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Desperately Seeking Susan or Johnny: Transitions to Motherhood for Infertile Women

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ABSTRACT

This study focuses on infertile women who desperately seek to become mothers. Four different groups of infertile women are analyzed: biological mothers, adoptive mothers, wannabe mothers, and the child-free. Data from focus groups and individual interviews are used in a qualitative analysis of their family building strategies. All of the women in this study sought at least minimal medical intervention to overcome infertility; all were remarkably tenacious; and all spoke of infertility as a life altering experience. The respondents were acutely aware of cultural norms and an innate biological desire to reproduce. This study illuminates the difficulties and joys of reaching motherhood for infertile women who are successful in their attempt to make the transition, describes the ongoing optimism of the wannabe mothers, and details the difficult transformation some women experience in finalizing their decision to be childfree.

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PROLOGUE

Rachel knew she was going to have problems getting pregnant because her periods had never been regular. She didn't know much about her reproductive system and certainly had never heard the word anovulatory, but she had a feeling it wasn't going to be easy to get pregnant. Rachel and Eric had been married a year when they started thinking about having a family. Rachel was seeing her regular obstetrician then and continued to see her for almost another year. "I'll never speak to her again. Infertility was so beyond her and she wouldn't take it seriously. The first gynecologist you see usually doesn't take infertility seriously; it's just not what they practice. They see women of all ages and deal more with menopause related issues than infertility."

Rachel and Eric were on a fast-track to get pregnant. Unlike most couples, Eric had excellent health insurance that would cover most infertility treatments. Rachel sought out an infertility specialist (a reproductive endocrinologist) after her disappointing experiences with her first gynecologist. Diagnostic tests showed that Rachel was not ovulating and Eric had a low sperm count. The reproductive endocrinologist was certain, however, that he could "fix" their problems. Rachel was single-minded in her quest for a child, "I didn't care what I had to do to get pregnant. I thought if this is going to get me pregnant, I'll do it; I'll do anything. I was like a dog with a bone. I was really naive."

After a couple of treatments, Rachel did get pregnant, but then miscarried a week after a positive pregnancy test. About eight months and several treatments later, Rachel got pregnant again. Immediately something didn't seem right to her; it turned out it was a tubal (ectopic) pregnancy. Unfortunately her doctor had to remove a part of her left Fallopian tube, which would

make getting pregnant even more difficult.

Eric didn't seem to know what to do, what to say, or how to react. One day after Rachel had just found out yet another infertility treatment had failed, she decided to trim her azaleas. Eric came out and saw that they were very uneven, but only days later he admitted to her that he had thought at the time, "I'm not going to say anything to her, not while she has the shears." Another time Rachel was so depressed over a failed in vitro fertilization procedure that she went to Saks Fifth Avenue and bought $500 worth of clothes. Then she took them all back.

Rachel returned to the same reproductive endocrinologist after the ectopic pregnancy and tubal surgery. She had another in vitro fertilization (IVF) procedure in February and delivered a son (prematurely) in September. But Rachel didn't stop there; a year and a half later she was ready to try again. She and Eric had a couple of embryos frozen from the IVF procedure so she had them transferred. She described the procedure so casually: "That was really easy, all you have to do is take a couple of pills, and then you show up one day and they put the embryos in. It's literally nothing." But the procedure didn't work. Rachel and Eric tried another intrauterine insemination in May. Rachel got pregnant, again, but it was another ectopic pregnancy requiring surgery, again. In September she tried another IVF procedure and got pregnant with twins: one was an ectopic pregnancy and one had implanted in her uterus. She had surgery, again, and lost the twins. Some people might have stopped there, but Rachel had one more IVF opportunity that her insurance would pay for. As it turned out, she had the egg retrieval on a Sunday in February, the exact date she had her retrieval for her son, three years earlier. Her embryo transfer was on a Wednesday in February, again the same date as her son three years prior. And as luck would have it, after six lost pregnancies, Rachel delivered a healthy baby girl the following November.

INTRODUCTION

The transition to motherhood may come too early for some young teenagers; it may come after education is completed for other women; it may come after marriage for some; but for other women, the transition to motherhood may not come at all. Given the advent of modern contraceptives and reproductive technologies, in combination with the legalization of abortion, we assume that the transition to motherhood involves choice. The Baby Boomers grew up with the notion that "choices about if, when, and how to mother are ours to make"(Rothman 2000: 189). But clearly there are forces outside of our control: "Social actors must respond to the constraints of their circumstances and choose from among the options it provides. Meaningful choice thus depends on our being able to distinguish between what is beyond human control and what is subject to human intervention" (Gerson 2000:180). For women who have difficulty conceiving a child, the transition to motherhood becomes a holy grail: desperately sought but not within reach. For some women, it is not only their biology, but technology that also fails them.

