance to have a genetic connection was very difficult for many women. They had looked forward to having children that resembled them, their husbands, their families -- to passing on positive family traits as well as the family name. The possible loss of this genetic connection was especially difficult for those women whose husbands or families put a great emphasis on genetic traits and heritage.

On the other hand, the genetic issue created special problems for two of the women who were themselves adopted.

They seemed to have a particularly hard time dealing with this potential loss. As one of the adopted women so poignantly described,

I can't reproduce myself. I won't have any blood relative. Nobody will look like me. I won't leave a visible mark on the world...To love a child, I can do that without physically giving birth to one. To have a family, I don't have to physically give birth. But to reproduce myself, I do. And I think because I'm adopted, the desire to look at someone who looks like me is perhaps stronger. (Sara)

### Grief and Mourning

Because of the losses involved, infertility, for many women, is actually experienced as a death -- the death of the dream of having their own children and the death of the child that will never be. Many of my respondents repeatedly used words like death and mourning when describing their emotional reactions. "You lose being part of this process that most women take very much for granted," said one woman. "That is a loss, a very real loss, and you mourn for that experience." (Gail)

Even though infertility is commonly experienced as a death, friends and relatives tend to have a hard time understanding that concept. Said one woman,

You really do grieve when you go through this process....But the sad part, as a friend of mine pointed out, is it's not as if an actual person has died. So you can't get the kind of support you'd like to get from people because you can't say, 'Oh, my mother died,' and everybody knows how to react. This child in me that never existed died. And you don't know how to say that to people. (Lynn)

For those who have had miscarriages, the equation of infertility and death is even more apt. "Although infertility involves a lot of losses -- possibilities and dreams and having your own child...miscarriage involves a real loss or real losses," said Elaine, a psychiatrist who had experienced multiple miscarriages. "Anniversary reactions of when you got pregnant and when you miscarried, and also seeing babies who are the same age as your baby would have been," are especially difficult for women who miscarry, she explained.

Although a miscarriage is actually the death of a fetus, several women in my sample complained that friends, relatives and even doctors did not see it as such and often did not understand the depth of their despair. They were told it was nature's way of getting rid of a mistake and they could always get pregnant again. But to these women, it was the actual death of their child. A few women described having private funerals or memorial services, burying items such as baby booties, or performing other rituals that helped them mourn the loss of their child.

### Blame and Guilt

The majority of the women felt, at times, overwhelmed by their feelings of loss. Many felt guilty and a few felt victimized. Like most people to whom bad things happen,

they sought answers to the impossible question, "Why me?" They wanted to know why was this happening to them? Why were they failing at something that came easily to most women, something so fundamental to womanhood and essential to human survival -- reproduction?

When my respondents speculated as to why this was happening to them, some blamed God or "the fates" or bad luck. A few blamed themselves for having waited too long to get pregnant, and still others blamed it on a past real or imagined sin or transgression. A few women mentioned that perhaps they married the wrong man and the chemistry with their spouse just was not right. One woman thought that she had a fertility problem because she did not love her husband enough. She also thought her "extraordinary high state of emotionalism" has had something to do with it. (Bonnie)

Quite a few women blamed themselves for some specific past deed or behavior. One woman wondered if she was being punished because she had had an abortion, and because when she first got involved with her husband, he had been married to another woman. (Helen) For some, it was not a specific act, but rather their behavior in general. "I was a rotten, rebellious daughter and rotten to my mother. And this is why I'm being punished...I don't deserve to be happy," said one woman. (Janet) And another woman, an ardent feminist said that she felt that she "was being punished for wanting to be a career person, for putting things off.... for being

different, for going against my mother's wishes." (Lynn)

A few worried that their infertility was the result of masturbation. "Maybe I should never have used a vibrator," said one woman, "that it's not natural. That it's too strong and electrical charge and something's happened."

(Terry)

In the cases where they believed their infertility was caused by something they had control over, such as contraception, some women tended to blame themselves. Several felt guilty because they had used IUD's (intrauterine devices) for contraception, and IUD's had been linked to infertility. "The IUD is something I did to myself and it's really upsetting to think that I did something that hurt myself," said one woman. (Helen) Other women blamed themselves for being on the pill too long and one thought that her diaphragm jelly had caused her to develop antibodies to her husband's sperm. (Hannah)

### Divine Intervention

Although some women said that they thought they were being punished by God for some past transgression, some thought that God was not so much punishing them as trying to teach them a lesson. "It's as if some sort of divine power has set upon me to have an infertility problem so that I will become compassionate, understanding, sympathetic," said

Hannah, a physician. She, in fact, did think that her experience with infertility helped her with her patients, many of whom had fertility problems.

Others believed that the purpose of the divine intervention was to protect their potential offspring by preventing them from being born in the first place. One woman said she felt that she was infertile because God felt she would be a "rotten mother." (Nina) And another thought that "some God or some big computer in the sky or something thinks that there's something wrong with me, either genetically or psychologically or physically, that I'm not to procreate." (Ruth)

One woman, Kay, found what she thought to be concrete evidence for why God might not want her to reproduce. Her brother who had been sick for many years died of an embolism at the age of 34. "It occurred to me that perhaps there was something genetically wrong," Kay explained, "and our not having children was God's way of protecting us from having a deficient child."

In general, the women said they realized that their theories of divine intervention or punishment were "irrational", "neurotic" or even "psychotic". Yet because they had no rational explanations and answers for "Why me?", many admitted to believing on some level that there might be some truth to these irrational thoughts.

## COPING MECHANISMS

In general, my respondents tended to use two types of coping mechanisms -- interpersonal or external, and intrapersonal or internal. Most used external emotional support systems and sought help from others. But many also found they had their own internal support systems. The women above, for example, discovered that finding rational -- or even irrational -- explanations for their fertility problems helped them cope.

### Intrapersonal Coping Mechanisms

Intrapersonal or internal coping mechanisms such as seeking philosophical or religious explanations for infertility or even life in general, were very helpful for many of my respondents. For one woman, it was not just religion and philosophy, but "things like Darwin, creation and evolution, and just the meaning of life in general" that she found helpful in coping with infertility. (Gail)

### Religion

Religion became source of support and a coping mechanism for some women. It was not the actual participation in organized religion that seemed to help

them. Rather it was the spiritual or symbolic meaning of religion that they found helpful. As one woman put it,

I guess I am just one of the masses that when the crisis hits, you just gravitate towards something which apparently has hopefully a higher consciousness and a higher state of benevolence than what you can find on earth. (Bonnie)

Several women talked about praying more frequently or harder, but most claimed that they never actually prayed for a baby. "To this day, I've never prayed, you know, go light a candle, do a novena for a baby," said a Catholic woman. "I have prayed for strength. God only knows we need a lot of that going through this process. I've prayed for the insight to make good decisions for us." (Gail)

Some found that they had, to their surprise, become more religious or even turned to religion for the first time. One woman who claimed to be an atheist but was Jewish by birth, said when things got really bad, she went to a church, lit candles and spoke to Jesus. "It helped because I just felt like I was trying basically, I think, to get a feeling that there was something outside myself helping me to cope with this," she explained. (Helen)

And another woman who had always previously regarded herself as an agnostic and viewed religion as a crutch, said:

I became more Jewish about this for a while. I thought if I became Jewish that would help...I was wearing a 'chai' around my neck for a year because that was a symbol for life. I thought if you wore a 'chai' you'd get pregnant. I can't even tell you the ridiculous

things. Going to Israel, that was another part of the Jewish year. (Hannah)

As the above examples show, there is a fine line between religion and superstition.

### Superstition and Magical Thinking

Many women found that, to their surprise, they had become very superstitious or were frequently resorting to magical thinking. "I'm very superstitious...it started in last ten years when things started to go haywire," said one woman. "My knuckles were black and blue from knocking on wood." (Fran)

Several talked about how they were always very rational, factual people who had never been superstitious in the past. They were somewhat surprised by this new development. Superstitions seemed to help some of these women feel that they had some control over their lives by attributing magical powers to objects or actions. Like those who turned to religion, some women saw their superstitions as helpful and innocuous. But others viewed them as negative, embarrassing and a even a hindrance.

Many of the superstitions the women developed were based on clothing, especially maternity or baby clothes. One woman preferred buying loose-fitting dresses in case she got pregnant. However, she only bought tight-fitting dresses because she believed that if she bought loose-

fitting dresses, she would not get pregnant. (Laura)

Several women mentioned that when they became pregnant, they were afraid to buy maternity dresses for fear of having a miscarriage. In some cases, the superstitious fears were borne out, and this further intensified these beliefs. One woman, for example, did in fact have a miscarriage a week after she bought maternity clothes. But she also attributed the miscarriage to the fact that they had bought a bassinet she had been hesitant to buy because she thought it would be bad luck to do so. (Janet)

For some, the superstitions were directly related to trying to overcome infertility. These women tended to develop beliefs in the supernatural, had their fortunes told, or took to wearing amulets or fertility symbols. Elaine, a psychiatrist who was pregnant again after several miscarriages, started wearing a religious medal her mother sent her after her first miscarriage. "I feel I need an amulet so that every time I take a shit, I don't have to worry about bleeding!" she explained. And Alice, a psychologist, described how she had her fortune told by a Tarot Card reader. To Alice's amazement, the fortune teller, read in her cards that her reproductive system was blocked and not working. Alice's left fallopian tube was, in fact, blocked.

## Interpersonal Coping Mechanisms

While many women sought comfort and support from within, most also sought support from external sources. When asked who or what was most helpful going through infertility, many said it was the support of another person or several people. About a third of the women cited their husbands as having been the most helpful and supportive. Others mentioned friends, family members, therapists and support groups. One cited her doctor as being the most helpful. A few mentioned religion and work. But for many women it was a combination of factors and they found different things helpful at different times.

There were times when (my husband) was an anchor for me...At other times my mother has been very good. At other times it's been my nephews...just going in and seeing two normal children playing and having a marvelous time is a reaffirmation of what you want to do when you get discouraged. At other times it's been work. Being able to say I have other things that make me important and that I can contribute..At other times it's been me. I'm sure that permeating this whole experience has been a religious orientation. (Gail)

## Therapy

Psychotherapy is a common way for upper socio-economic level people, especially in areas like New York and its suburbs, deal with everything from severe emotional problems to the stresses the stresses of everyday life. Many of the women were in some form of individual or group therapy.

Some had been in therapy before they had a fertility problem, and some sought therapy because they were having a difficult time dealing emotionally with infertility.

Most of the women in therapy said they found it helpful primarily because their therapists were supportive. However several complained that their therapists did not really understand the emotional and physical aspects of infertility, and they were not as helpful as they would have liked. Some therapists, for example, persisted in blaming their patients for their infertility, saying that stress was a major factor, if not a direct cause of their fertility problems. My respondents found this not only counterproductive, but confusing. In most of these cases, their physicians were treating them for specific, diagnosed physical problems while their therapists said or implied that stress, ambivalence, or some other psychological factor was causing their infertility. Because of what their therapists had said, some women became convinced that their fertility problems were in fact the result of their psychological problems and felt guilty if not even more depressed. Their therapists -- like insensitive friends and relatives -- tended to blame the victim for her infertility, thus exacerbating rather than ameliorating their problems. Said Terry, a woman who had an ovulatory problem,

A couple of years ago when I was in the worst of my misery I came back into the city for a couple of months every couple of times a week to see my old therapist because I was miserable. And he really said, "You know,

it's a very complicated process. You've had all the basic tests which are okay. Your mind is very powerful. It could be that this is case in which the harder you try the more difficult conception becomes."

