

**'NO-ONE WILL EVER CALL ME MUMMY':
MAKING SENSE OF THE END OF IVF TREATMENT**

Karen Throsby

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Introduction

It is a sobering reality that over 80% of all cycles of *in vitro* fertilisation (IVF) that are started are not successful¹, and even those cycles that are successful in producing a baby will probably have been preceded by failed cycles. Consequently, contrary to popular representations of IVF, the dominant experience of treatment is of failure rather than success. Therefore, it is inevitable that a significant majority of those who engage with IVF as a means of overcoming their problems conceiving will have to end treatment without their desired biological child².

In terms of medical technologies, IVF and the constellation of procedures associated with it constitutes the most sophisticated treatment currently available to those experiencing infertility, and consequently, the point at which IVF is no longer felt to be a viable option generally marks the end of the line in terms of medical treatments³. Therefore, confronting the withdrawal from IVF treatment also necessitates confronting the very real possibility of never achieving the desired pregnancy. It is important to note, however, that failure of what turns out to be

¹ Human Fertilisation and Embryology Authority (www.hfea.gov.uk)

² It is important to remember that not all of those undergoing treatment are living without children. They may be experiencing secondary infertility, have conceived through earlier fertility treatment or be living with children of either partner from former relationships. For the purposes of conciseness, this paper will assume childlessness, except where the presence of other children is particularly pertinent to the analysis.

the final cycle of treatment does not necessarily coincide with the decision to end treatment, which may come several months or even years later, if at all. Furthermore, the *recognition* of the end of treatment, whether voluntarily or involuntarily arrived at, does not necessarily coincide with the transition from identifying as child*less* to child*free* - that is, a life that has ceased to be defined by the lack of children⁴. Consequently, the transition from being 'not yet pregnant' (Daniluk 1996) to 'not going to be pregnant' should be seen as a long, complex process rather than an identifiable transitional moment, and it is the ways in which that transitional process is made sense of by those for whom treatment fails that is the focus of this paper.

One of the most commonly cited reasons for undergoing IVF in spite of the relatively low chances of success is that of pre-empting future regrets (Franklin 1997). The very existence of the technology as providing a possible route to biological parenthood generates an imperative to pursue treatment, since the failure to leave any stone unturned could be the cause of a distressing 'if only' in later life. However, the peace of mind promised by IVF is deceptive, and the 'maybe-next-time' hope generated by the technology makes it impossible to know exactly where the end of treatment lies (Braverman 1996). Consequently, while those undergoing IVF emphatically report the need to have tried everything before being able to accept a life without their own

³ This is not always the case, and patients may return to treatments lower down the technological hierarchy, such as fertility drugs or tubal surgery following IVF failure.

⁴ The concept of being childfree does not necessarily mean the complete absence of regret or sadness around the fact of not being able to have a desired child, or number of children. It is simply a means of constructing an identity that is not dependent on something that is missing. The concept of being childfree is explored in detail in (Ireland 1993; Tyler May 1995; Carter and Carter 1998; Campbell

biological children, it is not at all clear what doing 'everything' actually constitutes. IVF can be seen to create the very uncertainty that it is believed to resolve (Franklin 1997). Furthermore, while there are well-trodden, if circuitous and often painfully slow, paths *into* IVF, the routes *out* of treatment are more obscure. This is particularly true for women, given the plethora of negative associations and the paucity of positive role models for women living without children, whether by choice or by necessity (Morell 1994; Daniluk 1996; Campbell 1999; Morell 2000). Ironically, even when IVF *is* successful, the end of treatment is still not clearly marked, since the successful cycle may well provide the motivation to return to treatment to try for a second child to 'complete' the family. There is, therefore, no self-evident, objectively identifiable end to IVF treatment, but rather, the point at which treatment ends is subjectively determined by a wide range of factors, events and personal circumstances.

Furthermore, where the end of treatment is determined by the patient, rather than being imposed by financial limitations, medical necessity or other insurmountable factors, the distinction between voluntary and involuntary childlessness becomes blurred, since the strong possibility of biological childlessness is being *chosen* over continued cycles of treatment. As a result, the decision to end treatment brings with it the implication, particularly for women, that they simply didn't want a baby enough to continue, suggesting the transgression of the

1999). What is perhaps most interesting to note is the difficulty in locating a term with positive connotations to describe women who live without children.

social and cultural norms which construct womanhood as inseparable from motherhood (Ireland 1993; Ulrich and Weatherall 2000).

Ironically, the decision to *continue* with treatment is not necessarily any safer in terms of achieving conformity to social and cultural reproductive norms. For as long as the outcome of IVF treatment is a baby, the tension inherent to the juxtaposition of reproduction and technology finds an uneasy resolution in the concept of 'giving nature a helping hand'. However, aside from the obvious potential financial, relationship and health costs implicit in the continuation of treatment, each additional cycle of treatment can be seen to be putting this construction of IVF as helping nature increasingly under stress. For as long as treatment continues without the counterbalancing 'natural' outcome of a baby, the process of reproduction, which is constructed as natural and inevitable, becomes increasingly subordinate to the technological aspects of the treatment process. The further away from nature the procreative process moves, the greater the danger that process is perceived to pose both to the individual and society. The burgeoning history within the science fiction genre of monsters created at the hands of obsessed, egotistical scientists attests to this concern⁵. The unnatural mother is a tabloid staple, where lesbian or post-menopausal women seeking treatment are excoriated as undermining nature and society. However, even for those who would otherwise meet the normative reproductive standards in terms of age and sexual

orientation, the subjective determination of the degree of engagement with treatment as excessive brings with it the suggestion of obsession - a dangerously selfish instability that is transgressive of normative femininity, although perhaps a lesser transgression than that of the decision not to have children.

The precarious tightrope walk between stopping treatment too soon or too late is just one element in complex and potent mix of considerations that contribute to the actual decision to end treatment. However, the *demonstration* of the decision to stop as an act of conformity to normative reproductive standards is fundamental to the retrospective discursive construction of that decision. This research has identified 7 key discourses or repertoires (Potter and Wetherell 1987) which the participants used to demonstrate this conformity: (1) doing everything possible; (2) desperation; (3) resistance; (4) benevolence; (5) the sensible consumer; (6) fertility; and (7) fitness to parent. These discourses should not be seen as mutually exclusive, and frequently overlap within individual accounts. It is by means of these repertoires that the difficult transition from 'not yet pregnant' to 'not going to be pregnant' is made sense of.