This paper analyzes the tribulations and motivations of women who seek the transition to motherhood, but who experience infertility as an obstacle in the path to that transition. Although infertility is caused by both male and female factors, in about equal proportion, this paper focuses on women and the transition to motherhood. The number of infertile women is neither a small nor an insignificant group. In 1995 there were 6.2 million women in the United States with impaired fecundity, which was an increase from 4.9 million in 1988 (Chandra and Stephen 1998).

The rates of impaired fecundity in the United States rose between 1988 and 1995 from 8.4% to 10.2% (Chandra and Stephen 1998), due in large part to the large baby boom cohort, many of whom had delayed childbearing until the later and less fecund reproductive years, particularly among the more educated women (Martin 2000).

Among women with current fertility problems, about 42 percent have ever used infertility services, and the vast majority who sought treatment got advice and diagnostic testing (Chandra and Stephen 1998). As of 1995, less than 2 percent of women with current fertility problems used assisted reproductive technologies such as in vitro fertilization (Stephen and Chandra 2000), which average $12,400 for one cycle of treatment (American Society of Reproductive Medicine 2004). The success rates vary by age of the woman and procedure used, but in 2001, just under a third (32.8%) of in vitro cycles using fresh non-donor eggs or embryos resulted in a clinical pregnancy. Of those clinical pregnancies, 82.2% resulted in a live birth, which can be subdivided into 53.1% singleton births and 29.1% multiple births (Centers for Disease Control and American Society for Reproductive Medicine 2003).

This paper examines the motivations and decision-making processes of women who seek medical treatment for infertility and/or go through the adoption process, in order to make the transition to motherhood. Data from focus groups and individual interviews are utilized to add to our knowledge about family formation for women who are infertile. Narrative, as described by Becker (1997), are the stories that people tell about themselves that reflect their experience, represent action, and give them agency. The narratives presented here are reconstructions of how these infertile women overcame obstacles in their pursuit of becoming a mother.

For an analysis of transition to motherhood, it is beneficial to disaggregate infertile women by their reproductive outcome: biological mothers, adoptive mothers, wannabe mothers, and childfree women. For each group, their motives and obstacles in achieving their childbearing goals are presented. All the women started in the same place: seeking a healthy, biological child. From there the paths of each group diverged, although all the women in this analysis sought at least some form of infertility treatment as one step in the process.

There are choices other than medical treatments available to women who experience infertility. Although adoption is another option for family formation for infertile women, it is not widely prevalent in the United States. In 1995, 1.3 percent of ever-married women aged 18-44 had ever adopted a child (Chandra et al. 1999). Part of the reason for the low number of adoptions is the decrease in the number of children available in the United States for adoption. Between 1989 and 1995, about 1 percent of children born to never-married mothers were given up for adoption (Chandra et al. 1999). International adoption offers an avenue for some potential parents. Adoptions of children from other countries increased from 8,102 in 1989 to 20,099 in 2002 (United States State Department 2003). The total number of children adopted each year--domestic and international--remains a very small number as compared with the total number of children born in the United States (4.0 million in 2002) (Martin et al. 2003). In addition to the limited number of children available for adoption, it may be out of reach financially for some couples. The cost for an adoption ranges from $0-$30,000 depending on whether the adoption is from a public or private agency, domestic or international (Adoption Family Center 2004).

Part of the motivation to seek infertility treatment and/or to pursue adoption is that parenthood, and in particular, motherhood, is idealized in American culture to a nearly universal

level (Glenn 1994). In seeking the source of the societal origins of this phenomenon, Chodorow (1978) argues that identity formations occur as a natural process through young girls' attachment and identification with their mother (Glenn 1994). Although Coontz (1992) has effectively shown that the homemaker/mother of the 1950s in the United States was a new invention that did not necessarily lead to idyllic lives as some would like us to believe, mothers are still idealized for their nurturing skills. Even a woman who is fulfilled in other areas of her life may find that being a mother is a critical component of her personal identity (Cooper and Glazer 1994). The vast majority of American women want to have children; recent data show that American women aged 15-44 expect to have on average 2.2 children (Abma et al. 1997).

