The Elusive Pregnancy:
Choice & Empowerment In Medically Assisted Conception

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Procreation is increasingly becoming a choice in OECD countries. Although a growing percentage of the population seems to be rejecting parenthood, others choose to procreate -but cannot. Considerable research indicates that inability to conceive alters identity, strains relationships, and diminishes self-esteem. This paper examines the meanings attributed to infertility and the perception of choices among couples undergoing medically assisted conception in New Zealand. Their discourses are influenced by gender, class and culture, but tend to conflate parenthood with normality, social inclusion and being a loving partner. Assisted conception can turn subfertile couples into 'normal' parents and can offer hope to others. However, instead of being empowering, it can also encourage some clients to prolong stressful treatments, to continue to live with uncertainty, and to postpone other life choices.

Becoming a parent is increasingly a choice that can be postponed or avoided in industrialized countries. More heterosexual couples are using contraception or becoming sterilized, and women are bearing their first child at later ages and having fewer children (OECD, 2001, p. 24). Especially middle-class women now expect to complete their education, travel or establish a career before becoming a mother. Delayed pregnancy leads to fewer children per family but also contributes to conception problems for couples choosing to reproduce later in life. Conception problems are also augmented by environmental pollutants, hormonal imbalances and sexually-transmitted diseases, as well as lifestyle factors such as prolonged stress, excessive use of drugs and alcohol, and prolonged use of certain contraceptives (Bryant, 1990; Coney & Else, 1999). However, the medical profession is unable to diagnose the cause of many infertility problems.

1 I thank my former research assistant Gerda Roelvink, who helped me survey some of this literature. Send requests for prints to Maureen Baker, University of Auckland, Auckland, New Zealand (e-mail: ma.baker@auckland.ac.nz).
Married or cohabiting couples often view the creation of a child as a joint project that will ‘complete’ their relationship. They say that having children will offer them opportunities to pass on their knowledge and values, to expand their social networks, to relive the discoveries of childhood, to receive unconditional love, and to pass on their name, genes or family line (Veevers, 1980; Callan, 1982; Ramu & Tavuchis, 1986; Cameron, 1990). Some also articulate the belief that children will care for them in their old age. Consequently, the inability to conceive can disrupt the normal life expectations of both men and women (Daniluk, 2001, Exley & Letherby, 2001) and is often viewed as a major life crisis (Bergart, 2000).

In recent years, fertility clinics have been established in most developed countries, offering a variety of services, including fertility diagnosis, assisted insemination with sperm from the husband or a donor, egg donation, in vitro fertilization, and counselling. These services are sometimes available to patients through the public health care system, but not everyone choosing to use these services is accepted for treatment or financed by the public purse. Married or cohabiting couples in stable relationships are usually given treatment priority but the woman is usually expected to be younger than 35 to 38 years old. Heavy smokers and very obese women are sometimes excluded, as are lesbians or single women. In some jurisdictions, including New Zealand, fertility clinics operate in both private and public hospitals. Private clinics tend to be less stringent about who they accept for treatment as long as the patient can pay, and sometimes permit older women to continue treatment even when the probability of pregnancy is low.

Childbirth increasingly involves standard medical interventions such as amniocentesis, episiotomies and caesarean sections (Eichler, 1997). New reproductive technologies have been promoted by medical researchers and the medical profession, and legitimized by the media through discourse about scientific progress, medical expertise, humanistic cures for disease and the politics of choice (Van-Dyck, 1995; Bharadwaj, 2000). Social researchers have been ambivalent about the impact of these technologies on women, families and society in general. Eichler (1996) argues that they are fundamentally transforming families, separating social and biological parenthood, and changing generational lines. Others focus on the opportunities they offer to lesbian women, who want to become mothers but do not choose to engage in heterosexual intercourse (Michaels, 1996). Most researchers also acknowledge that more women and couples who choose to reproduce can now become parents, whereas in the past they would have not had that option.

At the same time, success rates remain low, but are rising and
increase with the duration of treatment. Nevertheless, only 50 to 60 percent of couples are able to conceive even after four cycles of treatment (Pearn, 1997; Bergart, 2000). However, most couples do not continue that long because treatments are stressful and costly, and public health care systems often pay for only one cycle for eligible couples under specific conditions (Gillett & Peek, 1997). Doyal (1995: 149) concluded that only about one third of clients end up with a healthy baby but notes that we know little about the rest.