Terry's therapist had -- like many others who do not understand infertility -- jumped to the conclusion that her ovulatory problems were the result of her psychological problems. While there is some evidence that stress can interfere with ovulation in certain cases, fertility drugs more than compensates for emotionally-induced anovulation. Terry -- like most women being treated for ovulatory problems -- was taking fertility drugs. So even if her therapists was correct and stress was a causative factor, it was not relevant to her current medical situation.

#### Fertility Counselors

A few of the women who felt they were being misunderstood by their therapists were able to quit therapy. Several of them sought other means of emotional support, as did other women who could not find a appropriate therapist to begin with. Some found, or were referred to fertility counselors -- therapists who specialize in infertility.

Those who saw fertility counselors tended to feel that it was more helpful than regular therapy because they focused on both the emotional and physical aspects of infertility. But seeing someone who claimed to be a

fertility counselor was no guarantee that the therapist was any more knowledgeable or sensitive to infertility than any other therapist. One woman, a therapist herself, was referred to a counselor that worked with the fertility clinic they attended. "It was a disaster," she said. "We felt that she was saying that our relationship was imperfect and that was why we weren't getting pregnant... I was enraged and felt that she really did a disservice to us."

(Beth)

There is no specific or uniform training for fertility counselors. Infertility counseling is a relatively new, unorganized and unregulated profession. Many of the men and women who go into it do so because they themselves had experienced infertility. But others go into it because they are looking for patients and see infertility patients as an untapped source. They also see them as an educated, affluent group who can both benefit by, and perhaps more importantly, afford therapy. Many therapists would persistently contact RESOLVE, trying to get on their referral list and/or offering to be quest speakers. Some fertility counselors do receive formal or at least some training in reproductive medicine by working closely with fertility specialists or by attending post-graduate medical courses. But some who claim to be fertility counselors have no training in infertility whatsoever.

## Support Groups and Self-Help Organizations

As mentioned above, it is difficult for infertility patients to find therapists who are trained in the physical and emotional aspects of infertility, and who truly understand infertility in a non-judgmental way. And it is equally difficult for women experiencing infertility to find others to talk to who really understand what they are going through. As we saw in previous chapters, spouses often do not want to discuss infertility, and those in the "fertile world" often lack empathy and understanding about the subject. For this reason, some infertile women seek out or are referred to support groups or self-help organizations.

The largest self-help organization for infertile couples in the United States is RESOLVE. It is a national, non-profit organization that has chapters in most states including New York. RESOLVE offers referrals to fertility specialists and therapists, and has a telephone helpline, information brochures, reading lists and other relevant information for infertile couples. Most local RESOLVE chapters offer monthly meetings where doctors or therapists who specialize in infertility come to speak. Most chapters also offer support groups for men, women and couples.

Half of my respondents were recruited through the New York City Chapter of RESOLVE, which had just been recently formed. My sample, therefore, was over-represented by women

who had chosen to join a support group.

The women who joined RESOLVE (or other support groups) said they did so for a variety of reasons. Some joined to get information about infertility treatment or fertility specialists. Many said they joined because they felt isolated -- they did not know anyone else with a fertility problem and they wanted to meet people in the same boat. Some said they wanted to see what other infertile couples looked like. Others went for emotional support or because of a combination of factors. The following woman decided to attend a support group at the fertility clinic she attended primarily because her husband had forbidden her to discuss their problem:

It was very helpful and it was also very shocking to hear all these women. All of us in our thirties and none of us getting pregnant...And then one would get pregnant and she would miscarry. One finally carried to term and she had a stillborn. It was just horrible, very bad stories. [But] it was good for us because at least we had each other to talk to. (Nina)

Some of the women were self-referred and had sought out or found out about RESOLVE or other support groups through the yellow pages, fertility clinics, doctors' offices or friends. A few were referred by their doctors or therapists or friends. One woman, Hannah, had been seeing a fertility counselor who referred her to RESOLVE. She was hesitant to go at first because she did not think she would fit in because she was a physician and over 30. Her counselor reassured her by telling her that being a professional woman

in her thirties was the basic qualification for joining! Hannah decided to attend a meeting, and subsequently joined RESOLVE and become very active in the organization.

When someone joins an infertility support group, they are labeling themselves infertile, as well as coming out of the closet and admitting to others that they have a fertility problem. Because of this, many women hesitated to contact RESOLVE or other support groups. One woman, Nell, said her cousin had sent her information about RESOLVE. But Nell threw it out because she refused to consider herself infertile. It took her another year-and-a-half to contact the organization. Another woman, Jane, remained very ambivalent about RESOLVE even after she joined it.

I don't really want to be in a roomful of people that have identified themselves as being infertile. It's a two-edged feeling...I believe very much in the process. I felt the help of having the RESOLVE group. At the same time, I don't like labels.

After she read some of RESOLVES material, another woman, Claire, decided that she wanted nothing to do with the organization.

RESOLVE really turned me off because it seemed...so concentrated on the steps of mourning and the loss. And the name, RESOLVE, in the sense that ultimately you are somehow resigned. And I guess I just don't believe that....I don't feel very resigned at all. I feel very angry.

Most of the women said their husbands were also very hesitant to attend a RESOLVE meeting, much less join a support group. A few mentioned having to practically drag their husbands to meetings.

One woman, Helen, was referred to a RESOLVE by her infertility counselor because she felt her husband could not understand what she was going through, and was feeling very isolated. She was anxious to go because she was feeling very angry at men in general and her husband in particular, and wanted to talk to other women. However, there was only a couple's group available, and Helen reluctantly approached her husband about it.

I tried in my least pressured way to go to my husband and say, look, this is available. If you want to go fine, if you don't want to go, fine...and he just really went hysterical and he says, "I'm so sick of all this, and I can't stand this. I just thought we were going to have a baby and I wanted to make you happy. And I feel so bad." ...I said, "Look we don't have to do this. I would never make you be in a therapy group."...He said, "I'll try it and if I don't like it then we'll stop." And I said fine. So we went and he's really glad he's in it.

Several other women said their husbands flatly refused to attend a meeting or support group. As a result some went by themselves, while others joined but never attended a meeting. Those who did not go to meetings said that they used the organization primarily to obtain information through its telephone helpline, brochures or newsletters.

For those who did attend meetings or support groups, most found it comforting, reassuring, educational or helpful in some way. "It was a relief to meet other people and also to find out that my reactions to the whole thing were not as bizarre as I was being told [by her husband]," said Elaine, a psychiatrist married to a psychologist.

Support groups fulfilled needs that spouses, friends, relatives, therapists and doctors could not fulfill. Like Elaine, many others also said that one of the major benefits to support groups was finding others like them to relate to.

They said it was not just an issue of "misery loves company". It was also an issue of finding people to who were non-judgmental they could share their problems with.

I was astonished to find that there were a lot of other women, men and women, in the same boat...it definitely has helped because I never discuss this with anyone for a lot of reasons. It was all inside of me...the only one I spoke about or cried about this with was my husband. And I guess it became too overwhelming and I felt we couldn't help each other any more. So I started going to meetings. (Anna)

Others had more mixed reactions. Said one woman, Diane, about her first RESOLVE meeting, "I really didn't want to be there. I really didn't want to talk to anybody about this problem. I didn't want to hear anybody else's problem. I didn't want to hear how bad someone else's problem was." But Diane also admitted that a major reason she was so upset about being there was that it made her face the fact that she had a fertility problem. As she explained,

I saw people who were just regular human people just like I am, primarily upwardly mobile professional types, dual career couples, you know, middle class just like John and I. And it made me feel sad too that this is happening to all of us when all those people on welfare can just churn out babies like crazy and have nothing to offer them.

One of the major benefits of being in support or

self-help groups was that the women began to become extremely knowledgeable about many of the medical aspects of infertility. They had the opportunity to listen to and have their questions answered by guest speakers who were often top fertility specialists. They also got to hear first-person accounts by their fellow patients. By the time I interviewed my respondents, many of them were extremely well-informed about infertility. They knew who the top specialists were and what the latest treatments were. Some, for the first time, learned that fertility decreased with age. Many discovered, to their dismay, that they wasted precious years with OB-GYN's instead of going directly to fertility specialists.

Even those women who had not joined a support or self-help organization usually had read articles and books about infertility, But by not being in a group, they did not hear first-person accounts by other patients, or have the opportunity to have their questions answered by the fertility specialists. Several women who had not joined a support group said that they wished they had.

I think that if I were to go through it all over again I would really try to be in a support group. I value talking and sharing and I like to hear other people's stories and feel commonality. And I think it would have been very helpful for me. (Terry)

Being in a support group provided my respondents with more than a non-judgmental peer group with whom they could identify and share feelings. They were able to receive

valuable information about doctors, therapists, new treatments and adoption.

### Conclusion

The conceptualization of infertility as a major life crisis was valid for most of the women in my study. Because infertility adversely affected marriages, sexuality, interpersonal relationships, careers and self-esteem, my respondents suffered emotionally. Many women talked about feeling out of control of their lives and destinies for the first time in their adult lives. They were used to success, to accomplishing what they set out to accomplish. This made them feel like failures. Some felt guilty about not being able to get pregnant and blamed themselves for their infertility. Many felt that they were incomplete women because they could not do what every other woman seemed capable of -- reproducing. And most felt a profound sense of loss and mourned their losses, especially the loss of having their own biological child.

All my respondents sought ways to cope these losses and the other emotional aspects of infertility with varying degrees of success. Those who used intrapersonal methods such as religion and philosophy found some comfort, however it was primarily the interpersonal coping mechanisms that were most beneficial for my respondents. Support from

spouses was especially beneficial. And while a few found that therapy helped to some extent, most therapists were not qualified to deal specifically with infertility, and some patients were more harmed than helped.

Next to support from spouses, interacting with other infertile people in support groups or being involved in self-help organizations was the most helpful emotional support for many of the women. Those who attended these groups tended to feel less isolated. They were able to identify with and relate to others going through the same experiences. In addition, the interchange of ideas and information gathered at these groups was invaluable for many of my respondents.

After going through a major life crisis, one would expect that there are some lasting effects. How did the women ultimately resolve their infertility? What impact did those resolutions have on their lives? What, if any, are the long-term consequences of infertility? In the next chapter, a subsample of my original respondents are followed up in order to try to answer these questions.

CHAPTER SEVEN  
INFERTILITY REVISITED

In this chapter, I follow up a subsample of respondents more than a decade after my first interviews. How they resolved their infertility is explored, as well as how they feel about those resolutions. I also explore the long-term effects of infertility on their marriages, their relationships with others including their children and their careers. Lastly, I look at the long-term emotional impact of infertility, including their present feelings about their past decision to delay childbearing.

In the past five chapters, we have seen how the various aspects of a woman's life are affected by infertility and its treatment. At some point, however, treatment ends. Regardless of the outcome of treatment, all women resolve their infertility one way or another -- they may have a successful pregnancy, adopt, do both, or remain childfree.

How a woman feels about her resolution depends on many factors including marital, family and social support. For those who give birth or adopt, the children themselves are a crucial factor. For those who choose to not have children, their satisfaction with this resolution depends on the acceptability of childfree living among their peers as well as their own feelings of fulfillment and self-worth.

After a woman resolves her infertility, she must get on with her life. But is her life permanently affected by her past experiences with infertility? Does infertility continue to influence her marital and other relationships, her self-esteem, her career? If she does become a parent, does her past infertility affect her relationship with her children or her parenting style? In other words, what -- if any -- are the long-term effects of infertility?

This follow-up component of my research was initiated in order to answer these questions. Others have looked at how couples resolve infertility and how women react to pregnancy, adoption, and childrearing in the early years (Menning 1977; Notman 1984; Lasker and Borg, 1987; Glazer 1990). There is little information, however, on the long-term impact of infertility on other aspects of a woman's life.