The remainder of the paper will be divided into three sections. The first section gives a brief overview of the research project of which this analysis forms a part. The following section - the main body of the paper - will contain the analysis of the participants'

⁵ Hirsch's interviews with people with no direct experience of reproductive technology revealed fears of the creation of a master race as a primary concern with the technologies, alongside worries about the commodification of life.

accounts from the perspective of the seven discourses, and the final section will draw some tentative conclusions.

The research project

The data is drawn from a series of in-depth interviews with 15 women whose male partners chose not to be interviewed and 13 couples, all of whom had had at least one cycle of IVF, with the most recent cycle no later than 1997. All of the participants had withdrawn, at least provisionally, from IVF programmes. The aim of the study was primarily to identify the factors which inform the decision to end treatment, and to consider the ways in which the unsuccessful engagement with IVF marked both the experience of infertility and the participants' own perceptions of that technology. The study also hoped to explore the ways in which those feelings might change over time and the influence they might have on subsequent choices.

The participants were interviewed twice, 6-8 months apart, and they also completed two simple questionnaires prior to the interviews covering basic demographic information and their treatment history. All the participants had undergone at least one cycle of treatment at a specialist fertility unit at a large teaching hospital, the dormant patient records of which were used to recruit participants for this study. Treatment within this hospital was either health authority funded, or funded at a subsidised rate by the patient. However, it was not uncommon for patients to have sought additional or prior treatment in other National Health Service (NHS) and private clinics. The number of

cycles undergone ranged from 1 to 12, and the amount spent on treatment ranged from zero to well over £20,000.

Of those interviewed, 15 already had children. 7 of these children were born prior to the final unsuccessful IVF cycle, either through fertility treatment or natural conception, and the remainder were conceived after withdrawing from IVF, either spontaneously or following alternative therapies or conventional treatments other than IVF⁶. One child was the result of a surrogacy arrangement with the participant's sister, one baby was adopted from China and a third couple had just been approved for domestic adoption and were waiting to be matched with a sibling group. Apart from one participant who was separated from her husband, and another whose relationship broke down while the study was being conducted⁷, all the participants were in stable heterosexual relationships. They were predominantly, although not exclusively, middle class, white and educated to degree or professional level, reflecting not only the exclusivity of IVF itself, but also the emotional and time demands of articulating those experiences. This is an outcome which is common to the experience of other researchers in this field (Sandelowski 1993; Daniluk 1996; Franklin 1997; Becker 2000)

⁶ The accounts of those who went on to have children, though obviously influenced by the presence of children in their lives, are still relevant to this project, which focuses on the process of making the decision to stop *at that time*. It is also inevitable that those who have subsequently gone on to become parents would be more willing to discuss such a sensitive issue, suggesting that this sample group should in no way be seen as representative of the wider population in this regard. There are no figures available on how many people ending IVF do go on to have children.

⁷ Unfortunately, the participation in the interviews raised difficult issues for this couple, and particularly the female partner, whose self-esteem had been severely damaged by the experience of infertility and of IVF failure. While I would not suggest that the research project was responsible for the breakdown of the relationship, it was certainly a catalyst in the crisis - a sobering realisation for me as an interviewer.

The interviews were taped and transcribed, all the participants had the opportunity to review the transcripts and make any changes, although very few actually amended the transcript other than providing clarifications. The transcripts were analysed using discourse analysis - that is, focussing '...on talk and texts as social practices and on the resources that are drawn on to enable those practices (Potter 1996: 129). The key analytical question is not *what* is being said, but what that discourse is intended to achieve and how⁸.

Given the sensitivity of the subject, confidentiality is imperative, and therefore all names and any identifying information has either been removed or changed in the writing.

Analysis

1. Doing everything possible

As discussed in the introduction, the need to have tried every possible means of achieving pregnancy before accepting childlessness is frequently cited by those undergoing treatment. However, for as long as people are embroiled in the treatment process, what actually constitutes doing everything is frustratingly unclear. However, although the accounts recalled this confusion over how and when to end treatment, the argument that they had done everything possible regained currency in the context of the positive construction of the end of treatment:

⁸ See also: (Potter and Wetherell 1987; Burman and Parker 1993; Gill 1996; Gill 2000; Wood and Kroger 2000).

Karen: Are you glad you did it [IVF]?

Katy: Yes.

Tim: I am, yeah.

Karen: Why would you say that?

Tim: Because if we hadn't had, we would never have known.

Katy: I mean, it wasn't an option not to have a go.

Tim: Because we had to do all we thought we could do to try and have a family, so if we'd not tried IVF, we would just have thought, 'Oh well, we haven't done everything we could have done.' So at least our consciences are clear of that sort of ...alright, we've tried our best. That's it, we can't have a family. That's life.

Katy and Tim had originally decided to undergo six cycles of treatment, although eventually stopped after five following Katy's emergency hospitalisation relating to ovarian hyperstimulation in response to the drug treatments. Even though they fell short of their original limit of 6 before stopping, they asserted with confidence that they could have done no more. Tim's insistence that their 'consciences are clear' demonstrates the way in which IVF has a public, confessional dimension through which the intention and desire to parent is demonstrated in spite of the absence of a child. According to Foucault, confession 'exonerates, redeems and purifies' (Foucault 1976: 62), and in seeking exoneration through IVF, Tim reveals the extent to which those living outside of the normative reproductive standards are subject to constant evaluation by others.

In spite of the assertion that everything possible had been done, Tim continued to speculate as to whether private treatment at a more local clinic might have had a different outcome. This continued speculation marks the extent to which the assertion of having exhausted the IVF option facilitates closure around IVF, rather than reflecting an objective point at which every possible

avenue can be said to have been explored. Furthermore, it is clear that in setting limits to treatment early on in the process, the goal is actually to have done everything *reasonably*, rather than *literally*, possible.