This paper is based on qualitative interviews with a non-random sample of men and women undergoing fertility treatment in New Zealand’s largest city —Auckland. It focuses on the yearning for parenthood among these participants, and how parenthood represents a deep desire to be ‘normal’ and to fit in with friends and relatives in a pronatalist society that equates marital childbearing with maturity and social inclusion (Cameron 1990). The ‘stories’ of these participants are used to discuss the expectation of reproductive choice and the subsequent feelings of powerlessness with infertility. The paper argues that although some people’s experiences with assisted reproduction can be empowering, especially those who produce a healthy child, for others it can be restrictive. For some participants in this study, the strong desire to conceive and the determination to continue with fertility treatment became a preoccupation that closed off other choices and caused women (and sometimes their partners) to put their lives ‘on hold’.

THEORETICAL BACKGROUND

Debates about assisted reproductive technology have continued for several decades, especially since the first ‘test-tube baby’ was born in the United Kingdom in 1978 (Coney & Else, 1999). Now, a wide variety of procedures have become routine, such as sperm screening, donor insemination, egg retrieval and re-implantation, and in vitro fertilization. Feminist voices, while often contradictory and fragmented, have added complexity to these debates by heralding warnings about the ways that these technologies can be used to medicalize childbirth, permit sex-selection and use low-income women as ‘rented wombs’ (Eichler, 1996; Baird, 1997; Coney & Else 1999). At the same time, they have noted that reproductive technologies present new possibilities for both heterosexual and lesbian women to realise their dreams of motherhood, although many actually find that they are excluded from state-funded treatment. A growing body of feminist literature highlights the interwoven discourses of fertility, womanhood, motherhood and femininity
confronting childless women, and how these discourses affect their identity and choices (Letherby, 1999; Ulrich & Weatherall, 2000; Wager, 2000).

Ulrich and Weatherall identify several discourses contributing to the desire for motherhood, including ‘motherhood as natural instinct’, ‘as a social expectation’ and as positive ‘decision making’. Similarly, both Franklin and Letherby note that motherhood is discursively constituted as the primary role for women, a natural instinct or drive, and a life goal. Consequently, involuntary childless women are seen to deploy a discourse of social loss, their expression of loss centred on the institutions of marriage and the family, thus revealing the foundations of accepted procreation. Furthermore, children are often viewed as proof of adulthood, and without them women are considered to be childlike (Letherby, 1999). However, for women ‘on the margins of femininity’ (such as lesbians, women of colour, those with disabilities or low socio-economic status), exclusionary discourses are deployed, rendering motherhood less appropriate.

Drawing on Goffman’s theory of stigma, studies conducted within the United Kingdom and Israel suggest that in departing from the ‘ordinary’, an infertile woman’s whole person is tainted, infertility becoming her overriding status and defining her identity. However, analysing interviews with involuntary and voluntary childless women in India, Riessman critiques this use of Goffman’s theory because it fails to account for resistance and privileges gender over class and race in shaping the experience of infertility. Studies from Egypt and Israeli research confirm the role of class and race in determining both women’s and men’s access to coping strategies and alternative discourses to parenthood (such as the choice of a career over children).

A discourse of illness and disease is often used in medical and popular representations of infertility and by scholars (such as , contributing to the social construction of childless women as ‘abnormal’. Van-Dyck’s analysis of the shift of assisted reproduction from an experimental and contentious practice into mainstream medicine suggests that the representation of infertility as a disease requiring a cure was vital to the legitimization and expansion of reproductive technologies, rendering the low success rates irrelevant. Despite admitting that infertility is not necessarily a medical problem, Kirkman and Rosenthal frame their analysis of women’s stories of infertility through a narrative of illness, using terms such as ‘chronic’ and ‘aetiology’. One consequence of the dominant medical discourse of infertility highlighted by Ulrich and Weatherall is the claim that restricted access to medical assistance is unethical and discriminatory.
Generally, researchers agree that women and men experiencing fertility problems are mentally healthy. However, infertility is shown to present an unexpected interruption in many couples’ lives or even a major life crisis. Several studies highlight the stress brought with the knowledge of one’s own or a partner’s infertility, which they argue is aggravated by the nature of the various medical treatments involved.

Researchers disagree about gender differences in the psychological impact of infertility. Doyal (1995: 146) suggests that women are more affected than men are because social ideas conflate femininity and motherhood, and because the major medical focus is on women’s treatment. Adair and Rogan (1998) argue that infertile men in New Zealand experience a loss of status. Hurst et al., (1999) discuss the threat to masculinity among ‘subfertile’ men, who develop coping strategies such as avoiding discussion of the topic, also discusses men’s unwillingness to talk about their fertility problems or treatment, either to significant others or researchers. On the other hand, women are found to take greater responsibility for infertility (despite the problem’s source), talk about it more, and experience a high degree of emotional pain and life disruption. These gender differences strongly correspond with dominant constructions of femininity and masculinity, perhaps reflecting the primary focus of much of the psychological research on heterosexual cohabiting relationships or the researchers’ frameworks of understanding.