By following up a subsample of my original respondents more than a decade after my initial interviews, I was able to discover not only how the women resolved their infertility and how they felt about it, but whether or not infertility had any lasting effects. After ten years we might expect that the issues surrounding infertility and its resolution might fade into the background, if not disappear all together. My research, however, shows that the traumas and other aspects of infertility did have lasting effects, both negative and positive, on these women and their lives.

In-depth follow-up interviews were conducted with 10 of my original 35 respondents at least 10 years after my first interviews with them. The women were chosen according to accessibility and availability for interview. I also attempted to get a variety of resolutions and outcomes. Two of the ten women gave birth, another woman adopted and subsequently gave birth to two children, four other women adopted children, and two remained childfree.

Since I had previously conducted in-depth interviews with these ten women over a decade ago, I did not specifically ask about their past experiences with infertility. However, during the course of the follow-up interviews, these women often spontaneously brought up their past experiences. They talked about these experiences as if they occurred a year, rather than more than a decade ago. Several repeated the same stories that they had previously told me almost verbatim. They were able to recall in great detail their diagnoses, their prognoses, and even their drug dosages. They vividly recalled their clashes and conflicts with their doctors. But it was mostly their descriptions of their past emotional experiences with infertility -- especially the impact on their marriages and other relationships -- that were as detailed and emotionally charged as they were during their first interviews.

### Long-Term Effects on Marriage

I demonstrated in Chapter Four that the marital and the sexual relationships of virtually all the women in my sample were significantly and often negatively affected by infertility. I also showed, however, that in spite of the negative impact, many of the women felt that because of going through infertility together, their marital relationships became closer and stronger. I therefore anticipated that infertility would also have some long-term effects on a couple's marriage.

Most of the women I followed-up did claim that their marriages were indeed permanently affected by infertility. For some, the affect was positive, for a few negative, and for some mixed. While the couples were no longer arguing about whether or not to adopt, remain childfree, or pursue expensive new treatments, they were now living with the consequences of those decisions, for better or for worse.

In general, the women were very pleased with how they resolved their infertility. They felt that they had made the right decisions for them at that time. The majority had wanted to become parents, and that is what they now were. Those who became parents through adoption felt fulfilled as parents, and the issues of pregnancy and childbirth receded into the background.

All the women except one said that they and their

spouses were very satisfied with the decisions they made and how they resolved their infertility. The only woman who really was unhappy with her resolution was Janet, one of the two women who remained childfree. She was the oldest woman in my sample -- 43 when I first interviewed her and 54 when I did the follow-up. Even though she was 38 when she started trying to conceive, she primarily blamed their infertility on her husband's low sperm count. Janet had become pregnant once during infertility treatment, but she miscarried. Her husband Barry refused to consider adoption, so they remained childfree by default. She said at the follow-up interview that she regretted not having or adopting children. She also believed, in retrospect, that she had delayed trying to have children too long.

It was probably a mistake, I was probably another casualty of the women's movement. I didn't marry till I was 35. I used to look askance at people who stayed home and took care of children.

So for Janet, infertility definitely had a lasting negative impact on her marriage. She not only resents Barry for having the problem to begin with, but for making childfree living their only option, since he was so adamantly opposed to adoption. Although she claims to be happily married, remaining childfree has caused on-going tensions in their relationship. She said that sometimes when she gets angry at her husband, she would think, "If not for you, I could have had three children."

Not surprisingly, those women who had conflicts over

sex during infertility treatment continued to have a difficult time long after. Said Janet about her sexual relationship with her husband, "I don't think it's totally resolved. I don't think either of us have the same carefree approach," she admitted. "In the back of our minds, you can't help remembering the horrible things we had to do that are very offputting."

Another woman, Bonnie, had said during that initial interview that she was having serious sexual difficulties with her husband because he was not a very sexual person. She also said at that first interview that infertility wrecked havoc with their marriage and admitted to being "concerned with the future of the marriage if it continued like this."

At the follow-up interview Bonnie said she and her husband Brian had succeeded in having two children, and that they had recently gotten divorced after 13 years of marriage. "I think probably infertility, which doesn't do anybody any good in bed, probably hurt us more than it hurt the average person," she admitted. "So it became a great big mess." However, she added that the main reason she divorced Brian was that he was an alcoholic. She claimed that she had known he had a drinking problem early on in their marriage, but said she was so obsessed with trying to get pregnant that she stayed in the marriage. She was afraid that if she left him, it would have been too difficult to

find a new husband and start all over again. Infertility, then, was more instrumental in keeping Bonnie in an unhappy marriage rather than causing its demise. As she put it,

I hung on a lot longer than I should have simply because the desire for children and the mania for these pregnancies and these babies was so strong. Had I not wanted a baby so much, I would have started divorce proceedings over 10 years ago.

The other woman in my follow-up sample who got divorced, Diane, did so when her adopted daughter was four years old. She claimed that neither infertility nor the adoption had anything to do with their divorce. "The worst thing I did was marry my ex-husband, the best thing I did was adopt my daughter," Diane admitted. "I married a very unhappy, depressed human being who's very very selfish," she explained. "We were a very poor match for each other. He didn't love me and I didn't love him."

Although some marriages like the two above worsened, most of the women felt that their marriages became strengthened over the years. During the initial interviews, I had been struck with the number of women who said that in spite of the marital problems it caused, infertility ultimately had a positive effect on their marital relationships. It was interesting to see that many of the women I followed-up said that this positive effect on their marriages continued. "Through infertility, we were able to see how each other dealt with stress," said one woman, "and I think both of us learned to respect the way the other one

dealt with stress or at least to accept it. And I think that's been really helpful over the years." (Amy)

Another woman said that because of going through infertility, she and her husband now appreciate each other more.

We feel like we came through a storm and we're closer for it. We've gone through things that other couples never did and survived it. That brought us closer together. We don't take anything for granted with our kids or each other. (Anna)

Most of the women I followed-up believed that -- to some extent -- infertility did have some lasting effects on their marital and sexual relationships. However, Elaine, a psychiatrist who gave birth to two children, felt differently. She said that having children had a much greater impact on her marriage and sex life than infertility ever did.

#### Long-Term Effects on Other Relationships

During my initial interviews, many of my respondents described having had strained relationships with their friends and/or relatives. Some relationships were even severed. Pregnant women and new mothers were commonly avoided, and hurt feelings often resulted. On the positive side, many of my respondents made new friends with other infertile women.

I was interested in exploring whether or not the old

relationships recovered and the new friendships endured over the years. While "time heals all wounds" might apply to some relationships, I expected that the old wounds might easily be re-opened since infertility is such an emotionally-charged subject. While many of the women in my study may have been overly-sensitive about their infertility, many of their relatives and friends had been extremely insensitive, and time was unlikely to change that.

Hannah, a physician, had been extremely sensitive and angry about her infertility. She had had many conflicts with her family -- especially with her mother and sister -- while she was going through infertility. During the follow-up interview, Hannah said that her relationships with her family had improved after she adopted her first child. However, she still admitted to still having occasional interpersonal conflicts related to infertility.

At a Chanuka party, my sister said something to me like, "Remember how horrible you were in your infertile period?" which got me really angry at her and I laced out at her with all the ammunition I could. I still don't feel I have to excuse my feeling from my infertile period, although I realize that other people have not quite forgiven me for it.

When I first interviewed her, Hannah had also had extremely negative feelings towards pregnant women. She said, however, that having those negative feelings changed after the adoption of her first child and even more so after the adoption of her second. Hannah now felt comfortable around pregnant women and newborns, and no longer felt

hostile towards them.

Some of the women experienced increased problems with their relatives after they had children. One woman had previously found her mother-in-law merely annoying because she kept pushing them to have children. But with the arrival of each of her three children, she found even more annoying, interfering and unbearable. (Beth)

Another woman, Diane, who had adopted a child soon after my initial interview with her said her mother has since had difficulties accepting certain aspects of the adoption. Diane's mother would annoy her by saying such insensitive things to her as, "Do you ever hear from the real parents?"

### Adoption

The five women that I followed up who had adopted were all extremely happy with their resolution and their children. They were successful in achieving their goal -- they were now mothers. They no longer felt hostile towards pregnant women. Since they were now mothers they had no reason to be jealous of pregnant women, babies or even biological mothers. "I'm a parent and so I have so much in common with them," said Diane. "The thing we talk about is being a parent..and so I share with all parents the same aggravations, the same worries, the same joys,

the same everything."

For some women who adopt, however, the feeling of being different from their peers affected their relationships with them. Anna had adopted two children and lived in the suburbs. She explained that many of women in her community remained friends with women they met in Lamaze classes or in the hospital, and they continued to talk about these experiences years later, and this made her feel like an outsider.

Anna, like many of the other adoptive mothers I interviewed, told me that whenever they mentioned that their children were adopted, they were frequently met with insensitive and negative comments.

People ask such obnoxious questions like, "She must have cost you a fortune, wouldn't you have wanted your own?" The hardest thing is, "How do you know what you're getting into? Look at all the problems adopted kids have."

Because of these comments, Anna now only rarely and very selectively tells people her children are adopted. She also complained that people, especially teachers, were often quick to attribute any problems her children had to the fact that they were adopted. They never, however, attributed her children's positive traits to the fact they were adopted. I also heard this complaint from most of the other women in my sample who had adopted children.

### Childfree Living

While women who adopt occasionally have difficult times with their friends or relatives, women who remain childfree often face even more difficult problems. Since most married women have children, society in general, and some of their friends in particular consider these women to be deviant since most married women have children. Janet, the woman who was unhappy about remaining childfree, continued to have strained relationships with her friends who have children.

I always felt they looked at us as freaks or else they would feel sorry for us. A friend once said they feel so bad for us at holiday time because we had no children, and they'd like to invite us but they can't. Most people don't mean to be hurtful, but the thing of having children is so ingrained and so accepted they just say things without thinking of the effect it would have.

In order to deal with the issue of the holidays, which she found especially painful, Janet and a group of friends who have no children would get together during the major holidays.

Another problem for Janet was that her family and some friends avoided talking to her about infertility or the fact she did not have children. "The avoidance is more disturbing than discussing it," she admitted. Some of Janet's close friends had neglected to tell her that about the wife's pregnancy until she was in her last month. When they finally told her, Janet was very hurt and refused to visit the new baby.

Janet's relationships with her friends were not just affected by their feelings about her decision to remain childfree, but also by Janet's own feelings about that decision. She regretted her decision not to have children and whether or not she told her friends this, they were aware of it. In fact, Janet labeled herself "childless" rather than the more politically correct term, "childfree".

Alice was the other woman in my follow-up sample who remained childfree. She was happier with her decision than Janet was and did not experience the same interpersonal problems. In addition, she had no trouble referring to herself as childfree, and saw it as a very positive lifestyle choice.

Although both these woman were in their 50's when I re-interviewed them, Janet had many friends with young children which made things especially difficult for her. Alice, on the other hand, said that her social network did not consist of people who either had or were involved with young children. She also said that she considered herself and her husband "a family, a family of two." But Alice had another advantage that Janet did not have. Her husband's two daughters from his previous marriage had small children, so Alice was, in fact, a grandmother as well as a stepmother. Not only did this has put her in a more socially acceptable position, but it has helped her satisfy her need for children.

I enjoy those granddaughters enormously....It means I can have the best of all these worlds and not have the problems to go with them. I said to myself, "What difference does it make? Do I particularly want to raise kids, or can I just enjoy them?" My stepchildren will always be a part of their father's life and therefore part of mine, and I'll be a grandmother and that's fine. But I also have friends and a life of my own. I think that makes the big difference for me.

In general then, the women who had the more traditional family situations, that is they had biological children, tended to have the easiest time maintaining positive relationships with friends and relatives, because they were more easily accepted as normal by the others. Those who deviated from the norm by adopting or remaining childfree were more likely to have more strained interpersonal relationships with those friends who had traditional families. For this reason, many of the women who adopted formed friendships early on with other adoptive mothers, and tended to maintain those relationships.