By not pursuing treatment beyond the bounds of what they had determined as reasonable, the participants were demonstrating their own control over their engagement with the procedure, thereby distancing themselves from the suggestion of desperation:

Susan: I didn't want to be one of those women that you saw on television, that are sort of in their 50's, that have had sort of like hundreds and hundreds of it. And it does take over your life. I didn't want to be ...I mean, we did get obsessive, but I didn't want to be one of these completely obsessive people that that's all they live for. And we had to have some sort of...reality. You know, we had to have some sort of life. Although it did take over, that sort of three seemed...I don't know. Three just seemed a good control number, a good sort of, you know, that's your best shot.

Susan constructs her own three cycles of treatment as moderate by comparison with the desperate older woman, and this is reinforced by the use of the language of science - 'good control number' - to support the decision. She recognises in herself that capacity to become 'completely obsessive', thereby demonstrating her strong desire for a child, but she uses the limit that they set as a means of preventing this desire tipping over into excess, distinguishing herself from others who are less able to retain a sense of perspective. The recognition of the potential within herself to become obsessive also emphasises the fact that moderation is not to be confused with apathy. Stopping at three is to be understood as an act of strength rather than weakness,

marking the assertion of rationality over the nevertheless overwhelming desire to have a child.

Interestingly, the technological aspects of IVF were repeatedly played down in the interviews, since this was felt to undermine the naturalness of the reproductive process which the participants were eager to preserve in order to avoid the stigma that remains attached to the use of technology for reproduction. However, the most notable exception to this was in the assertion of having done everything possible:

Susan: I mean, personally, I felt that going to [hospital], having the IVF and the ICSI⁹, we had actually had the best we could try.

The hospital where Susan had her treatment is a major teaching hospital with an excellent research reputation. Furthermore, the consultant who heads the unit is a recognised expert in his field, with a high media profile, often appearing on television and radio debates. At the time when Susan underwent ICSI, it was a very new procedure, and certainly the most sophisticated treatment on the market at that time.

It can be seen from this analysis that the discursive construction of the ending of IVF as marking the end of what can reasonably be done to achieve pregnancy is central to the transition out of the suspended state of being 'not yet pregnant' that characterises the experience of fertility treatment, even where what constitutes 'doing everything' is individually and

⁹ Intra-cytoplasmic sperm injection (ICSI) - a micro-manipulation technique where a single sperm is injected directly into the egg *in vitro*.

situationally, rather than literally, determined. Furthermore, this demonstration confirms the essential conformity and commitment of the couple to normative standards which determine parenthood, particularly for women, as the obvious and inevitable life course. However, the successful construction of the experience of IVF as complete appeared in the accounts to be heavily dependent on the extent to which the participants perceived themselves to be able to exercise some control over the exit from treatment. As the following section describes, where the end of treatment was imposed rather than chosen, and particularly where that imposition was considered unjust, a sense of closure around IVF was far more elusive.

2. Desperation

Although the majority of the participants were careful to distance themselves from the suggestion of desperation, for a small number of participants, desperation was the only way to make sense of the end of treatment. For these participants, the end of treatment had been externally imposed and unwelcome, as a result, for example, of insurmountable financial limitations, age or a partner's refusal to participate in further treatment cycles. Consequently, these endings were understood as provisional, and the subsequent dissatisfaction and regret at the premature ending proved to be highly disruptive to the transitional process towards acceptance of the unlikelihood of future pregnancy. The continued pinning of hopes and expectations on future treatment precluded the consideration of other forms of resolution, such as living without children (or the

desired number of children) or pursuing adoption. Instead, the profound and unabated longing for biological parenthood led them to aspire to, or actively pursue (where possible), measures that many, including themselves, would consider to be indicative of desperation¹⁰.

Although desperation was closely linked in the minds of most of the participants with a loss of control and perspective, it is too simplistic to see those who are unable to extricate themselves from IVF as passive or utterly bereft of power. Ironically, it was among those who conformed most closely to the caricature of the 'desperate infertile woman' that individual agency was most forcefully, if not always productively, expressed. Alice's story demonstrates this well.

When I met Alice, it had been two years since she had had any treatment, but at the age of 47, she still considered her withdrawal from treatment to be provisional. In the absence of any immediate possibility of further treatment, she was trying a range of both mainstream and fringe alternative therapies:

Alice: [...] if I read and heard somewhere that eating dog poo mixed with broken glass would work, I would do it. I would do it. So I suppose there's an element of desperation in there somewhere.

She described herself as 'clutching at straws' and 'lurching from one [therapy] to another', desperately trying to fill what she

¹⁰ Measures included, for example, consulting clairvoyants; enduring incapacitating pain caused by conditions such as fibroid and endometriosis rather than undergo a hysterectomy; taking fertility drugs without the male partner's knowledge and then timing sex to maximise the chances of conception; self-administering medications left over from previous cycles; using mail order hormone treatments without medical supervision; and pursuing treatment into the menopause.

understood as a temporary hiatus between treatments with purposeful activity:

Alice: [...] It's the waiting about that gets you down, I think. All the time something's happening, whatever it is, it keeps you going.

She was planning to return to treatment if she could find a clinic that was willing to treat her using her own eggs in spite of her age, since her husband refused to agree to treatment that involved a donor. At the time of our second interview, she was researching a new and controversial treatment being attempted in Italy, but not yet licensed in the UK, but she was not hopeful either that she would be accepted for treatment, or that her husband would agree. The recent onset of early menopausal symptoms complicated matters further, and she also had significant uterine and tubal scarring following the removal of a fibroid some years previously. She expressed her exasperation that her age effectively excluded her from benefiting from future advances in technology:

Alice: [...] I'm probably 10 years behind everything, because these things are cropping up just as I'm reaching the too-old stage for it all, and in 10 years time, it will probably be so run-of-the-mill that it will be happening all over the place, and I'll be looking back thinking 'Why am I just 10 years too old for everything?! But erm...I feel like I'm trying to sort of catch the tail of a kite, you know, and it's always just fluttering out of reach. But I might grab it, you know.