For some women, involuntary childlessness can be constructed as an affirmative and empowering experience. Riessman’s (2000) research in India highlights the transformation of childlessness into a positive attribute through narratives expressing political concern about India’s future and growing population. British research suggests that involuntary childlessness can be constructed as an opportunity to achieve alternative dreams. The recognition of agency is important, with Zucker’s research suggesting that the expression of agency is intricately linked to well-being. The Finnish study by Malin et al., (2001) suggests that becoming an assertive consumer in the reproductive technologies market can be empowering for involuntary childless women attempting to resist the objectification and alienation of the body ‘under the medical gaze’. While highlighting the discourses of choice in reproductive decision making, Ulrich and Weatherall (2000) demonstrate that ‘choice’ is far from unproblematic because a woman’s decision not to have children is interpreted negatively. The discourse of choice is founded on the belief that women have the option to bear children, which disempowers women who are involuntarily childless.
RESEARCH METHODOLOGY

Participants for this study were found with the assistance of two hospital-based fertility clinics—one in a newer private hospital and the other in an older public hospital—as well as an infertility association in Auckland. The Human Subjects Ethics Committee at the Auckland university insisted that I find participants for the study by asking clinic staff to give new patients an information sheet about the study. If they were interested in participating, they contacted me. The local infertility association also provided information about the study in their newsletter. After one year of advertising in this way, twelve men and twelve women volunteered to participate in the study.

Most of the 24 participants are ‘middle class’, with annual household incomes of $60,000 or more, although two report household incomes between $40,000 and $60,000, and two under $40,000. Most were legally married (17/24) and the rest were cohabiting (except one woman living alone). The women are between the ages of 29 and 46 years, and the men range in age from 34 to 68 years. Most came from Pakeha backgrounds (the Maori word to describe ‘white’ New Zealanders of British/European origin), but several were recent British or Irish immigrants and several reported Maori ancestry.

With the assistance of a female graduate student, both the man and woman in eleven couples were interviewed separately. Two individuals were also interviewed—one was a gay woman without a live-in partner and the other was a man whose (Pasifika) wife could not speak English well enough to participate in the project. Therefore, information was obtained about twelve couples and one individual. Because we interviewed each person twice, the study represents at least 50 hours of qualitative interviews completed by two different interviewers. The interviews were carried out in the participants’ homes and audio-taped. These participants or their spouses have recently undergone fertility treatment in one or more clinics, with various interventions such as hormone stimulation, artificial insemination with husband’s sperm, egg or sperm donation, and in vitro fertilization (IVF).

The study was designed to talk to participants on two occasions: the first interview was expected to be towards the beginning of their treatment and the second was supposed to be about six months later, to see how their treatments altered their daily lives, their self-concepts, and their relationships. However, some people who contacted us had actually been receiving treatments for years but only recently approached these particular clinics. Others already had a child or children from previous relationships and were now trying for a baby with their new partner. Two
couples had already given birth to a child with medical assistance and were trying to have a second child. In order to ensure an adequate sample, I accepted all those who contacted me over a one-year period—a total of 24 people.

This small non-random sample does not permit generalizations but provides rich material illustrating dimensions of some experiences with low fertility and medically assisted conception in New Zealand. Parts of the ‘stories’ from these participants can be used to expand on several themes recurring in the international research, such as the concerns about normality and feelings of social exclusion among involuntarily childless people. However, these interviews also offer some insights into the role of reproductive technologies in prolonging the yearning to parent, and thereby delaying or inhibiting women from getting on with other aspects of their lives.

In this study, clinic staff offered their clients various treatment options, discussed the probabilities of pregnancy with them, highlighted the element of luck involved, and partly relied on client choices and decisions about how to proceed. After lengthy treatment, some would-be mothers did not want to stop even when the treatments proved ineffective because next month they might ‘get lucky’. Some couples refused treatment (or additional treatment) because they could not pay or because doctors could not diagnose the cause of their infertility and because state funding covered only those with a medically diagnosed reason. Others put their lives ‘on hold’ for months or years while waiting for the elusive pregnancy.

Several notable differences are apparent between New Zealand and Canada, which provide a context for my research and may influence the findings. First, the fertility rate is higher in New Zealand—over 1.9 children per woman compared to about 1.5 in Canada (Statistics New Zealand, 2002; Statistics Canada 2002, p. 29). Also, fertility is higher among Maori and Pacifika peoples, who together form about 20% of the New Zealand population. Within Maori culture, the ability to trace one’s lineage or tribal origins (whakapapa) is considered to be very important to the identity of both men and women. Furthermore, rates of voluntary childlessness seem to be lower in New Zealand than in Canada (Cameron, 1997; Baker, 2001).