Most of the women I followed up had, in fact, made friendships through infertility both in and out of support groups. When they became either biological or adoptive mothers, they continued to socialize with their friends from their infertile days. But now they got together as families, and their children would play together. In some cases, the children, as they grew older, formed independent relationships with each other. Some of these children, in fact, are unaware that their initial friendships were formed in infancy through their parents infertility.

### Long-Term Effects on Careers

During my initial interviews, my respondents indicated that they often had difficulties in their professional lives. As I demonstrated in Chapter Five, many put their careers on hold while waiting to conceive, or they were so distracted by their medical treatment that their work or even careers suffered. Elaine, a psychiatrist, not only felt her career was adversely affected by her initial inability to have children, but also by her ultimate success in having two children. She had decided not to go to analytic school and turned down some good full-time jobs in favor of less prestigious and less better paid part-time jobs both while she was going through infertility and after she had her two children.

I made career choices all along the way that has put my kids as a priority...I definitely put my career on the back burner. I have mixed feeling about it for two reasons. I like what I do a whole lot, but I feel like I'm working at a third rate job in a certain way.

On the other hand, some of the women felt that infertility had positive effects on their careers. Seven of the 10 women I followed up were in the helping professions and occasionally came in contact with women with fertility problems. They all mentioned that their experiences with infertility helped them professionally in their dealings with clients who had fertility problems. "I've been able to help a lot of people to pursue adoption or to pursue

infertility treatment," said Hannah, the physician who had adopted two children. "Not that you wish an illness upon a doctor or other medical personnel, but I think illnesses or body problems help people be better doctors, nurses or whatever."

Some of the women made dealing with infertile clients a sub-specialization. Diane, a career counselor who adopted a child through a private adoption started a side business in counseling women on how to adopt privately. Beth, a social worker, became president of the New York Chapter to RESOLVE and also did counseling and ran support groups for RESOLVE. After she adopted a child she broadened her practice to include infertility and adoption counseling, which she said she never would have gotten into before. Although Beth is now mainly doing child and adult psychotherapy, "doing infertility counseling was a very wonderful experience," she said. "I loved it and it helped me and I think I was good at it."

Two of the ten woman I followed up are no longer in the work force. The strains of infertility had previously caused Bonnie to leave her high-powered public relations job in the sports world. But infertility also motivated her to go back to school for her master's degree in English. "I was going so crazy and said I have to do something constructive or go really berserk...while I was waiting cycle by cycle," Bonnie explained. After she had her first

child, she student taught for awhile, but now that she has two children, is devoting herself full-time to motherhood. "I felt very strongly that once I had the babies, I was not interested in turning them over to a nanny...I love being a mother," she explained. Although Bonnie would love to teach Victorian Literature at some point, she says for the present time, she is very content being at home.

Anna used to commute to the city from the suburbs to her teaching job before she adopted her first child. Although she now does a lot of volunteer work and does desk-top publishing from her home, she is primarily a housewife and mother to her two children.

For most of the women I followed up that become mothers, having children rather than having had a fertility problem had more of a profound impact on their careers. As Anna put it, "It's the fertility part -- motherhood -- that knocks out the career!"

### Effect on Parenting

Motherhood is the goal of all women undergoing infertility treatment. As I have shown in the previous chapters, infertile women go through considerable physical and emotional efforts and turmoil to have children. One might expect then, that women who become mothers after years of infertility might value their children more and take them

less for granted than do women who conceive easily. As a result, mothers who had been infertile might have different parenting styles and attitudes towards their children than do other mothers.

Because I did not do a comparative study of women who conceived easily and those who did not, I could not definitively determine whether or not this was actually true. I only have my respondents impressions and opinions about being mothers and whether or not they thought that infertility affected their parenting styles or attitudes.

All the women I followed up who became mothers -- whether by giving birth or adopting -- said they were thrilled to be mothers and felt it was the best thing they ever did. Although they also all talked about the difficulties they have had in raising children, none regretted having them. In fact, having difficulties with or being angry at their children often made these women feel very uncomfortable, if not guilty.

I remember when Emily was home from the hospital a week and she was screaming and screaming, and I felt like throwing her out the window, I really did. I couldn't believe that here was this kid I wanted so much and I already was on the verge of child abuse. What surprised me not only then but at other times when I been furious at one or the other of them, is how angry you can get at a kid that you want so much. (Elaine)

The only woman who did express some ambivalence about being a mother was Diane, one of the two women who had gotten divorced. Although she said that becoming a parent was the best thing she ever did, and that she found

parenthood very fulfilling, she also said that it was very hard work, especially being a single mother. The fact that her 12-year-old adopted daughter had some learning disabilities, added to her difficulties. "Sometimes, frankly, there are times when I wish I hadn't done it because it's so hard and sometimes it's not rewarding or gratifying," Diane admitted. "But the times it really is gratifying is terrific."

Most of the mothers did say that they thought they felt more grateful for their children, and that their children were more precious to them because of infertility. "I don't take them for granted," said Elaine, the psychiatrist. "Maybe I wouldn't have taken them for granted having them later in life anyway, but I don't take them for granted, I don't think, as much as I might have."

On the other hand Beth -- the psychotherapist who had one adopted and two biological children -- said that she did not think infertility makes people appreciate their children more. "I think if you're capable of love then you'll love your kids." She, in fact, felt that infertility had a negative impact on her parenting style. "I think to go through that amount of pain makes you very intense in certain ways and to have that intensity is a burden for you and the kids...I'm sure we're very defensive, overprotective and perhaps over involved because of the infertility and the struggle we had to get through to get kids...I think it

created an anxiety about being a parent and about childrearing that is hard to overcome," she explained.

Bonnie, the full-time housewife with two children also admitted to being extremely overprotective. But she did not necessarily attribute this to infertility. "I would have been an overprotective nut anyhow. It's just my personality." On the other hand, Amy said that because infertility helped her learn how to relax and deal with stress, she was a less "uptight" mother than she would have been.

In general, those who adopted said they felt that adoption *per se*, more than infertility, affected their parenting styles or relationships with their children. Hannah, the physician with two adopted children said that adoption was a key factor in how she dealt with her children, especially the eldest who was 10. "She knows how to use adoption in a negative way," she explained. "Like 'My birthmother would have given me the candy and cookies and let me stay up as late as I want and let me go to sleepaway camp.'"

Hannah also feels that because her children are adopted, she has put more of an emphasis on religion so her children would develop a Jewish identity. "I sometimes question whether or not I would be so imbued with the idea you have to go to Hebrew school if I had a biological child," she admitted, "so that makes me feel a little bit --

guilty isn't the word, but I question my own motives."

Anna, the woman with two adopted children, said that while she did not think infertility affected her parenting style, it gave her "a real respect for how precious life is. I don't complain...You've gone through so much you appreciate things more." She added that when she and her husband were going through infertility treatment, they promised each other that when they finally had children, they would, "never let little things bother us or let things get out of hand. We would remember this moment -- how much we wanted children."

#### Being an Older Parent

One aspect of infertility that had a lasting affect on my respondents' parenting styles -- perhaps more than anything else -- was the fact that they were now "older mothers." These women were older than most mothers of young children in this country, both because they had delayed childbearing to begin with, and because infertility further delayed their parenthood. According to my respondents, there were both positives and negatives to being an older mother. Most regretted, to some extent, being older parents because they tired easily. On the other hand, at both the initial interview and the follow-up, most said they did not regret delaying childbearing, that they were not ready to be

parents when they were younger. They felt that being an older parent made them better, if not wiser parents. "I'm probably more patient and more mature than I would have been earlier on," said Amy, a 45-year-old mother of a 10-year-old daughter. "I think I have less energy and I'm a little more of an old foggy as an old parent." But Amy also admitted that while she might have had more energy while she was younger, she would also have had a "shorter fuse".

However, Beth -- the psychotherapist mother of three -- found that being 46 with three young children was extremely difficult. "I wish that I weren't so old," she said. "I had a lot more energy when I was younger and a lot more personal resilience, even though I was less experienced and less mature." Because of this, Beth says she wishes she started trying to conceive earlier. On the other hand, she admits there are some positives aspects to having delayed childbearing. "I'm glad I got my education done," she explained. "I think trying to study and raise a child is a tremendously tense experience. Trying to do a dissertation and having very young children is impossible."

Several women, however, while acknowledging some of the benefits of being an older parent, did worry about being quite old and possibly sick when their children were young adults. Said Elaine, a 48-year-old mother of two, "I was definitely more mature when they were younger, but I'm going to miss out on things at the other end of the

spectrum, so that sort of makes me feel sad sometimes," She says that she regret that when her youngest child was her age, she would be 88, if she's still around!

#### Long-Term Effect on Self-Esteem

While all my respondents had felt stigmatized when they were infertile, none of those I followed-up felt stigmatized or embarrassed because they were older mothers. If anything, they were proud of being older mothers, of their maturity, and of the way they overcame infertility either through adoption or a successful pregnancy.

One would expect that the negative effects of infertility on a woman's self-esteem would dissipate especially if she is able to become pregnant. A pregnancy is a verification that she is just like other women -- normal, healthy and fertile. Hannah had finally become pregnant after trying unsuccessfully for 10 years. She had had several bleeding incidents during the pregnancy and was very concerned about having a miscarriage.

I remember at one point even thinking that at least I had gotten pregnant, even if I had a miscarriage it wouldn't be so bad because I had now achieved something called 'getting pregnant'. I sort of felt grateful for even being pregnant...I was successful.

Unfortunately, she did have a miscarriage following an amniocentesis. "I had no idea how profound the disappointment of a miscarriage was going to be," she

recalled tearfully. Her adopted daughter was six at the time, and the miscarriage made her desperate to have a second child. Soon after the miscarriage, Hannah was able to adopt another baby, also a girl. In spite of the fact that she still was very upset about the miscarriage and would cry whenever she talked about it, she maintains that it was a positive experience.

I think the advantages of this whole pregnancy thing were I still had a feeling of at least I had gotten pregnant. And I still say that to this day even though it seems somewhat perverse to me feeling triumphant that I had gotten pregnant after 10 years.

While for some women a pregnancy is a validation that they are normal, healthy woman, their past infertility often remains part of their identity. "I look at these people who pop out babies one, two, three, and I still feel a little like there was some deficiency that I had", said Elaine, the psychiatrist who finally gave birth to two children after multiple miscarriages.

But when a women does not succeed in becoming pregnant, but becomes a mother through adoption or remains childfree, she does not have that validation that she is normal and just like everybody else. Years later she still might be labeled deviant, abnormal, unhealthy, infertile, and a failure -- not only in the eyes of others -- but in her own eyes. Said Amy, an adoptive mother, "I think that probably at some level, I still haven't done what other women have done. There's still that passage that I haven't gone

through. I still sometimes have to deal with people who think that I'm not a real parent."

Anna -- the mother of two adopted children -- said she still felt that to this day that having been infertile and not having given birth was a great loss, that still thinks of it as a death. Janet, the woman who was unhappy about remaining childfree, said that up until two years before I re-interviewed her, infertility continued to have a extremely negative impact on her self-esteem. She had seen herself as an over-achiever but her past experiences with infertility made her feel like a failure. However, after she went through menopause, she began exercising and working out with weights. "It's done more for my self esteem," she explained, "I feel more assertive, more aggressive...I have a very strong self-esteem right now, but there was a period when I felt like throwing myself in front of a bus."

While some women who adopt might still feel infertile and failures as women on some level, for many there is a sense of pride at having successfully resolved their infertility through adoption. Amy said she felt that adopting her daughter had a positive lasting effect on her self-image. "It gave me a perspective on what was good about myself that I might not have otherwise been cornered into doing," she explained.