Alice mourned the fact that 'nobody will ever call me mummy', indicating the beginnings of acceptance of her infertility, but she was holding out for the possibility of perhaps one more chance to become pregnant, modifying her goals in a heartbreaking footnote added to the transcript of our first interview, when she

suggested that 'even a miscarriage would be something - if I'm not meant to have children at all, at least we'd have had some hope and joy at the beginning, even if it was to be lost later, but we'll probably never even have that now.' It is important to note that desperation in this context is not concerned with the **denial** either of the inevitability of the end of treatment or even of the likelihood of further treatment not working, but rather aims at the **postponement** of the end of treatment until everything possible is perceived to have been done. Indeed, it is the very real proximity of the end of treatment that generates the urgency that characterises the lurching between therapies that she describes. This is compounded by her complete inability to contemplate a positive future for herself beyond that ending:

Alice: And I think to myself, right, this is it. You know, this is it forever, until we get taken into a home and we die. That's what life is. It'll just be work and more work.

Alice's story is redolent with defeat and a profound sense of pessimism about her future, and even with the most positive gloss, her story is certainly one of great personal sadness. However, what is also apparent from even the most cursory glance at her story is the astonishing determination and energy with which she meets the apparently intransigent barriers confronting her with regards to gaining access to a variety of treatments and improving her chances of conception. However, in spite of her rhetorical insistence that she would do **anything** for the chance to be a mother, she too has her limits, particularly in terms of not getting into financial difficulties or endangering her marriage. Furthermore, she acknowledged that

the end of treatment is 'becoming more real' and that she had 'dropped the fantasy now of thinking it might happen', marking the tension between her own need to manage her withdrawal from treatment in her own time and her recognition that time was running out.

At the heart of Alice's reluctance to let go of the promise of IVF lies a strong sense of injustice, feeling that she has been discriminated against because of her age. Instead, she argues that her case for treatment is actually stronger than that of much younger women:

Alice: But sometimes, I've read of younger women who - I don't know, say, 27, 28, who've had IVF because they've been trying to conceive for 3 years and haven't managed it. They had IVF on the NHS...well, they've probably got another 15 years that they could have...Okay, I'm not saying that they should have to wait 15 years for a baby, but technically, medically and naturally, there's more chance that they will conceive naturally when time's running out for people of my age.

Financing treatment was not an issue for Alice, but she had now reached an age where only a select few private clinics would treat her, and only if she used donor eggs. Her resentment was further compounded by the belief that prejudice against her because of her age had negatively affected the quality of the treatment she had received, both in the NHS and privately. This made it impossible for her to feel any sense of completion around her experience of IVF, which in turn precluded any kind of positive transition.

Franklin observes that while IVF appears to be a 'rite of passage' out of the liminal state of infertility, it actually constitutes only

a rite and not a passage, with the successful transition out of IVF being dependent on the capacity of the woman to make an 'inward transition' in coming to terms with the end of treatment (Franklin 1997: 183). However, Alice's conviction that discrimination against her on the grounds of age meant that everything possible had not yet been done, combined with her inability to imagine a positive future for herself without children, stands in the way of that inward transition. The agency, initiative and energy which characterises Alice's search for treatment opportunities is striking, but her determination to stave off the end of treatment carries with it significant costs in terms of self-esteem and quality of life, and she remains in a state of suspended uncertainty, unable to move positively in any direction and (self-) defined by failure and lack. Her determined search for treatment and her resistance to its end allow her to align herself with the popular discourse on IVF which posits women's inevitable and uncontrollable drive for motherhood as the prime motivation for turning to the new reproductive technologies (Franklin 1990). However, ultimately, her success in deferring the moment when she must actively confront a future without children is a pyrrhic victory which only perpetuates, rather than resolves, her despair.

Other forms of resistance, however, proved to be very effective in facilitating the successful transition out of being 'not yet pregnant'.

3. Resistance

IVF, while appearing to endorse conventional values with regards to reproduction, also has considerable potential to transgress and challenge those values by enabling the creation of novel family structures and fragmenting the conventionally unitary categories of mother and father through the separation of gamete provision, gestation and social parenting (Hartouni 1997). However, for those who participated in this study, the fact that they had been unable to have children, or the desired number of children, was experienced as already marking them out as 'abnormal' among their peers, and consequently, the vast majority of participants accounted for their engagement with IVF in terms of conformity rather than transgression in order to minimise the exclusionary effects of that abnormality. Consequently, direct expressions of resistance, particularly with regards to the assumed centrality of motherhood to female identity, were rare. However, two participants in particular stood out as having developed a critical approach to the ideology of motherhood, and in both cases, this critical approach was credited as central to the construction of a positive interpretation of the end of IVF treatment some time after the treatment itself had ended.

Claire

Of all the participants in this study, Claire took the most defiant stand against the pressures on women to be mothers, citing early memories of her social preparation for maternity:

Claire: [...] I remember thinking right back to being a little girl - you get a doll for Christmas and your mum says, 'oh, well, you know, if you look after this, you'll be able to give it to your little girl when you have one.'

Claire and her husband underwent 4 cycles of treatment without success, before deciding that IVF 'is a mug's game' and ending treatment. She was then free to invest her energies in other activities, acquiring a boisterous puppy, taking piano lessons and starting an Open University degree, which she successfully completed around the time I interviewed her. Claire expressed her frustration that in spite of her considerable achievements in other areas of her life, she felt that her personal success was being judged entirely on her failure to reproduce:

Claire: [...] being a whole person, being a good person, [having] a meaningful life, does not mean being a parent. You know, there's lots of ways that you can have a perfectly valid existence.

Claire suggests that although she had had these feelings of resentment and suspicion towards the assumption that motherhood is essential to female identity throughout the IVF treatment, it was the OU course that she took, and particularly its focus on social constructionism, that gave her the vocabulary and confidence to voice those views, offering 'credibility to what I'd sort of been working out in my own mind.'

This understanding of motherhood as stemming from a social rather than a biological imperative is central to the sense of closure that Claire has achieved around her experience of infertility. However, this resistant approach creates a number of key problems which she then has to resolve in her account. Her critical stance towards the ideology of motherhood is not without risk, since while IVF can be written off as a 'mug's game' as a

justification for ending treatment, and the assumed biological imperative to reproduce can be unmasked as a social construct, this does not escape the fact that she did engage significantly with the technology, suggesting a degree of complicity with those values and assumptions which she so readily rejects. This tension is resolved by the creation of a distinction between buying into those values and accounting for them:

Claire: [...] I can say, 'At least I tried.' So there can be no stage in the future when I might say to myself, 'Oh, well, if only I'd tried it could have been different.' Erm...it's almost like I can say to society, 'Look, I tried to be the typical female, and I tried to be the mother, you know, but it conspired against me so I now have the right to go off and spend my money on nice holidays or whatever and don't need to feel guilty.' So it's almost, sort of, explaining away my decision to society.