In New Zealand, there is also a stronger emphasis in public discourse about being a ‘good place to raise children’ (Bell, 1996) as well as the importance of mothering at home. Full-time labour force participation rates for mothers have been much lower than in Canada. In the mid-1990s, for example, 32% of Canadian lone mothers were employed full-time compared to 17% of NZ lone mothers. In the same
year, 41% of partnered mothers were employed full-time compared to 31% of comparable NZ mothers (Baker, 2001, p. 24). With larger families, more mothering at home, and public discourse about the country being a good place to raise children, I would label New Zealand a stronger 'pronatalist' society than Canada. I am assuming that individuals are influenced by these broad societal factors when they attribute meanings to fertility and when they discuss their life choices.

**‘NORMALITY’ AND MARITAL CONCEPTION**

Considerable research suggests that most heterosexual people assume that they will eventually become parents when they find a suitable partner and ‘settle down’ (Cameron, 1990; May, 1995). Even among those who delay the reproduction decision, most men and women give serious thought to children as they approach their mid-thirties or forties. However, between 14% and 20% of women of reproductive age never reproduce for a variety of reasons related to circumstances or choices (Cameron 1997, p. 33; Dumas & Bélanger 1997, p. 41).

Gillespie (1999) argues that British women who choose not to procreate are expected to account for their choices in ways that mothers do not. This accounting is expected from virtual strangers as well as friends and family. In other countries as well, procreation is often seen as an indicator of adulthood, so childless people (especially women) are often viewed as immature or abnormal (Morell 1994, Kirkman & Rosenthal 1999, Letherby 1999). Involuntarily childless people often experience feelings of uncertainty and loss (Zucker 1999) and particularly yearn for a baby when their siblings and friends reproduce, when they have achieved their career goals or financial stability, or at times of family reunion or celebration (such as Christmas).

One of the early questions in my study was why it was so important for respondents to become a mother or father. Both the women and the men seemed to assume that they would have children and saw it as an inevitable part of adult life. A 36-year-old factory worker commented that she always expected that she would have children:

*Oh yes, always. I had a really good friend that lived across the road from me and she had children very young — she is actually the same age as me. I was always living at her place and dreaming that her kids could be my kids— that’s all I wanted to do was get married and have children.*
Several women in our study talked about their strong “maternal instincts” and their dreams of becoming a mother. One Maori woman, who is now pregnant as a result of IVF, said: “Being pregnant has been like a fantasy of mine for a long time and it is going to be an amazing process to go through.” Later she commented:

I have worked my entire life and have only ever had short holidays and I would just really like to be a mother, be at home, and look after the house and children. I don’t want to have to go out and work again. I just want to be a mother.

A 34-year old husband talked about how his wife’s inability to conceive affected her identity (but said little about how it affected his own):

My [wife] has got really upset and she feels a great sense of unworth (sic) on whether she is not a woman or a proper woman and not providing for me, as she should—that is the way she has felt. It actually hasn’t hurt our relationship— I reassure her every month and every day.

When asked why it was important for him to become a father, a 38-year-old professional man said: “It’s like, why do we want to breathe? Because you do…” Later he jokingly commented: “You’ve got to have somebody to push you around in a wheelchair when you get older’. This man said that he and his wife first sought help at a fertility clinic after trying for eight months to conceive, that is, before the official definition of infertility (one year of unprotected sexual intercourse) (Coney & Else 1999). At the time of the first interview, they had been trying for nearly three years. He said:

So we went to the professionals and off we went down this process of tests, and this and that. We have basically done everything and have no answers. We’re normal. Well, we’re not normal because we can’t get pregnant.

A 34-year-old married male, now in a corporate managerial position, said:

I never envisaged that I would be [without children]. It doesn’t fit the model, you know, the socialization you go through. I mean, I come from a family of four… and so family to me has always been in the back of my mind … I never for one moment thought I would be without children…
imagine[d] being married at 30, director of a company by the time I was 33 and financially I wanted to be in the position, by the time I was 35, to have children... so I had it kind of formally mapped out in my mind.

The ability to reproduce is closely related to gender identity for both women and men but male ‘infertility’ is often the butt of jokes because it is more linked to sexual ‘performance’ (Meerabeau 1991). Male infertility is also associated with a decline in status and threat to masculinity (Adair & Rogan 1998, Hurst et al.,1999). One British man in my study hesitantly talked about his initial reluctance to approach the fertility clinic for an assessment: “I was afraid I might be sterile and that was... that was a bit of a... struggle, actually. [Now] knowing that I’m not firing blanks is... is very comfortable”.