Other women who adopted talked about feeling very proud of the way they were able to overcome the obstacles to and

complications of adoption. This in turn, made them feel powerful and independent. Just the process of going through infertility and surviving seemed to be an ego-booster for many of the women as Hannah realized:

Infertility is something that made me stronger as an individual because I had to seek out treatment myself, go for treatment myself, pursue adoption myself and it made me more confident that I could function on my own.

Although infertility tends to have negative long-term effects on many women, for those who are satisfied with the way they resolved their infertility, it can also had some positive effects as Diane realized:

Everybody has something in their life that's some sort of incapacity or inability. Infertility was one of my adversities that I had to overcome, and I overcame. The thing I also learned from the infertility process and adopting was that I am very powerful. And I can do just about anything I put my mind to. Once I found my daughter, I felt so potent and felt that I could move mountains and it just fueled me with so much confidence, it made me feel so extraordinarily powerful...I felt I could find anything and as a result I have really become very, very successful because that attitude and that feeling has enabled me to fuel a great deal of my optimism. That's what infertility did for me, gave me an enormous amount of confidence.

### Conclusion

For the women I followed up, infertility was no longer a daily obsession -- the ever-present reminder of a past failing. Nor was it entirely a thing of the past. For them infertility was an occasional reminder of their past difficulties that continued to have some impact on their

present circumstances. Infertility taught these women important lessons about themselves they might not otherwise have learned, lessons they have not forgotten in over 10 years. Bonnie described what she learned through her experiences with infertility:

If something is important to me, I'll take it to the limit. I'm not a quitter...I'll turn the world upsidedown to find an answer. And I did. I would have gone to every specialist in the world, I would have paid anything, I would have done anything. I was born to be a mother. More than I've known anything else in my life, I knew I was born to be a mother. And it was an aberration for me not to. It was like a birthright I needed to fulfill.

Regardless of how my respondents resolved their infertility, they experienced both positive and negative long-term effects on their marital relationships, relationships with friends and relatives, and for those who had children, their relationships with those children. Infertility also continued to have an impact on their careers and their self-esteem, and it remained a permanent part of their identities. As Anna, the mother of two adopted children put it, "Infertility shades all my relationships, it's part of who I am...I approach people even to this day with that in mind. Although as you get older, it gets further and further away."

In the next chapter, the past, present and future of delayed childbearing, infertility and infertility treatment are explored both from my respondents' and society's perspectives.

## CHAPTER EIGHT

DELAYED CHILDBEARING AND INFERTILITY:  
PAST, PRESENT AND FUTURE

In 1981, when I started researching the subject of delayed childbearing and infertility, delayed childbearing was defined as 30 or older. Louise Brown, the world's first "test-tube" baby was three years old, and there was only one in vitro fertilization (IVF) program in the United States. Women in their 40's neither sought nor received infertility treatment. All that changed dramatically over the next decade.

During the course of this study, I was able to observe the social, medical and ethical changes that occurred surrounding infertility and its treatment. My continued involvement with RESOLVE and my work with an in vitro fertilization organization allowed me to observe not only the changes that have taken place, but some of the ramifications of those changes on infertile men and women, and on the doctors who treat them.

Further, I was able to interview 10 of my original 35 respondents more than a decade after my first interviews with them. This provided me with tremendous insights into the long-term effects of infertility. It also provided me with an opportunity to hear first hand how these women's

lives had been transformed over the past decade, and how -- in retrospect -- they felt about their childbearing decisions.

#### THE PAST

The women in this study were, for the most part, successful career women who were used to achieving their goals. When they finally made the decision that they wanted to become pregnant, they expected it would happen almost instantly. They did not anticipate problems conceiving, nor did they anticipate the myriad of additional problems caused by infertility.

These women might have benefitted from knowing in advance that infertility increased with age, as well as what impact infertility might have on their lives. By anticipating the possible medical and social implications of delayed childbearing and infertility, they might have been better prepared to cope with them. But infertility had not yet come out of the closet.

When I conducted my first interviews in the early 1980's, infertility was a taboo word and a taboo subject. The women in my sample all delayed childbearing at a time when infertility was highly stigmatized and rarely discussed among friends, much less in the media. Most of them knew little if anything about infertility, and none of them knew

that fertility decreased after the age of 30. This was understandable given the dearth of information about age and infertility available to the public. Although the fact that fertility rates declined after the age of 30 was documented in medical books and journals, it was not widely known in the general population or even among physicians. Indeed, most of the doctors the women in my study consulted, seemed unaware of this fact.

A study conducted in France and published in the New England Journal of Medicine (CESOS 1982) was the first scientific study on delayed childbearing that was picked up by mass media. This French study confirmed not only that fertility declined rapidly after age 35, but also showed that it declined significantly after age 30. Editorials were written in response in both professional journals and the popular press. Older career women without children were admonished for delaying childbearing while pursuing their careers, and the younger ones were warned to get on with their reproductive responsibilities before their biological clocks stopped ticking. Women started to panic and call their doctors. "Women Reconsider Childbearing Over 30" was the headline of an article in The New York Times the week the New England Journal article came out (Dullea 1982).

In an editorial accompanying the New England Journal study the authors wrote:

As a result of the changing roles of women, many are facing the question of whether to delay childbearing until their 30's in exchange for career development...If the decline in fecundity after 30 is as great as the French investigation indicates, new guidelines for counseling on reproduction may have to be formulated... Individual and societal goals may also have to be reevaluated. Perhaps the third decade should be devoted to childbearing and the fourth to career development, rather than the converse, which is true for many women today (DeCherney and Berkowitz 1982, 424-425).

The authors did concede, however, that the "social ramifications of a return to younger ages for childbearing are important, since it might not only reverse the trend toward later ages of marriage but also affect future progress in the professional advancement of women" (Ibid.). But these social ramifications seemed to take a back seat to what the medical profession and media considered to be of more importance -- reversing the trend toward delayed childbearing. The pronatalist ideal of motherhood first and foremost appeared to be winning out over feminist ideal of self-realization before motherhood.

The authors of the editorial posed the question, "Would women reconsider the decision to postpone conceiving if the evidence showed that such a decision might compromise their reproductive capacity?" (Ibid., 424). I had posed this same question to the 35 women in my study during the initial interviews. If they knew ahead of time that they would or could have fertility problems, would they have tried to have their children earlier? In other words, did they regret having delayed childbearing?

The majority of my respondents said either that they did not regret delaying childbearing, or that if they could do it over again, they still would have postponed parenthood. They felt that, at the time they made the decision, delaying childbearing was the right decision for them and their particular circumstances.

I'm very sad about not being able to get pregnant, but I realize that I could not have done it differently. That this is me, this was my life. I did not have a good relationship in my twenties, and I wasn't ready. And that even if I had been told, you aren't going to be able to have children unless you try now, I couldn't have done it differently...I know that it could be as terrible a situation if I had been able to get pregnant early and it hadn't been the right time. And I've begun to think that there's nothing worse than having a disturbed child or a very very difficult child because you haven't been able to nurture and meet the needs -- or your own needs. That to me...might be even worse than not being able to get pregnant. (Terry)

Several women said that they did not regret delaying because it allowed them to succeed in their careers, a major priority for them. "I wasn't ready when I first got married, and I waited until I felt I was ready," said Diane, a career counselor, who got married at 29 but did not start trying to have children until she was 36. "I get so much satisfaction out of work...I would have been a shitty mother if I had become a mother much earlier," she admitted. "I would not have had anything to offer...I might have had an abortion. I was just not ready for it."

Postponing parenthood also provided these women with the opportunity to consolidate their marriages. A few who

did express some regret about delaying added that if they had had children earlier, it probably would have been detrimental to their marriages and/or their children. "I would not have waited," said one woman who wanted to have children before her husband did. "But if we had a child, it would have been a disaster," she admitted. "We got a dog instead, and I would hate to have a child turn out the way that dog turned out!" (Beth)

One 39-year-old woman, Laura, and her husband had just adopted a baby when I interviewed her. She felt they made the right decision about delaying because her husband was having some career problems, and if they had a baby when they were younger, they probably would have ended up divorced. "It would have been a disaster...I think our lives would have been very different in a bad sense," Laura explained. "We would have had a baby, maybe. But I don't think either one of us would have been as happy as we are now. So I guess I'm glad we waited."

Some women, on the other hand, were ambivalent about having postponed parenthood. The following physician, Hannah, said that she should have tried in her fourth year of medical school because it was an easy year:

I would have tried earlier if I had known about these problems I was going to have...but my husband wasn't ready to have a child then. And I feel sorry that I didn't try that year. That was when I was 24 years old. And I don't know if emotionally or whatever I was as ready to have a child then. But I would have liked to have that problem rather than this problem.

While a few of my respondents expressed some regret or ambivalence about having delayed childbearing, only two felt strongly that they had made a mistake -- that they definitely should have tried getting pregnant sooner. One of these women, Janet, had gotten married at 34 and waited until she was 38 to start trying. She finally conceived but the pregnancy ended in a miscarriage. Janet said that while she felt fine about marrying late, she did regret waiting those additional four years before trying to get pregnant.

The other woman, Michelle, got married when she was 33 after living with her husband for three-and-a-half-years. Although she said they got married in order to have children, they delayed for several more months because she was very concerned about her career as a fund raiser. "It seemed to be just taking off," she explained. "I wanted to get myself really established, because I was sure I'd get pregnant right away. I just thought bang bang bang and there I would be and I'd have to resign." She said she both regretted marrying late and delaying childbearing. For Michelle, age became an especially pertinent issue because although she finally conceived, the fetus had Down Syndrome and had it aborted. While she admitted that delaying gave her a chance to develop her career, she added,

I don't know whether that's really the thing to shoot for...if you want to have a baby, then you ought to do the things that will help you have a baby. And waiting until you're 34 years old or 35 or 36 just doesn't help your chances...It just doesn't pay to wait this long and go through an increased risk of genetic abnormalities,

an increased risk that you just won't get pregnant. Just waiting and waiting, it gets so twisted. I mean, it's not worth it. The career isn't worth it. You can go back and pick it up. If (having a baby) is really a priority, then you ought to do it younger. I would.

### Age and Infertility

Although most of the women in my study said that they did not regret delaying childbearing, or that it would not have been appropriate or practical for them to start trying sooner, many said that they would have liked to have known that their chances of conceiving declined after 30. Many were angry with their doctors because they had not warned them that fertility decreases with age.

I really do feel that it was the doctor's responsibility at some point... I was the kind that regularly saw a gynecologist every single year and no mention was ever made. I never hear the term endometriosis, never. And here I read that it's "the career woman's disease" and it's all so prevalent. Well this is news to me. I'm a well-read educated person and I have to be 31 and infertile to find out what endometriosis is. I had never heard that your fertility quotient went down after a certain age. These are things that just in passing any decent gynecologist worth his salt really should have mentioned. (Bonnie)

Many of the women also said they would have liked more medical information about infertility in general when they made their childbearing decisions. Rather than encouraging them to start sooner, my they said that it would helped prepare them for the disappointment of infertility.

If these women had known more about infertility and its effects, would, they, in fact, done things differently?

When I asked this question, some women said -- in retrospect -- that they would have first gone to a fertility specialist rather than their regular OB-GYN. Others said they would have changed doctors sooner, initiated testing and treatment sooner, or speeded up the diagnostic process. Those women whose husbands had fertility problems said that they would have had their husbands tested first or at the same time they were tested. Quite a few said they would have changed jobs or careers, and others mentioned that they would have lived elsewhere or traveled more. One woman who had been extremely ambivalent about having children to begin with, said that if she knew then what she knew now, she would have married a man who did not want children. (Jane)

While my most of my respondents might have benefitted from information about the possible risks and ramifications of delayed childbearing and infertility, it is clear that they did not want to be dictated to or lectured to by their physicians -- or anyone else for that matter -- about when they should or should not have children.