Like many of the participants, Claire was motivated to try IVF by the need to assuage future doubts and regrets. However, the experience of IVF also has a demonstrative function, illustrating that her deviation from the normative standards of womanhood by not becoming a mother is an accidental rather than a deliberate act of transgression. While Claire is able to offer a powerful critique of the ideology of motherhood, it is very important to her that others recognise that her childlessness is ***involuntary***, since this forestalls criticism from others in response to the lifestyle she is able to enjoy because she does not have children.

Claire herself recognises the usefulness of this resistant position as a coping strategy for dealing with her involuntary childlessness, and questions the extent of her commitment to the values she is espousing. Remarking upon her general disinterest

in children and her reluctance to coo adoringly over friends' and colleagues' babies as convention demands, she wonders whether it is all 'a big defence mechanism':

Claire: Whether it's because I've intellectualised it [the biological urge to reproduce] out because it was helpful to me to think that it was socially imposed...you know, 'I'm not going to be conditioned!', because it actually helps me to move on away from the children issue. I don't know.

When I interviewed her for the second time, Claire commented on the defensive way in which she had responded to my questions in the first interview regarding whether she considered herself as infertile. She had been surprised at how difficult the question had been to answer and at her own reluctance to accept the label of infertility, causing her to exclaim laughingly: 'So I haven't completely escaped the social expectations of being a woman at all, have I?!'

Charlotte

For Charlotte, the development of her critical stance towards the ideology of motherhood came **after** she had become a mother. Charlotte and her husband, Len, had a son through IVF using donor sperm, and a couple of years later underwent two more cycles in the hope of having a second child. Charlotte reflected on the experience of infertility:

Charlotte: And I remember being very angry at this God-like person who I'd decided was responsible. I remember saying, 'You've taken away from me the one thing that I'd be good at!' [...] Why did I think that? [...] When I actually had a child, I'm not that good at it [...] And I might well have been good at other things, had I allowed myself to just keep...get off this track of wanting a child [...] That's what's interesting - how you limit yourself by what you believe is important to you.

The realisation for Charlotte that 'a woman can be fine without a child' came gradually over the years after the birth of her son as she recalled the ways in which social and cultural images of motherhood compounded her own conditioning that she was incomplete without a child:

Charlotte: [...] one thing that I did notice, when we wanted children, there seemed to be children all around, in the media and television, and it sold the wrong idea. It sold this idea of marital bliss, children [...] And you think, 'What a load of crap!' You know - little babies in their Pampers, with their mums looking unharrassed. And you think, 'Why does society sell...?' It's an illusion, isn't it.

Like Claire, Charlotte's cynicism is not directed at the desire to have a child *per se*, and nor is she expressing regret at having become a mother. Instead, her concern is her belief at the time that motherhood would be the **only** thing she would have been good at, closing off other opportunities. She sees the idealisation of motherhood in the media as reinforcing those ideas, particularly at a time when she was vulnerable to them. Now that she has accepted that she will almost certainly have no more children, these images have lost their seductiveness and she is able to approach them with scepticism and with increasing self-confidence.

In the case of both Claire and Charlotte, an approach of resistance towards the conventional **ideology** of motherhood, rather than motherhood itself, offers a successful means of achieving closure around the experience of infertility, and particularly of IVF, without allowing themselves to be portrayed as child-hating or selfish. However, as was suggested at the

beginning of this section, this critical stance is not without risk, in that it clearly poses a challenge to conventional values. Particularly for those experiencing infertility who do not become parents, whether biologically or by other means, this defiance compounds the transgression of living without children, and is consequently not a strategy for coping with IVF failure that was widely used in this study. Instead, the majority of the participants opted for more direct displays of conformity, as the remaining sections will demonstrate.

4. Benevolence

One of the key conventional attributes of motherhood and femininity is that of self-sacrifice and benevolence. This is precisely why the suggestion of selfishness is so potent when directed against women who live without children, or women who have children but fail to meet the normative reproductive standards, such as older women, single mothers, or even working mothers, who are judged (in some quarters) to be insufficiently willing to sacrifice their own personal interests for the sake of their children. In this context, one of the key problems faced by those for whom IVF fails is that there is nothing that marks them out from those who have chosen to live without children. Consequently, the accusation of selfishness sticks easily, particularly when the involuntarily childless couple are sufficiently affluent to be able to enjoy the freedom and increased mobility and flexibility that living without children can bring, or the female partner invests time and energy heavily into her career.

In response to these pressures, the construction of the ending of treatment as an act of giving affirms the participant as conforming to key criteria for motherhood, even while being unable to reproduce¹¹. This demonstration of benevolence is apparent in the accounts in two key areas: firstly, by giving someone else a chance to try IVF by ending your own treatment; and secondly, acting in the interests of existing children;

Giving others a chance

IVF treatment that is performed in an NHS context, whether it is funded by the health authority or privately funded at cost by the patient¹², is widely recognised by those receiving treatment as making a claim on a limited resource. While the vast majority of the participants in this study asserted that their claim on those resources was justified, this was frequently accompanied by considerable discomfort:

Melissa: [...] but I did worry that I was using up vital NHS resources over something that wasn't going to kill me. And there's, you know, people with cancer, people with heart trouble, you know. Cutting up the cake. But maybe that sort of infertility area really shouldn't get any money. That was really hard to cope with.