The oldest male participant in the study (68 years) told us that his young wife had undergone assisted insemination with his sperm and had become pregnant. When asked how he felt about that, he said: “Well, it gave me a good feeling... I thought that I still had it in me and the doctor said something about a testosterone level. Anyway, for a person of 68, it was quite a pick me up.”

Many participants in this study felt that if they could not reproduce with their current partner, they would be ‘letting them down’ and would be an ‘inadequate’ spouse. The romantic ideal portrayed was that when a couple falls in love, the ‘natural’ outcome and expression of this love is the creation of a baby together (Baker & Bertenshaw 2002). The ‘normal family’ for the people in this study is one with children who are biologically connected to both partners even though statistically this kind of family is diminishing relative to others and is now in the minority in both Canada and New Zealand (Baker, 2001, p. 29).

**CHILDLESSNESS & SOCIAL EXCLUSION**

Medically assisted reproduction has the potential to create socially accepted parents out of involuntarily childless couples, who often feel excluded from ‘normal’ adult life. Inability to reproduce can interfere with friendships and family relationships and can make childless people feel like social outcasts. In my study, one 38-year-old woman in a cohabiting relationship said:

> We’ve had nine friends in the last two months who told us that they’re pregnant and only four of those I think it was planned as such. So we’ve very quietly and privately
struggled with that… Deep down, we’re saying ‘What about us? What about us?’

A 38-year-old man discussed similar feelings of exclusion:

You definitely miss out on something [if you don’t have children] because a lot of my friends have got kids and… you gradually get further and further away… When we’ve gone out with couples who have got kids and we haven’t and the couples with kids talk kids. It’s all kid talk and we, you know, we can’t contribute…

One woman mentioned that she discussed their fertility treatments with her sister, mother and several female friends but her partner was unable to talk to his male friends and relatives, and consequently had little social support to help deal with his experiences:

He was afraid that he would be mocked, ridiculed, made to feel he wasn’t a ‘real man’… a guy’s reaction to another guy would be that he hadn’t got the goods… [but] he communicates very well with women so he’s quite happy for my sister to be his confidante…

Men’s reluctance to confide in other men about their experiences with infertility or with the treatment has been noted in other research (Lloyd, 1996) and was also apparent in my study. Women usually talked to their female friends and relatives about both, but several mentioned that their friends and relatives did not always understand the extent of their frustration about being unable to conceive or their grief over miscarriages or still births. So some participants felt excluded because they were childless and their friends and siblings were reproducing and continually talking about their children. They also felt excluded because others did not understand the difficult nature of fertility treatments, including the side effects of drugs, the emotional ups and downs, and frequent miscarriages.

THE JOYS AND COSTS OF MEDICALLY ASSISTED REPRODUCTION

Fertility treatments are disruptive and time-consuming, involving regular visits to the clinic and the requirement to have sexual intercourse on a tight schedule. The price of individual treatments varies but in New
Zealand IVF costs around $8,000 per treatment, or about $7,000 Canadian. More than one treatment raises the probability of pregnancy but women are limited to one treatment per month. In New Zealand, the government health program pays for one cycle of treatment for women who qualify because of their marital status, age, weight and medical condition. Their infertility must be diagnosed as having a medical rather than social basis, which excludes the high percentage with undiagnosed infertility (HFEA, 1997) as well as lesbians who choose to avoid heterosexual intercourse or who want the donor’s sperm to be screened.

Most clinics depend on referrals from family physicians and provide a variety of services, including artificial insemination with sperm from a donor. However, women requiring egg donation are sometimes asked to find their own donor and to pay for any advertising costs involved. In my study, some participants paid only the incidental costs of drugs because their treatment was covered by the public health plan but most went on to have additional treatments at their own expense. Most paid about $10,000 but several paid much more. Multiple treatments cost one couple about $34,000 and several had taken out bank loans or used up their inheritance to pay for treatments.

Over half of the couples became pregnant during the study year, which is higher than the ‘success rates’ reported in earlier studies from Canada, USA and the UK (Bryant, 1990; Doyal, 1995; HFEA, 1997). However, most women in my study had received multiple treatments and some had been trying to conceive for years. Also, pregnancy does not always mean a live birth, as there is an above-average miscarriage rate among people undergoing fertility treatments (Adair & Rogan, 1998). Not all participants in my study seemed to be aware of this, but several had experienced miscarriages and one had given birth to a stillborn child.