## THE PRESENT

When I first interviewed my respondents they were in the midst of the physical and emotional trauma of infertility. Yet the overwhelming majority said they had no serious regrets about delaying childbearing. Now, more than

a decade later, when they were living with the repercussions of that decision, did these women feel the same way about having delayed childbearing? What were their present feelings about their past decisions?

### Childbearing Decisions in Retrospect

While most of the 10 women I was able to follow up did not say that they regretted delaying childbearing, three said that, in retrospect, they maybe should have started trying a little sooner. It is interesting to note that these three women were among the youngest in my sample. Ruth, a physician, had said in the initial interview that she made the right decision for her at that time. By the time I did the follow-up, she was 41, had had three children and two abortions. (One was because she became pregnant again soon after the birth of her second child, and the other because the fetus had Down Syndrome.) She said she wished she started at 26 instead of 29 because by now she would have had even more children.

Hannah, also a physician, had gotten married at 18 and delayed trying for 10 years. She wound up adopting two children. Hannah said she felt that maybe she should have started trying a little earlier, although she said it would have been very difficult for her since she was a medical student at the time.

The third woman, Bonnie, had gotten married at 28 and started trying at 31. She ultimately had three pregnancies with her first husband -- one ended in a miscarriage and the other two were successful. She had just gotten divorced and remarried when I did the follow up interview. During that interview she said that if she knew she and her husband were going to have a fertility problem, she might have tried getting pregnant when she was 30 rather than 31. On the other hand, she also added the following:

I do think delayed childbearing is a wonderful thing. I think it's great to get your romances and career and everything going in your 20's and to use your 30's to have babies. But it's unfortunate that statistically, infertility rises at that point.

The only woman who strongly regretted her decision to delay childbearing was Janet, the woman who was unhappy about her decision to remain childfree. Even when I first interviewed Janet -- before her decision to remain childfree -- she had said she regretted her decision to delay childbearing. At the follow-up interview, she reiterated that delaying childbearing had probably been a mistake for her. "We know now if you want to have a full life, you have to look at your whole life and not just chunks of it. You have to have some overall plan, which I didn't do," she admitted.

Six of the 10 women I followed up said they felt they had made the right decision for them at that time. They talked about the positive aspects of postponed parenthood.

By delaying childbearing they were able to accomplish other things in their lives that they might not have been able to do had they had their children earlier. "It enabled me to establish my career. If I hadn't gone back to school and gotten a doctorate, I wouldn't have a career," said Beth, a psychotherapist. Another woman, Anna, explained, "Had I tried to have a child earlier and then found out I was infertile, I might have ruined the best 10 years of my life. My 20's would have been ruined...I had some good years at a time I deserved them."

As we have seen, most of the women I followed up did not regret their past decisions about childbearing. They were pleased with how they resolved their infertility. Those who now had children were very happy with motherhood. However, while my respondents were going through the process of infertility treatment and resolution, their lives were often in extreme turmoil. My initial interviews, follow-up interviews, and observations have convinced me that these women -- and others with fertility problems -- could have had an easier time coping had they been better informed about infertility. If they had known more about the potential adverse effects of age on fertility and of infertility on their lives, they might have been spared considerable pain. But that was the 1980's, and infertility was still a highly stigmatized, insufficiently discussed condition.

Delayed Childbearing and Infertility Today

In the 1990's infertility, the previously taboo subject, infertility, came out of the closet with a vengeance. It made its appearance on daytime talk shows, nighttime news magazines, soap operas and "sit coms." The media seemed to love the idea that career women who delayed childbearing had fertility problems, and the older and more successful the woman, the better. Infertile men and women -- the media discovered -- were intelligent, articulate and attractive, and some of them even worked in the media. Although there is still a stigma attached to infertility, it is less now than it had been in the 80's. Connie Chung, Roseanne Arnold and Geraldo Rivera came out of the closet and discussed their problems with infertility on their own and other's TV shows.

The public cannot not seem to get enough of the tragic stories of infertile couples and their happy, dramatic endings. These stories are often accompanied by pictures of twins, if not triplets or quadruplets. Today, it is virtually impossible to pick up a woman's magazine without finding an article on infertility, its mental anguish, its miracle cures and miracle babies.

One would think that we are in the midst of a major epidemic. But infertility is more of a media epidemic than a medical one. As we saw in Chapter One, the incidence of

infertility has not increased. What has increased is the number of women who have delayed childbearing. Because many of these women are infertile and seeking medical help in record numbers, it appears that infertility is on the rise.

### The Definition of Delayed Childbearing

Not only has the number of women who delay childbearing increased, but the age at which a woman is defined as having delayed childbearing has also increased. When I conducted my initial interviews in the early 1980's, the definition of delayed childbearing was over the age of 30. By the 1990's, that definition rose to over 35. This shift was in part due to the trend in delayed childbearing itself, since the average age of first birth has increased. Women who have their first child in their early 30's are now well within the normal range of childbearing.

In addition, there has been an increase in the number of studies on age and infertility, and most of these studies show that 35 and not 30 is the age at which infertility starts to dramatically increase.

The definition of delayed childbearing has also changed among my respondents. In the early 80's, they had all defined themselves as having delayed childbearing, yet the ages they first started trying to conceive ranged from 28 to 38. When I did my follow-up interviews in the mid 90's,

most said that they now considered delayed childbearing to be over the age of 35 or even to the early 40's. Said one woman, Diane, who delayed until she was 36 and was now a 51-year-old divorced mother of an adopted child, "I think 40 is delayed, 50 is insane!"

### How Old is Too Old?

The new reproductive technologies and prenatal diagnoses have made it possible for more older women to have healthy babies. A recent study has shown that the majority of healthy older woman can give birth to healthy babies without major risks to themselves or their offspring (Berkowitz et al. 1990). It now appears that women do not necessarily have to be slaves to their biological clocks.

Increasing numbers of women who choose to delay childbearing are able to do so successfully and at older ages. To be become pregnant, these older women may have to go through many months or even years of infertility treatment, treatments that can cost \$10,000 -- \$15,000 per cycle and may not be covered by health insurance. A woman can wind up spending over \$100,000 on infertility treatment with no guarantee of having a biological baby. She can wind up with empty pockets and an empty cradle.

On the other hand, no one forces these women to undergo infertility treatment. Many of these women are very often

successful women with established careers. Whether they are single or married, most are quite capable of making an informed decisions about their own reproduction. Certainly more so than most unmarried teenagers. As Alice, one of my oldest respondents (55 when I re-interviewed her) put it, "As long as you want to have a kid and you can pull it off, go ahead and do it. Age is not a factor, it's just an arbitrary number we pick."

Reproductive freedom is about controlling one's reproduction. It means the right to choose to have a baby as well as the right to choose not to have a baby. And it means the right to decide when to have that baby. Whether or not a baby is actually in the cards is a gamble these older women choose to take. The right of older women to bear children helps put them on more equal footing with men who have been able to father children at practically any age. Ironically, the older a man is when he fathers a child, the more he is cheered on -- if not revered -- while the older a woman is, the more she is ridiculed.

While having a child at fifty might be considered insane by some, it is not impossible. The new reproductive technologies have now helped hundreds of post-menopausal women become mothers. These women are having successful pregnancies and healthy babies with eggs donated by younger women. In February 1994, news came across the United Press International Wire (UPI) that a 60-year-old European woman

gave birth in Israel, making her the oldest known woman to give birth. She conceived her baby through IVF using a donor egg. A few months later, a 62-year-old Italian woman gave birth. Law makers in England responded by making it illegal for doctors to help postmenopausal women become pregnant. Reports started appearing of women in the US over 50 giving birth.

The debate has continued, but the focus has changed. Whereas before the issue was whether or not women should delay childbearing until their early thirties, with the availability of the new reproductive technologies, the issue is now and will continue to be, "How old is too old?". Should women who delay until their 50's and 60's be allowed to have children? If they do, who should pay the costs the reproductive technologies they would require? And what will those costs be for the women, their offspring and society?

#### THE FUTURE

What will be the ultimate effect of the reproductive technologies that allow women of practically any age to have babies? Will more women delay childbearing to an even later age knowing that -- with the help of technology and perhaps an egg donor -- they can become pregnant and have a healthy baby?

Today, embryos -- but not eggs -- can be successfully

frozen for use in the future. But soon -- eggs, even immature eggs -- will be able to be successfully frozen. New developments in reproductive technologies are going to make it possible for women to have their eggs removed when they are young, even before they reach puberty if need be. The eggs will be frozen, and then thawed, matured and fertilized at a future date. This will enable women who have degenerative diseases or have to undergo chemotherapy, for example, to become pregnant at some later date with their own eggs. By the same token, it will also enable women beyond menopause to become pregnant. Because an egg donor would not be involved, the cost would be cheaper, and the legal-ethical issues would become mute.

What will stop women in their 70's from having children? Might we be creating mothers who are in Depends while their babies are still in diapers? Editorials have appeared in major newspapers and professional journals denouncing older motherhood. Is it because we are "ageophobic"? Why are people so upset about older mothers but not older fathers? What about older mothers disgusts us? Why, when we are in the midst of a real epidemic of teenage pregnancies, are we concerned about a trivial number of mature, and usually financially well-off older mothers?

The media attention given to these women makes it appear as if hoards of post-menopausal women are swamping the offices of fertility specialists. But this is not the

case according to the American Society of Reproductive Medicine. Most doctors and IVF programs impose age limits on their patients. And even though these limits have been continually pushed upward because of new technologies and the increased availability of donor eggs, most programs have an upper limit of the mid-forties.

There is also no evidence to suggest that the age women are delaying childbearing is increasing or will increase significantly enough in the future to warrant concern. There may be more women over the age of 40 having children, and there certainly are more women over 50 having children, but these are anomalies.

The trend towards delayed childbearing until the mid-thirties to early 40's is, however, a reality and shows no signs of abating. What will be the long-term effect of the increasing number of children of older mothers? Will we be creating a society of young orphans? Most of the women who delay childbearing into their late 30's or older will have trouble conceiving. What impact will infertility have on them and their children?

#### Children of Older Mothers

My follow-up interviews have shown that the children of my respondents -- whether born to them or adopted -- were both very much wanted and loved. Many of the mothers I

interviewed believed that they appreciated their children more because they were harder to come by. They also felt that, by being older, more mature mothers, they and their children were at a social psychological advantage. But they also admitted to being more tired, and felt badly that they did not always have enough energy to devote to their small children.

Recent studies have shown that, except for genetic disorders, children of healthy older mothers are at no increased risk for medical disorders. Nor are the mothers themselves (Berkowitz et al. 1990). Frankel and Wise (1982) found that older mothers who had established careers were "more accepting and less conflicted in the parenting role than were younger professional women" (p. 220). They also found that older mothers, because they tend to have more marital and financial stability than younger mothers, can more easily afford to provide material, cultural and social advantages for their children.

In addition, children raised by older mothers are certainly more likely to be better off than children raised by teenaged mothers. In fact, one study reported that when older mothers were compared with teenaged mothers, "the older the mother the higher the IQ" of their children (Stein 1985, 338).

Because my respondents had fertility problems subsequent to having delayed childbearing, most of them were

raising small children while they were in their late 30's through early 50's. Although they tended to complain about being tired they, for the most part, were thoroughly enjoying the motherhood they fought so hard to attain.

But what about women who delay childbearing even longer and then discover they have fertility problems? They may be raising young children when they are in their 60's. What will the effects be on them and their children?

Abbey et al. (1994) found that when infertile women became parents, many of the negative effects of infertility are mitigated. Would this hold true for infertile women who become parents when they are in their 50's or 60's? More research is needed to understand the long-term implications infertility and older parenthood on women, their spouses and their children. These issues need to be studied objectively so women can make informed decisions about the timing of their childbearing.