In addition to the concern that the funding of IVF might detract from other more deserving treatments, the injustice of a distribution of health authority funding which was dependent on

¹¹ Layne's edited collection of essays considers how the language of the gift is used to transform non-conformative acts of mothering such as adoption, surrogacy, fostering, raising children with disabilities and pregnancy loss (Layne 1999)

¹² Not all health authorities are willing to fund IVF treatment, and those that do limit the number of cycles and enforce stringent eligibility criteria. However, NHS clinics frequently offer self-funded treatment on a non-profit basis, often well under £1000 per cycle, compared to £2-3000 for a cycle in a private clinic. Furthermore, drugs may be funded by the GP, although this is not guaranteed, particularly within fund holding GP practices.

post-codes was a source of considerable discomfort to those who happened to live in an area where funding was available. However, the complex issues of 'cutting up the cake' also offered the participants a means of translating the decision to end treatment as an act of benevolence to others who were also competing for those scarce resources. After a disappointing first cycle, where the embryos had fragmented soon after fertilisation, Paula and Robert were advised by the NHS hospital where they were being treated that if the second cycle had a similar outcome, they would not be offered any more treatment unless they agreed to the use of either donor eggs or sperm:

Karen: And how did you feel about that?

Paula: Oh, I thought it was a very fair thing to do.

Robert: There are so many other people waiting for treatment.

By acknowledging the needs of other prospective patients, Paula and Robert successfully turn the potentially disempowering imposed end of treatment, at least at that hospital, into an act of generosity. For Liz, the end of treatment was imposed by repeated poor results from the hormonal drugs which are intended to stimulate the growth of egg follicles. Having discovered 'poor performer' written across the top of her medical records, she felt labelled and believed that treatment had been subsequently refused because she would not be able to make a positive contribution to the clinic's success rates:

Liz: [...] I felt very much like I am not going to make your figures look good at the end of the day, and another part of me thought, well, yeah...stand aside and let someone else have a go who would have a chance. [...] You do sometimes see women who, you know, had ten goes [...] so I thought that was a bit unfair. Someone else could have a go.

By interpreting the end of treatment as an act of benevolence rather than something imposed by the doctors, Liz firstly reasserts her control over the process in contrast to the excessive number of cycles she ascribes to others; but secondly, she also marks the end of treatment as a positive and generous act on her part. This stands in stark contrast with commercial motivations which she suspects to be behind the clinic's decision to refuse her further treatment.

Protecting existing children

Seven of the participants in this study already had one child prior to the final, unsuccessful IVF. Two of these were conceived through earlier IVF attempts, and the remainder were either conceived within that relationship prior to the onset of fertility problems, or were the product of earlier relationships. While one of these children was almost in adulthood by the time his mother and her partner were undergoing IVF, the remainder were relatively young at the time their parents were pursuing treatment, and the hope of producing a sibling for the existing child was frequently cited as an important motivation for pursuing treatment. However, concern about the possible loneliness or isolation of an only child was also balanced against concern that the engagement with IVF would impact negatively on that child, both in terms of the redirection of resources and the worry that repeated hospital visits might generate:

Courtney: Poking and prodding... operation after operation...ever since [daughter's] been born it's 'My Mum's in hospital, my Mum's in hospital'...and I don't want that for her. [...] I don't want her to constantly

keep worrying ... at school, 'My Mum's in hospital again.' I don't want that.

Sharon: And the thing is, we could have spent that [IVF money] on [son]. I mean, we was like forsaking holidays and things like that, to take him away on holiday, because...oh no, that's our IVF money. [...] And the thing is, like, really, we weren't neglecting [son], but he was sort of like pushed into the background because IVF was in the front.

Consequently, while existing children were frequently cited as a reason for pursuing treatment, they featured equally prominently in the decision to stop, allowing those withdrawing from treatment to establish their credentials as appropriately caring parents, even while withdrawing from the possibility of the 'complete' family that they desired. This was also apparent in discussions of adoption, where the potential disruption to existing children of introducing a child into the family who may have behavioural problems was cited as a key reason for not proceeding.

5. The sensible consumer

IVF is big business, and over 80% of all treatment cycles in the UK are performed privately (Challoner 1999: 58). However, the location of IVF within consumer culture creates a fundamental problem for those seeking and receiving treatment in that the redefinition of the IVF patient as *consumer* contravenes normative standards of parenthood in general, and motherhood in particular, through the introduction of commercial exchange into the reproductive process (Layne 1999). The constructed selflessness of motherhood, in particular, does not sit easily with the individualism of consumption. However, conversely, the familiarity of the consumerist discourse and its centrality to

contemporary UK society enables those who withdraw from treatment for which they have paid to construct that decision as one of sensible financial management, confirming the rationality of the individual and their control over their engagement with the IVF process. This good financial management is demonstrated in two ways: firstly, by not spending more money than you have or can reasonably borrow, and secondly, by getting value for your money:

Alice: And I've heard of people who've second mortgaged their homes and get into debt over it, and I thought, I don't want to get onto that slippery slope.

Jane: [private hospital] was a good one.

Brian: And so was their price...and that was something that's got to be considered as well. I mean, people remortgage their homes.

The unwise, compulsive IVF shopper is another version of the caricatured desperate, infertile woman - the irrational Other who engages immoderately with technology - and she (and it is always **she**) serves as a foil to the rationality and moderation of those being interviewed. However, knowing when to stop 'consuming' before getting onto a 'slippery slope' into financial crisis is just one aspect of being a sensible consumer. It is also important to ensure that money is not simply being wasted:

Sharon: And it's the fact that you're paying out, and you've got nothing at the end of it. It's like if you're paying a couple of thousand pounds out for a car, you've got a car, or a holiday or whatever. You've got nothing to show for this couple of thousand pounds you've just spent, you know. Just nothing.

Not getting value for your money is suggestive of irrational wastefulness, and consequently, represents a significant

justification for ending treatment. This is reinforced by repeated references to paying for IVF as a form of gambling. The explanation of the withdrawal from treatment in terms of the recognisable standards of consumer culture retains intact both the expression of the desire for a child and the assertion of rationality over that desire.

6. Fertility

One of the most striking features of the interviews was the regularity with which the participants asserted the continued possibility of conception, even in those participants, like Sarah, who could be described as living a childfree life:

Sarah: We never really made the decision not to try on our own - in fact, we still have unprotected sex. [...] It's not that we decided not to have children. We just don't see something happening. And if it does, great. But we're not even expecting it to happen.