Some women we interviewed were very excited about pregnancy, and this excitement grew as they approached the due date. One woman, who was seven months pregnant from her third IVF treatment, was still working at a house-cleaning job but was exceptionally enthusiastic about the pregnancy experience:

*It’s been an awesome pregnancy. I’ve really enjoyed it… I think the baby kicking - that’s the most amazing feeling… To think that there’s a baby in there, it’s just mind blowing… that’s why I think it’s so awesome for women when babies are first born because it is just such a miracle…*

Later in the interview, she was asked to imagine how it might have been if she had not become pregnant. She said:
I would have been really disappointed if it hadn't worked, especially for the second time round, but I don't think I would have tried IVF for five years unsuccessfully. Realistically, I wouldn't have been able to try again for quite a few years because I would have had to pay off an $8,000 loan that it cost for the 2nd treatment. …I think I would like to try again in another year's time [to have a second child]. Financially, we couldn't afford it but I would still like to use the [frozen] embryo and hope that it works. It costs $350 a year to keep it frozen and we will pay for the first year and when it comes around to the next payment, I think we will then reconsider because of the cost…

Not all male partners shared the women's excitement about pregnancy. The above woman's working-class partner, who produced children in two previous relationships, was asked in the second interview how the pregnancy was going:

I'm just answering for me and it's been fine, no drama at all…This is her experience, I feel, more than mine…It's been far more relaxed than I initially envisaged… (Interviewer: What was the worry you were feeling?) I don't have a great track record. As soon as babies tend to come, the relationship tends to fall apart… Hopefully, it will be 3rd time lucky.

He seemed unaware that there was another embryo left over from the IVF, and when explicitly asked about it and if he wanted to have another child later, said: 'I don't know if there is still a frozen embryo - [my partner] hasn't said. I sort of said that one is enough. My thinking was $8000 was enough and let's get out of here'.

These few examples illustrate my finding that women were more likely than their male partners in this study to downplay the financial cost of fertility treatments, although they did talk at length about drug side effects, the emotional stress, and the physical pain and problems caused by the treatments. Men were more vocal about the stressful nature of dealing with their partner's mood changes throughout the treatments, the difficulty of having sex 'on command', and the high financial cost of the treatments. All these issues clearly caused tensions within their relationships.
THE COMPELLING NATURE OF MEDICALLY-ASSISTED CONCEPTION

Most of the couples in my study gave themselves a limited time to undergo fertility treatments. If that didn’t work, they said that they would ‘get on with their lives’ and stop their self-confessed preoccupation with conception and pregnancy. The 38-year-old professional male, mentioned above, whose wife’s treatments were not successful, said:

I’m not adverse to trying IVF again but I think it would just cripple you financially and devastate your relationship. It’s more invasive than AIH [assisted insemination with husband’s sperm] and I found that quite invasive… We don’t want to, ad infinitum, carry on with that and end up an emotionally drained couple. We have to get on with our lives.

A 38-year-old woman with professional qualifications already has twins from IVF (one with developmental difficulties). In the second interview, she told us that she and her husband had given up trying for a third child:

To be honest, it was a kind of relief to stop thinking about it… I spent the entire weekend sorting baby clothes, baby equipment—delivering to people, delivering it to ‘op’ shops, waiting for the Salvation Army to come and pick up stuff. That was good and we decided it was time to move on… I’m very happy for life to be moving on now.

The yearning for parenthood, however, seemed to be very strong in other individuals, especially women with few career prospects, working class backgrounds, or cultural preferences for large families. Some kept trying to have a child long after their doctor, partner, family or friends thought that they should. For example, one Maori woman in the study is already a 46-year-old mother with four children from a previous marriage (all through caesarean births) but wanted to have a baby with her current partner. Although she has had seven miscarriages in four years, she and her husband continue to try to conceive. This woman is an extreme example of someone who won’t give up. She described the process of trying to have a baby as:

Very frustrating and very disappointing. Even if you do get pregnant, the chances of miscarrying are really high. You keep thinking that you just get on with your busy life, you
have your study and you have your existing children, grandchildren and lots of things happening in your life. I'm not prepared to let that go yet because I still feel quite young and I still have some options that I can explore before I chuck it in… I think at the age of 50 that would be a determining point for me… I know of a woman who is 50 something and she has just conceived through an egg donor, in New Zealand, in fact she has conceived to the lady who has offered me an egg as well. That's amazing because it's her 3\textsuperscript{rd} time round with egg donors. I was just blown away.