### Should Women Delay Childbearing?

Putting one's life in order, "sowing one's oats", establishing one's career before becoming a parent is often advocated for men. Why not for women, if that is what they want? As long as a couple (or single woman for that matter) is contemplating delaying childbearing truly understands that (1) their chances of having a child will decrease with

age, and (2) that if they experience infertility, their lives will be disrupted emotionally, financially and medically for a period of time, and (3) that infertility might have some lasting effects on them and their children, then their decision to delay childbearing is an informed decision and should be treated as such.

Another factor to take into account is that women in their 40's and 50's today are a lot healthier than their contemporaries were even two decades ago. Middle-aged women today also look younger, act younger, dress younger than their mothers did. They exercise more and eat healthier diets. Said Bonnie, who was 42, remarried and considering trying to have another child when I did the follow-up interview,

Age doesn't seem to mean what it did in my mother's day when women started to get middle-aged in their 30's. They started to get very settled, very kind of old and humdrum- looking. I just had my OB check me out and he said, "You're probably in better shape now than when you were trying to have Rebecca in the first place." He said, "I'm not talking eggs and hormonal level, I'm talking medically in terms of strength and muscle structure." He said, "Your insides and outsides could easily be 32."

While the debate continues about how old a woman should be when she becomes a mother, women who are considering delaying childbearing can better educate themselves to understand the risks of infertility and miscarriages at various ages. If they delay until their mid-30's or later and fail to conceive within a few months, ideally they

should consult a certified reproductive endocrinologist and have some basic, non-invasive diagnostic tests done. If treatment is called for, they should understand what is involved, what are the success rates, and what are the side effects and risks of that treatment. If they are dissatisfied with their doctor, they should switch as soon as possible. They should join RESOLVE or another self-help organization or support group. They should read and learn more about the medical aspects of infertility so they can make informed medical decisions and avoid being exploited by doctors or seduced by IVF programs that might promise them babies again all odds. They should read and learn about the psycho-social aspects of infertility so they make intelligent psycho-social decisions. In other words, they should take control of their health care, thus insuring that they make informed decisions about their future lives.

Given what we now know about delayed childbearing and infertility, should women postpone parenthood until their 40's or 50's? I would argue that this is a choice that a woman should be free to make. The average life expectancy of a woman today is around 80 (Stein 1985). If a woman chooses to delay childbearing until she is in her 40's even in their 50's -- if she succeeds in having children -- she will have a good chance of seeing those children grow to adulthood. To deny her the opportunity to be a mother is to deny her freedom of reproductive choice. And perhaps more

importantly, it would also deny her one of the most meaningful and momentous experiences in adult life -- motherhood.

CHAPTER NINE  
CONCLUSIONS AND IMPLICATIONS

This dissertation is an in-depth study of infertile women who had delayed childbearing. I have shown how infertility affected virtually every aspect of these women's lives -- not only while they were experiencing it -- but for many years to follow. My research demonstrates that there are both positive and negative effects of both delayed childbearing and infertility that can last longer than a decade. I also demonstrated that if women do delay childbearing and wind up with a fertility problem, their lives -- while profoundly affected -- are not permanently damaged. That many infertile women, in fact, gain a lot from their experiences with infertility.

While this study has looked at the ramifications and implications of delayed childbearing and infertility on a specific group of women, it has broader sociological implications.

Changes in the Conceptualization of Delayed Childbearing

When sociologist Dudley Poston wrote about women who delayed childbearing in 1976 (p. 203) or what he referred to

as "the temporarily childless", he considered women in this category to be an anomaly. "Childbearing itself, let alone the birth of the first child is virtually complete by age 30," said Poston. "If a woman is childless at age 30, chances are not good that she will bear a child." Poston has been proven wrong. For a sizable portion of the population, childbearing barely begins at age 30.

In 1979, Rindfuss and Bumpass, who also wrote about the trend toward delayed childbearing, focused on the importance the social definition of childbearing age or what they called "the relativity of age" in the sociological study of fertility. As we have seen, what was considered old then is not considered old now. In addition, they hypothesized that delayed childbearing would have the following effects on women:

- \* the older the woman, the more likely she is to be involved in nonfamilial activities.
- \* the older the woman, the more likely it is that her age contemporaries have completed their childbearing; and
- \* the older the woman at the time of marriage, the less support and urging she will receive from significant others to have more children (1979; 226).

My research has verified only the first of these hypotheses -- most of the women in my sample were indeed very involved in their careers and other non-familial activities. The other two hypotheses were not borne out. The majority of women in my study were hardly unique among their peers. Late childbearing was, in fact, the norm -- or

rapidly becoming the norm -- for their peer groups. While they may have been considered deviant by their families and society at large, their decisions to delay childbearing were acceptable in their own peer group. As far as Rindfuss and Bumpass's third proposition that older women who wanted children would not get much support from significant others, my respondents were -- on the contrary -- often and continually urged by relatives and others to hurry up and have children. While they did not feel the need to heed this advice, it was there nonetheless. Perhaps these hypotheses of Rindfuss and Bumpass would have been somewhat more applicable today to women in their 40's rather than women in their 30's. The relativity of age is indeed a relevant concept as this study has shown.

#### Deviance and Stigma

The changes in the conceptualization and definition of delayed childbearing also have implications for the stigma surrounding delayed childbearing and infertility. As delayed childbearing increasingly becomes the norm, the less stigmatized it becomes. However, my research has reaffirmed what other sociologists, especially Miall and Greil, have found over the past decade -- that stigma is still very much attached to childlessness in our pronatalist society.

In the 70's, Veevers (1971, 1973, 1979) wrote about the

distinction between involuntary and voluntary childlessness and the increased stigma attached to voluntary childlessness. She said that women who are childless by choice do not receive the same sympathy that infertile women do. Miall (1986) also found that some of her respondents preferred being labeled infertile to being labeled voluntarily childless. I would argue, however, that more stigma is attached to involuntary childlessness -- infertility rather than voluntarily childlessness. Many of the women in my study and their spouses preferred "passing" as voluntarily childless rather than risk the stigma of infertility. Goffman (1963) also found this to be the case and talked about how easy it is to conceal infertility since there are no overt signs or symptoms of the disorder.

For many men and women, the admission of being infertile is an admission of failure -- failure of one reproductive system and failure to fulfill a social role. The assertion, on the other hand, that one has chosen to be childfree is often seen as a positive decision by those who make it. Others may consider it deviant and selfish, but those who are childless by choice are unlikely to feel as stigmatized as those who are childless by chance. In addition, in spite of the fact this is a pronatalist society, over-population and the zero-population movement have helped to destigmatize childlessness.

Miall (1986) also addresses the issue of the stigma of

involuntary childlessness -- especially "courtesy stigma" -- that is a stigma someone has that is "based on their association with someone who has a stigmatizing attribute, but not their own personal attributes" (p. 271). I did not find this concept to be particularly relevant to the women in my study whose husbands had fertility problems. These women tended to label themselves as "infertile couples" regardless of who had the primary problem. Greil et al. (1988) also found that the wives of infertile men considered themselves infertile. This may have been because the women, at least in my study, also had fertility problems or were being given fertility drugs to usually compensate for their husbands' infertility. I found that wives tended to relieve their husband's of the stigma of infertility in two ways, either by accepting the "blame" for the fertility problem, or by "passing" as a childless by choice couple. But in either case, the wife felt stigmatized whether or not she helped her husband avoid feeling stigmatized.

Veevers (1971) also claims that because infertility can be cured in many cases, "if medical facilities are available, and they choose to do nothing about their subfecundity, they are in a sense childless by choice" (p. 288). However, my follow-up study and observations have provided me with data that suggest otherwise. The decision of an infertile woman to stop infertility treatment or not to adopt is determined by many factors such as financial

constraints, interpersonal constraints (her spouse may refuse to consider further treatment or adoption), and societal constraints (the difficulty of adoption, especially for older couples). Consequently, remaining childfree becomes necessary but not necessarily desirable. Therefore, many of these women cannot legitimately be considered childless by choice.

My research also looked at the long-term impact of the stigma of infertility. I found that society still stigmatizes the infertile long after they have resolved their infertility. Adoptive mothers, for example, are not considered "real" and those who remain childfree are often certainly considered deviant and consequently stigmatized.

#### The Doctor-Patient Relationship

This dissertation also has important implications for the doctor-patient relationship. As I discussed in earlier chapters, because infertility is not a disease in the usual sense, it is more accurately defined socially rather than medically. A patient is infertile only as long as she or he is trying to become pregnant in order to fulfill a social role -- that of parent.

Infertility, therefore, is a condition which essentially has been limited to a medical framework, but is a condition for which the general conceptions of illness do

not apply. For example infertility that results from delayed childbearing is an ambiguous medical condition. It violates the Parsonian proposition that patienthood involves involuntary victimization. Although these women are involuntarily infertile, they are so as a result of having voluntarily delaying childbearing.

Most models of the doctor-patient relationship, especially the Parsonian model, do not apply to the treatment of infertility. The Parsonian model does, however, have some relevance for the doctor's role in infertility treatment. According to Bloom (1965) in the Parsonian model, "...the physician is expected to apply highly specialized technical skills based on scientific training to problems of illness and health and to the control of disease" (p. 95). This is certainly true of the fertility specialist today.

Parson's depiction of the patient's role, on the other hand, is not particularly useful. The patient, according to Parsons, is obligated to seek medical treatment and cooperate with the doctor in order to become cured. But as we have seen, not all patients are willing to do anything to be "cured" of infertility.

As I demonstrated in Chapter Three, infertility patients do best with the model of doctor-patient relationship Szasz-Hollender referred to as "mutual participation" (1956). "According to this model, the

physician *helps the patient help himself*" (Bloom 1965, 41). Mutual participation is the model mainly for chronic illness and infertility more closely resembles a chronic condition than an acute one.

There are some differences, however. Most chronic conditions tend to be long-term and disabling. But infertility is a chronic condition that is time-limited and not particularly physically disabling. In addition, the patient normally does not suffer from physical pain or other symptoms. The major pain is the emotional pain of the failure to fulfill the role of parent. Therefore, infertility is a unique medical condition.

As I demonstrated throughout this dissertation, infertility patients often have the feeling of being out of control. For them, control becomes an even more salient issue in the doctor-patient relationship. When all control is relinquished to the doctor, the patient can feel and indeed be out-of-control and victimized.

Infertility treatment requires constant negotiation as well as mutual participation. According to Becker and Nachtigall (1991), in the doctor-infertile patient relationship, "Tension is created as responsibility shifts back and forth, between patient and doctor" (p. 876). They found that "When physicians were able to give patients control over the decision-making process, they helped to dispel ambiguity by enabling patients to take responsibility

for themselves" (p. 880). In my study, I found that it was not the *physicians* who gave the patients control, rather, it tended to be the *patients themselves* who took control.

In general, I found that the typical doctor-patient relationship in infertility underwent a set pattern: Dependency, Disappointment, Discord and Disassociation. This pattern went from the least amount of control -- dependency to the most -- disassociation. While this pattern tended to repeat itself with each new doctor, the patient also tended to gain autonomy and control with each subsequent encounter.

The above schema can be applied to other doctor patient-relationships as well. It may be especially applicable to those involving chronic conditions that lead to high expectations or hope for cure, but are, in fact, not easily curable.