Throughout the experience of infertility, including IVF, many of the participants complained about being regaled with stories of women who tried to conceive for years and years and then suddenly and unexpectedly conceived. These stories were told by family members, friends and especially doctors, as well as being reported in the press. While these stories were generally approached with scepticism and annoyance, the fact remains that for some people, this does happen, and so even after stopping treatment, for as long there is no pharmaceutical or surgical prevention of pregnancy, the possibility technically remains. In fact, one of the women in this study was embarrassed to have become one of those stories by conceiving spontaneously

after 12 cycles of treatment! However, very few women in the study were actively pursuing the possibility of spontaneous pregnancy in terms of counting days of the menstrual cycle and timing sex to coincide with ovulation. The remainder, like Sarah, were simply not taking any steps to prevent conception and had ceased the scrutiny of the menstrual cycle that is habitual to many women trying to conceive. In fact, conversely, several felt that the use of contraception was actually disruptive towards their gradual acceptance of the fact that they were not able to conceive, since its very use suggests the 'risk' of pregnancy.

The claiming of fertility does not express the straightforward expectation of conception. Instead, the assertion of the continued possibility of pregnancy enables them to avoid the label of infertility, which the majority of participants found distasteful, and in the case of women was suggestive of pejorative, unfeminine terms such as 'barren'. In particular, continued menstruation or ovulation were cited as indications of essential fertility, even where other reproductive health problems made conception impossible:

Karen: Would you identify yourselves as infertile?

Susan: Well, yes.

Matthew: Yeah. I don't think we've ever used the term as such.

Karen: Right. What does the term mean to you?

Susan: Well, you see, the thing is, people talk about sub-fertility, but having never had a child, and never actually being able to conceive, so I always consider that I was completely infertile, because I've never, ever...although that's not strictly true because I've produced eggs.

Susan draws on the medical definition of infertility as the inability to conceive after one year of regular unprotected

intercourse. However, this is also modified by observing that she has produced eggs, preferring instead the category of *sub*-fertility. Others, and particularly those whose infertility was caused by blocked tubes, rejected the category of infertility entirely, arguing that it was simply a technical problem that prevents them from conceiving - what Claire described as a 'transport problem', continuing to view her essential fertility intact.

This construction of a retained core fertility, in spite of the inability to become pregnant, constitutes a response to the way in which cultural and social values have constructed reproductive capacity as central to female identity, and the fatalistic insistence that you can never say never enables women to conform to those ideals regardless of their actual capacity to reproduce.

7. Being fit to mother

As has already been discussed, one of the key functions of the accounts of the end of IVF treatment is to assert the essential 'normality' of the participants in terms of social and cultural values with regards to reproduction, even where they have been unable to achieve the most obvious display of that conformity - a biological child. Consequently, a key feature of the accounts in this study was the demonstration of the self as being fit to mother by highlighting other areas where those skills and attributes have manifested themselves in their lives post-IVF.

This was particularly apparent with regards to relationships with other children:

Sarah: [...] but I've got my god-children, and [husband] has got a god-daughter.

Karen: Are they near? I mean, do you see them?

Sarah: Very near. I can borrow them. The two special ones, [naming her god-daughters], used to live next door. In fact, we heard [god-daughter] being born! It was really weird. We heard all the awful language that was coming out of the house, and within hours we were round there. [...] so we borrow them for weekends, and I must say that a lot of my girlfriends at the same time as I had my miscarriage had a baby, so they are all around 7 years old, and younger, because those were all the first batch, and they went on to have a second...So I know a lot of children. And we kind of get the vicarious pleasure out of them [...]

It is important to note that these are not substitute children for Sarah, and she has managed to construct new non-parental relationships with them, which she values very highly. For many of those undergoing IVF, other people's pregnancies and children are hugely problematic, and many of the women reported being appalled by their own feelings of jealousy towards friends and family. Consequently, the reintroduction of children into their lives served for many as confirmation of their recovery, and their successful transition towards acceptance that pregnancy was no longer a realistic possibility for them. Susan and Matthew spoke with delight about a recent weekend they had spent with friends, who have three young children:

Susan: They used to be our neighbours, and I mean, there was a time when I used to find it really, really hard, because she was sort of having her children - when she was living next door - she was having her children and sort of every time another treatment had failed, she was pregnant again. I mean, she's only got three, but, you know, it felt like that. You just go, 'Every time! Oh, for goodness sake. She's having another one!' And this time, when we went down, you sort of said to me on the way back [...] and he said, 'How did you find it?' and I said, 'I enjoy it. It's nice.' I go down...we go down, we really play with the children, but I don't have this awful...

Matthew: This gut-wrenching feeling.

Susan: This, 'Oh, my god. Isn't it awful. I haven't got any of my own!' We just felt we could enjoy them, and play with them - because we haven't got children, they tend to think we can't be parents so we must be children like them. So we play with them, but then we wave goodbye! [laughing]

Susan identifies this playful relationship with the children as marking a definite and positive transition in her own attitude towards her inability to conceive, and something that had evolved out of the grieving process initiated by three failed cycles and the ending of treatment. Contemporary social and cultural values dictate that for women, the unwillingness to be around children, for whatever reason, is dysfunctional. Indeed, one of the most difficult situations many of the women faced during treatment was the pressure to admire and fuss over other people's new babies, particularly in the workplace, where colleagues tended to be less aware of the treatment. Ironically, however, it is at the point when they were most determinedly pursuing parenthood that the participants were least able to conform to this normative assumption that women will (or at least should) always love being around children. Consequently, the restoration of the capacity to relate positively to children marks a return to 'normality'.

However, the ease with which this constructed 'normality' is achievable in practice should not be overstated, and many of the female participants reported the continuing, very literal social exclusion of not being a parent in a world full of children:

Michelle: But even like the other week [husband's] brother and his wife had some cousins down to stay for the weekend, and they invited us all round there for the Sunday. And when we got there, all the men were in

the lounge, watching the rugby on TV, and all the women were sitting in the dining room, and they were all talking about their children. You know, 'Is yours doing this yet?' And I just think, 'Where do I go?' You know. Erm...and that is difficult, because you feel like you haven't got anything to contribute.

Michelle's story highlights the extent to which it is the women, rather than their male partners, who are continually exposed to reminders of their childlessness and the practical ways in which that continues to set them apart, no matter how accepting they are of their own lives without children. This highlights the way in which those women living without children can find themselves curiously bereft of gender, inhabiting an ill-defined third space. As Cathy observed of her husband's club, 'I go over there and sit with them...because I'm odd. I'm one of the boys. Well, not one of the boys, but I mean...they wouldn't choose to ask me to go and play golf with them.'