When discussing the decision about whether to accept the offer of the egg donor, she explained that she would be doing this more for her partner than for herself because she already had children of her own but he did not. Later, she explained:

For me, going on this journey of trying desperately to have a baby has got a lot to do with my relationship with [my partner]… A lot of people when they meet their soul mate, the most important gift they can give that person is to reproduce a life and this is one of the reasons why we have children -we want to reflect something of ourselves into that child… I feel it would be the best gift I could give him and I feel he deserves it. He has not only raised my four children but he has raised seven children from his previous relationship. He is the most caring, loving person that I want him to experience that joy. To me, that is my primary goal in wanting to get pregnant. Secondly, I am very maternal and love babies… I know there are huge risks at my age getting pregnant, with my history… High chance of miscarriage, etc. Those are the two reasons for me.

Despite the fact that her mother and female friends tried to persuade her to stop trying, she was determined to continue.

Another woman we interviewed seemed addicted to trying for the elusive pregnancy. This working class woman, married for fourteen years, had experienced a stillbirth after her first in vitro fertilisation six years ago, and kept a photograph on her living room mantle of herself holding her dead baby. She insisted on being called a mother and was offended when other people did not see her this way. She told me that all her friends were mothers and that she felt left out when they talked about their children. In discussing her feelings of social isolation, she projected
onto other mothers, who she felt did not deserve their children, saying:

> And then, there are the solo mothers… they have babies one after another and they just don’t care. I remember… after I lost [my still-born baby] I used to go up the road [to the shops] and sit and look at these mothers and think how it was unfair. She would have about four of them hanging off her and I don’t know if she was married or not, that was just me looking at them and picturing what it would be like for me… I said to [my husband], if we don’t have children I don’t want to work for the rest of my life either. Most women who have children give up work for, what, two years or something. All my friends don’t work because they have children and they say, meet for coffee, and I can’t, so I feel I sometimes miss out that way.

Later she said that she was finished with IVF and had ‘moved on’. But toward the end of the interview she said: “It is the loneliness that I am really scared of. If I am by myself, am I ever going to have people come and visit me and even ask me for dinner? If I get sick who will look after me?”

This woman said that she was intending to quit her full-time factory job to establish a home-based job, working part-time at massage and aromatherapy (and earning less money) so that she could spend more time with her female friends and their children during the daytime. She also told the interviewer that in her working class job and suburban community, she had not met any other married women who did not have children. Consequently, without children, she did not feel as though she belonged with her women friends, who were all mothers. Instead of seeking out other childless or childfree women, she was trying hard to fit in with a group of mothers.

Another couple already had a 13-month-old IVF child at the time of the first interview and are trying for a second, even though the wife is 44 years old and was told by clinic staff that the probability of success was less than 5%. In the first interview, the 46-year-old husband talked about the treatment being stressful and negatively affecting their relationship:

> I did my best to try and support [my wife] but perhaps there were times when I felt like yelling: ‘Enough is enough. I’m sick to death of hearing about another injection. I’m sick to death of it not happening. I’ve had a gutsful!’
He went on to say that he felt that he had to be supportive to his wife because a second child was so important to her. In the second interview, his wife was still not pregnant, after fertility treatments lasting over a year. He spoke of the “sense of sadness” at having only one child but rejected egg donation:

\[\text{Egg donors I wouldn’t take -I think not, because it is akin to adultery to me. Like adoption - you wouldn’t know what you are going to get and I guess it would be a part of me but never a part of [my wife]… there’s always the risk- with someone else’s egg it is a bit of a lottery… if push comes to shove, I would consider adopting but that would mean looking overseas and it is really expensive.}\]

His wife reiterated these views but said:

\[\text{Basically because of my age there is practically no hope. If I am able to have another baby it is just going to be sheer luck… it is the luck factor rather than anything else. (Interviewer: How long can you see continuing?) I don’t know. Not much longer. They basically said that if I couldn’t have a live pregnancy by now, it is not going to happen. I guess you just hang on to that last bit of hope because they didn’t think we would have [my daughter] either. I can’t really go on forever… it is costing too much as well… }\]

Especially the women who do not currently have satisfying careers see few alternatives to motherhood. In their social circles, they feel excluded if they cannot contribute to female conversations about their children or participate in child-related activities. Yet careers or paid jobs were not enough to compensate for childlessness, even for some men. Although most of the participants in this study already have some contact with children —stepchildren, the offspring of their siblings, or neighbours’ children—they still yearn for their own.