Although not the focus of this study, the doctor's point of view is also of relevance. The majority of fertility specialists are initially trained in obstetrics/gynecology, what is traditionally a "happy" specialization. Although increasing numbers of OB-GYN's are going directly into reproductive endocrinology, many had previously spent years delivering good news and healthy babies to happy parents. These doctors now find themselves in a field in which the news is frequently bad, and failure to deliver a pregnancy -- much less a baby -- is

commonplace. Their patients are left literally empty handed. As Hertz (1982) graphically put it, "anger and feelings of impotence are often elicited in the physician when he fails to cure the infertility" (p. 97). Further research is needed into the doctor side of the doctor-patient relationship in infertility treatment. It is important for doctors to understand their own as well as their patient's reactions to infertility, and the consequences that has for both the doctor-patient relationship and the patient's treatment outcome.

#### The Influence of Reproductive Technology

The changes in the conditions of childbearing have had radical effects on both society and the role of women. The trend toward delayed childbearing is one of the results of those changes. The development of effective methods of birth control and safe legal abortion led directly to advances in the status of women. Women were freed from the most extreme costs of childbearing -- the endless pregnancies and the resulting medical problems. By finally being able to control their reproductive lives, women were able to live more economically productive lives. Fertility rates began to drop as women began to postpone marriage and childbearing while they established themselves in their careers or continued their education.

The result has been that several decades later, there have been parallel socio-medical developments: the increase in the numbers of older women with fertility problems, the increase in the numbers of doctors treating infertility patients, and the increase in the numbers of patients seeking infertility treatment.

As a direct result of these increases, there have also been major advances in reproductive technologies as well as an increase in the number of women using them. The development of the newer reproductive technologies have both benefits and risks for individuals and society. While increasing numbers of women with severe reproductive disorders can now conceive, these "high-tech" treatments are expensive and out of reach of many of the women who can benefit from their use. In addition, virtually all infertility treatment -- whether ovulation induction or in vitro fertilization -- carries some risk. In fact, many of the diagnostic techniques used in a basic infertility work-up carry risks of infection or even death. But there are other more common risks -- the social-psychological risks of giving older women false hopes that they, at any age, can have a baby. That should it occur, given enough money, infertility is easily cured. But this is not the case. The advanced reproductive technologies -- which have limited success rates for younger women -- have very poor success rates for women over 40. Even if donated eggs are used,

success --while improved -- is not guaranteed.

The availability of these reproductive technologies, can also lead to their over-utilization, and there are indications this has already happened. Some women are being prematurely or inappropriately being treated by IVF and other such techniques. This is not surprising since, when technology is available, it tends to be used.

In addition, with continual advances in the technology associated with childbearing, societies norms are being challenged. It is not just that older successful women are bearing children. As mentioned above, women past menopause -- some of them grandmothers -- have borne children. And increasing numbers of older single women who have no interest in or prospects for marriage are also having children.

Increasing numbers of women are also using both eggs and sperm from donors, and those donors may be either known or anonymous. The combinations and permutations of family constellations are endless, and the repercussions and implications for both the individuals involved and society are unknown.

More research -- especially longitudinal studies -- are needed to determine the long-term effects and implications of the technological advances and the societal changes they have generated. In addition, because of the potential for abuse, the potentially high risks, and high costs of the

"high-tech" treatments, strict guidelines and restrictions are becoming increasingly necessary.

### Socio-Economic Status and Infertility

This study has demonstrated the difficulty middle- and upper-middle class women have in finding appropriate physicians to treat their infertility, and in negotiating with those physicians in order to obtain optimal care. If well-educated upper socio-economic level women have trouble negotiating the health-care system, what happens to the poorer, less-educated women?

Although infertile women who had delayed childbearing tend to be from upper socio-economic levels, infertility itself strikes women of all socioeconomic levels and races. In fact, the prevalence of childlessness due to infertility has persistently been found to be higher among lower-income women. This is thought to be the result of inadequate prenatal care -- the poor are more likely to suffer from pregnancy loss than the rich -- and the fact that the poor cannot afford medical treatment necessary to correct their fertility problems (Kunz et al. 1973; Poston 1974). Poor black women, especially, have been found to have a higher incidence of infertility than white women (Rothman 1989; Chandra and Mosher 1994). According to Chandra and Mosher,

The apparent association of race with infertility is confounded by socioeconomic differentials in risk

factors for infertility. For example, black women have lower levels of income, education, and access to health care than white women. In addition, the prevalence of sexually transmitted disease and pelvic inflammatory disease has been found to be higher among black women than among white women (p. 290).

On the other hand, infertile minority women are less likely to use infertility services than infertile white women (Ibid.). Very often minority women do not have financial access to normal infertility services, much less the advanced reproductive technologies that may be able to help them. Nor are they sought after as patients by individual practitioners or clinics. Therefore, however significant the advances in reproductive technology may be for some women, they are not relevant to a large segment of the infertile population because of socio-economic constraints.

But "high-tech" treatment is not even the issue. According to Chandra and Mosher, in 1988, 28% of all women who had ever used infertility services were given ovulation inducing drugs, and 15% were treated (surgically) for blocked tubes. Only two percent of women seeking infertility services underwent IVF. Those few women undergoing IVF were overwhelmingly white.

The demand for infertility services has increased dramatically over the past two decades (Ibid.). Between 1982 and 1988 alone there was a 25% increase in the number of women using infertility services. Women who sought treatment for infertility tended to be non-Hispanic white,

over 30, married and college-educated. They also held higher status and income jobs than infertile women who did not use fertility services. Perhaps more interestingly, Chandra and Mosher found that childless infertile women between the ages of 30 and 44 were nearly twice as likely to have received such specialized infertility services as drug treatment, artificial insemination, surgery and in vitro fertilization than were childless infertile women under 30 (38% vs. 20%). And the percentage who received specialized services increased with both income and educational level. They conclude from this data that "there is an unmet need for infertility service primarily among those with low incomes and less education" (p. 294).

#### The Physical and Financial Costs of "High-Tech" Treatment

Although there has been some recent evidence that there might be a correlation between the use of fertility drugs and ovarian cancer (Whittemore et al. 1994; Rossing et al. 1994), these drugs are extremely helpful in the treatment of some forms of infertility. And are widely, and not always appropriately prescribed. Therefore, the long-term medical consequences of the use of these fertility drugs and other forms of infertility treatment warrants further investigation. Women need to know both the long-term as well as short-term negative effects of these drugs so they

can weigh the risks and benefits and make informed decisions.

Many women, however, cannot even afford a basic infertility workup much less the costs of fertility drugs -- which can cost up to \$1500 per month -- or other specialized treatment. If surgery is needed the costs can be astronomical and out of reach of even a middle class patient unless she has insurance coverage that covers infertility treatment, an unlikely situation for most women. Insurance coverage for infertility is mandated in only eight states, and many insurance companies in the other states consider infertility treatment elective and refuse to cover it. (In fact, in vitro fertilization was one of the few treatments singled out in the Clinton Health Care Plan that would not be paid for under managed care.)

If infertility is a medical disorder that can be cured, it follows logically that insurance should cover its costs and -- should treatment fail -- the costs of adoption. But what about the millions of Americans who cannot afford health insurance much less the cost of infertility treatment? Should Medicaid cover the costs of their infertility treatment? If infertility treatments, whether standard or "high-tech", are effective for certain conditions, then all patients with those conditions -- regardless of their socio-economic level -- should have financial access to treatment. To do otherwise is to

discriminate. But does this mean unlimited access?

There is some question as to the effectiveness and not to mention cost-effectiveness of IVF and the other "high-tech" treatments. According to the most recent statistics published by the Society for Assisted Reproductive Technology (SART, 1995), of the 33,543 IVF cycles initiated in 1993, the success rate for women of all ages was only 18.3% deliveries per retrieval.

In addition, most IVF programs encourage their patients to undergo multiple IVF cycles in order to improve their chances of success. While some patients conceive after multiple cycles, many do not. Multiple cycles do, however, increase the chance of a program's financial success. Some programs have been criticized for encouraging women to have repeat IVF cycles even though some women's chances of success may diminish rather than increase with each successive cycle. In addition, some women themselves insist on undergoing multiple cycles even though they are told they have little chance of success. Therefore, it makes sense to set limits on the number of IVF treatment cycles a woman for which a woman may be entitled to insurance coverage.

What about limits on age? Since women can conceivably conceive at any age, should tax payers cover the cost of infertility that results from postponement of childbearing to the late 30's or early 40's? According to the SART study, the success rates per retrieval for women 40 and over

were only 8.6% for those with no male factor and 6.8% for those with male factor. For women under 40 the rates were considerably higher -- 21.6% and 16.5% respectively (Ibid.).

What about women who delay childbearing past menopause? The only way they can conceive is with donor eggs. While the IVF success rates are higher for women over 40 who use donated eggs, this is even a more costly procedure than standard IVF since two patients are involved, and most donors are financially compensated by the recipient for their time and inconvenience. In addition to the risks involved for the donor, there are also many legal/ethical considerations which need to be addressed and further evaluated. Eggs, for example, might have to be rationed. How can this be done equitably? Since there is often a shortage of eggs for donation, should the eggs go to younger infertile women who would have a greater chance of success, or to older infertile women for whom donor eggs is the only option? Should the women who donate the eggs have a say in whether or not a post-menopausal woman who delayed childbearing should raise their genetic child?

Rationing of all health care is inevitable. It therefore might make fiscal sense to restrict taxed-based medical services for infertility to women of childbearing age. However, whether this makes good sociological, ethical or even legal sense is questionable and likely to be debated for decades. Further research is necessary before specific

recommendations can and should be made.

### The Right to Have Children

In order to properly address the above issues, one important question has to be answered: Do all women have the right to bear children? If bearing children is a right than it follows that society guarantee that all women should have access, including financial access, to infertility treatment.

From society's point of view, however, infertility can be considered a non-problem. Population replacement is not an important issue in our society today -- not every woman needs to have a child in order for our society to survive. Children are not necessary for the economic well-being of family life. On the contrary, children are often a burden on a family's finances. Indeed, in our over-populated world with its abundance of unwanted children, some may view infertility as a godsend.

On the other hand, the overwhelming majority of Americans want to have and do have children (Menken, 1985). We, as a nation, value the right of all women to have children. We are justifiably outraged when any woman, whether rich or poor, black or white, healthy or handicapped is sterilized against her will.

Those who are deprived of having children because of

infertility are, in fact, deprived of what most Americans want and feel they have a right to have. This of course does not necessarily mean that the child has to be biologically related to the parents. Families come in many forms, and satisfaction can be derived from various family constellations including a family of two adults living together. However, most of those who seek to have children prefer -- rightly or wrongly -- to have their own biological children.

When women and men delay childbearing, they are taking a chance that they will not be able to fulfill this desire to have biological offspring. But that is their decision to make. Rather than dictate when they should or should not have children, society should work towards emphasizing the importance of the *social role* of parent rather than the *biological role*. This does not mean we should denigrate biological parenthood. It just means that motherhood and fatherhood are first and foremost social roles that -- in order to be fulfilled -- require active on-going social participation. Parenthood, like all achieved roles, should be a choice. It is incumbent upon our society to support that choice. If that choice is denied to a couple because of infertility, society should help that couple achieve what most Americans feel women should have a right to -- the right to have a family.

Summary

This dissertation is a study of a specific group of women whose childbearing decisions may or may not have contributed the development of a medical condition -- infertility. It contributes to our understanding of the decision-making processes involved in family planning. It demonstrates what the sociological impact is of the failure to fulfill a social role -- the role of motherhood.

Further, this study adds to our understanding of how the doctor-patient relationship functions and malfunctions in a chronic condition. It also increases our understanding of both short-term and long-term effects of a highly stigmatized condition.

In addition, because this is a longitudinal study, it provides us with insight into the long-term effects of a chronic, but time-limited condition on the women who experienced it and on their families. It also allows us the opportunity to follow the development of an important social trend -- delayed childbearing -- over the course of more than a decade.

Finally, this study contributes to our sociological understanding of a unique medical condition which primarily is socially defined, as well as the impact that this condition has on the lives of the women who have experienced it.

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