The demonstration of a general concern for the welfare of children also featured significantly in the accounts. This manifested itself over small issues such as concern about friends or acquaintances not reading to their children, not disciplining them properly, or smoking during pregnancy or around young children, but also over more serious child welfare issues:

Susan: [...] it's like the sort of paedophile business on the television. You know, I mean, that incenses me, you know, that if somebody was like anywhere near my godchildren, or our nephews, I'd be out there banging on the door, and yet, no, because I've got no children, therefore I should believe that everyone should live in harmony with everybody else. But I don't -- I still have that I mean, I would kill somebody if they went anywhere near any of the children we knew. [...] And we don't know what it's like [to be a parent], but that doesn't mean to say that we don't have that same anger or nurturing or wanting to protect those children, even when they're not ours.

Susan was interviewed at a time when paedophilia was in the news following a tabloid newspaper campaign which was publicly identifying sex offenders in response to the murder of a young girl, Sarah Payne. The subsequent protests and campaigns for a public register of known offenders was led by a group of **mothers**, and Susan resented the implication that only those who have children can care about children, asserting instead her own fiercely protective instincts towards the children in her life.

This desire to be seen as worthy of motherhood was influential for several of the participants in the decision not to enter into the adoption process, since it was perceived as carrying the risk of being professionally judged unfit to mother. Conversely, as Anne found, approval for adoption was experienced as a positive affirmation of the suitability to parent - perhaps even more so than when parenthood is achieved naturally:

Anne: [...] having gone through the adoption assessment, I feel incredibly validated, and, you know, affirmed as a parent. You know, because it is hard being assessed to adopt, and it...you know, it feels like...that feels good. It feels good to be able to ...because when you give birth, you don't go through this assessment, so that feels validating.

Another way in which the meeting of parenting criteria is demonstrated is through the assertion of creativity and nurturing in other areas of life not involving children:

Sarah: [...] I thought, I've got all this maternal energy that I've been saving up, because I wanted, I mean, I've...I'm not sure it's a broody thing, it's just that I've learned so much - and I want to pass it on to someone [...] And I kind of wanted that, and I'm quite good at teaching - I find myself in training situations quite a lot so this...I feel that I wanted to...I've learnt so many things since, you know, the age of 30 that I wish I'd known when I was 16, you know.

Karen: Yeah! [both laughing]

Sarah: So I just thought, this energy, I want to put it somewhere, but I'm not going to have kids. That's when I decided, I mean, it wasn't an overnight decision, but for a while I thought, 'Well, you know, I've got all this energy. I'm going to start a business.'

The energy Sarah describes herself as drawing on is explicitly maternal, which she applied to her business, and particularly to the teaching / training aspects of her work as a management consultant. The energy that she feels would have made her a good mother is now directed towards her business, but by focussing on the giving aspects of her job, she is affirming her suitability to mother and rejecting the selfish stereotype of women living without children. When we met 6 months later, Sarah described this energy as creative rather than maternal and had just won a major jewellery-making competition and her work was being displayed in a nationally renowned museum. This separation of the capacity to conceive from the core qualities and skills that define the social institution of motherhood facilitates the creation of a positive future which is not defined by lack or absence whilst still demonstrating the essential conformity to the socially and culturally determined standards of womanhood in all but actually becoming a mother.

Conclusion

This paper has attempted to explore some of the ways in which people make sense of the end of IVF treatment and account for the transition to acceptance of the unlikelihood of future pregnancy. The analysis has focused primarily on the accounts of the female participants, but it is important to note that the experience of IVF failure is profoundly gendered - an issue which

has been explored elsewhere¹³. While this analysis certainly cannot claim to be exhaustive, there are two preliminary conclusions which can be drawn.

Firstly, the meaning of the withdrawal from IVF is mediated by conventional normative standards of womanhood, to which motherhood is constructed as integral. Voluntary childlessness is replete in the popular imagination with negative associations, and those who are involuntarily childless find themselves indistinguishable to the eyes of others from those who have chosen to live without children. Consequently, a primary function of the accounts of the end of treatment is to refute those characteristics, conventionally assumed to reside in those who have chosen childlessness - most notably, selfishness and the dislike of children. Significantly, while a few of the participants expressed resistance to the construction of women as exclusively maternal, the fundamental concern in the accounts was to distinguish the self from the negative stereotype rather than to challenge the stereotype itself. Therefore, while IVF can be seen as potentially transgressive, the accounts are oriented towards communicating **conformity** to, rather than transgression of, those norms, even though, ultimately, the absence of a child precludes that conformity. Women without children are subjected to constant questioning about their reproductive plans (Morell 1994), and the extensive explanatory work that this discursive demonstration of conformity necessitates can only be relieved by the acceptance at a wider social and cultural level of

¹³ See for example, (Throsby and Gill)

the equal validity of a life without children - a project which is clearly beyond the scope of this paper!

And secondly, **the transition from 'not yet pregnant' to 'not going to be pregnant' is a long and complex process requiring considerable resources - personal, material and social.** There is little formal support or recognition of the difficulties inherent in moving on from IVF, and those experiencing IVF failure easily become invisible to treatment providers, as well as in media representations of IVF, leaving them to work out for themselves how best to move forwards. Consequently, those with limited recourse to the necessary resources can easily be left in suspension, unable to move constructively in either direction. This state of suspension is readily represented as resulting from personal weakness, but this is to ignore the inescapability of social and cultural pressure on women to be mothers, and the differential ways in which those pressures bear down upon different women. The seeking out of female insufficiency that currently prevails in relation to IVF failure is counterproductive in terms of facilitating the transition towards accepting childlessness. This transition would be more effectively facilitated, for example, by means of the prompt and equitable provision of health authority funded treatment, which would enable more effective planning in the engagement with IVF. More broadly, continuing to address the traditionally liberal feminist concerns about discriminatory practices in the workplace and education that prevent women from achieving their full potential in areas outside the institution of motherhood, alongside

increased positive representations of women living without children, are important steps in helping those for whom IVF has failed to make the difficult decision to stop treatment.

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