**DISCUSSION**

The literature on infertility concludes that women and men who remain voluntarily childfree are sometimes perceived as immature, selfish or ‘morally flawed’ (Morell, 1994; Cameron, 1997). Parenthood remains closely aligned with the discourse of ‘normality’ and social pressure to reproduce remains strong within heterosexual marriage (Cameron, 1997;
For those who yearn to become parents, opportunities to adopt infants have diminished in many OECD countries. Adoption is also rejected by some childless couples because of the lack of genetic ties (Ragone, 1999), the potential behavioural problems with older children, and the high cost of international adoptions. Some women try self fertilization but others want donated sperm to be screened for disease. Consequently, the ‘market’ is expanding for medically assisted conception.

Becker examined the cultural, social and economic forces that form the industry of reproduction, suggesting that mainstreaming reproductive technologies is “consumer culture at work” (p. 10), where consumption is seen as a means to exert power in a seemingly limited situation. Subsequently, the social order, infused with cultural meaning, is experienced as a moral order, while the objects of consumption come to constitute identity. For example, reproductive technologies connect individuals with the possibility of parenthood and ‘normal’ family life. Well aware of this process, consumers experience tension between the ideological value of biological children and the cost to acquire them (Becker, 2000).

In my study, some male partners told us they reluctantly participated in fertility treatment to please their female partners and also said that they wanted to terminate the treatment before their partners did. They said they worried about the high financial cost, the consequences for their sex life and their partner’s wellbeing, and the preoccupation with conception that was overriding other aspects of their lives. The fertility treatments involve women taking mood-altering drugs that sometimes make them queasy, anxious and difficult to live with. Treatments also interfere with women’s normal functioning, including paid work.

Less than half of the women in my study were in satisfying jobs or careers. Some of these were marginally employed or outside the labour force at the time of treatment, and had their life plans ‘on hold’ until they became pregnant. Others were in the process of changing jobs from something they did to earn a living to developing a ‘career’, but this usually involved lower remuneration and self-employment from home. Several women said that if they were successful at procreating with medical assistance, they would feel compelled to stay home and devote their full attention to this much-cherished child that they chose to bring into the world. In doing so, they help perpetuate the cultural discourse that conflates femininity and motherhood and suggests that the ‘normal’ family is a gendered one with two heterosexual parents, a father earning money and a mother at home caring for the children.
Social and cultural pressures, changing adoption possibilities, and new public discourses about reproductive technologies help to explain why some of the couples and individual women in my study agree to pay large sums of money and undergo invasive medical treatment to acquire ‘their own’ baby. In many cases, of course, they were using someone else’s sperm and occasionally someone else’s egg, but this was considered more desirable than overseas adoption or life without children.

In industrialised societies, two opposing trends are occurring at the same time: more young people in the general population are choosing childfree lifestyles and more couples are refusing to leave fertility to chance and are seeking medical assistance with conception. The prevalence of medically assisted fertility gives the clear message that reproduction is now possible for a larger percentage of the population, which may increase the social expectation to reproduce or at least to seek medical assistance and try to have a child. Now that fewer people legally marry, procreation remains one of the few distinguishing badges of maturity and stability.

Success rates, whether measured by pregnancy or live births, decline with women’s age and vary with patients’ medical history. Clearly, medical technology cannot cure all conception problems. The research on assisted fertility indicates that despite advances in medical technology, most patients treated in fertility clinics do not reproduce (Baird, 1997), although success rates are increasing with most interventions. Some clients in my study chose to continue their treatments even when they were told by clinic staff that the probability of pregnancy was very low, and used gambling metaphors about being lucky and ‘beating the odds’ to justify their decision to continue.

The research on medically assisted conception (including my NZ study) suggests that subfertile men and women choose to use fertility clinics to avoid the abnormality and social exclusion that they believe is associated with childlessness. Some clients are able to move on if their treatment is unsuccessful but others believe that there is an element of luck involved in conception, which can be reinforced by clinic staff and infertility pamphlets. In my study, several patients justified their persistence with treatment by using the gambling metaphor: ‘you can’t win unless you play’. Believing that they might get lucky next month, they delayed other activities such as holidays and new jobs, and even chose to go into debt in their attempts to conceive. Although their partners wanted to stop treatment and clinic staff told them that the probability of pregnancy was low, some women chose to persist, sometimes for years.
The social pressure to reproduce varies by culture and social class, as well as by the individual’s personal circumstances. This small New Zealand study illustrates that choosing to seek medical assistance with conception can be empowering, but reproductive technologies can also prolong uncertainty and inhibit women from getting on with other aspects of their lives. In my study, this was particularly apparent for low-income women with few career ambitions from those cultures that emphasize lineage and conflate status, as well as femininity and masculinity, with parenthood. Further research needs to investigate the impact of the social and cultural contexts on the use of fertility treatments and the perception of life choices.
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