Although some feminist writers have dismissed or diminished the biological component of motherhood (Chodorow 1978), Silver argues that (1997, p. 71): "For the vast majority of people, though, the desire to have children is so powerful that is outshines everything else they might possibly want to do during their lives."

In conjunction with the innate biological drive to procreate, there is a societal emphasis on the biological clock, which is evident in popular literature and the media (Faludi 1991). This message provides a strong motivation among women in their thirties to seek medical treatment for infertility before it is too late for them to conceive. Women in their later reproductive years (aged 35-45) feel they are racing against their biological clocks with the knowledge that they only have a limited number of years to conceive a biological child.

The desire for children in industrial countries is complex, but as described above, reproductive intentions are influenced by a mix of biological (Foster 2000; Udry 1996), economic (Friedman, Hechter, and Kanazawa 1994), and social factors (Schoen et al.1997) that are

mediated by ideology (Rovi 1994). Rindfuss and Brewster (1996) argue that very little data exist on the origins and nature of childbearing motives in economically developed countries, but we do know that at the individual level, fertility intentions tend to be poor predictors of performance (Hendershot and Placek 1981; Toulemon 1996).

This paper does not attempt to disentangle the biological, psychological, and social factors that influence reproductive intentions. Rather, the current analysis utilizes the voices of infertile women to address the dynamic processes associated with the transition to motherhood for women who have positive reproductive intentions, but (at least temporarily) negative outcomes. Because the paths to motherhood vary for the infertile, this analysis differentiates among four separate groups of women: biological mothers, adoptive mothers, wannabe mothers, and childfree women.

DATA AND METHODS

Data for this paper are from a series of four focus groups and four personal interviews conducted between October 1995 and March 1996. The criteria for inclusion was a self-report of having experienced infertility currently or at some point in the woman's reproductive life. Prior research by Greil (1991) has shown the value of in-depth interviews of infertile couples. The focus group sessions were quite lively; in all cases the women were very forthright and drew out other focus groups members. Four individual interviews were conducted with individuals who could not attend a focus group for scheduling or personal reasons. Institutional review board approval was given for the study.

In a similar fashion to Greil (1991), data were collected using relatively open-ended questions. Prior to the focus groups a "road map" of questions to be asked was prepared by the

investigator and the identical set of questions was used in each focus group. The dynamics of each focus group led to a slightly different ordering of the questions; some of the questions were not fully explored and others were added in each session.

Some ground rules were given at the beginning: no question had to be answered as the topics were very sensitive; one person spoke at a time; the moderator (myself) did not interject other than to direct questions to various members of the focus group. The respondents all agreed to be interviewed and taped. The tapes were then transcribed verbatim. The focus groups lasted on average two hours and on average had four members. The focus groups were conducted in neutral settings. One took place in a small town in a Western state; the others took place in the Washington, D.C. area.

The members of the focus groups were recruited through a variety of ways. A request for volunteers ran in a university faculty/staff newsletter, fliers were placed in gynecologists' offices, and snowball sampling techniques were used to identify friends and acquaintances who had experienced infertility. In addition, a notice requesting volunteers was put in a newsletter of a local RESOLVE chapter. (RESOLVE, Inc. is a national advocacy and support group for persons with infertility. Local chapters of RESOLVE sponsor support groups on a variety of infertility-related topics and hold regular educational meetings.)

The average age of the women in the focus groups was 40 years. Two women had experienced infertility as much as twenty years prior; 12 other women were still undergoing medical treatment; six women had recently completed their families through adoption, having a biological child, or deciding to be childfree. The mean number of years since treatment had started was seven. One woman was African American; all other women were white. There was

no attempt to have the women be a representative sample of infertile women. It is well-established that women seeking treatment for infertility are not representative of all women with infertility; they are more likely to be white, well-educated, and have a higher income (Chandra and Stephen, 1998). The women in the focus groups were much more representative of women seeking treatment than of the entire infertile population.

Of the 20 women interviewed, 11 women had children at the time of the interview for a total of 14 children. Nine were biological children and five were adopted. Two of the women had two biological children; one woman had adopted twins. Of the biological children, four were conceived naturally; three were born from an in vitro fertilization (IVF) procedure; one from an intrauterine insemination procedure; and one from an egg donation.

There are a number of medical treatments that are mentioned in this paper. In the broadest sense assisted reproductive technologies include all medical treatments or procedures that involve human eggs and/or sperm for the purpose of establishing a pregnancy. Intrauterine insemination involves a transfer of a large number of washed, concentrated motile sperm into the female reproductive tract, usually the uterus. With an in vitro fertilization (IVF) procedure eggs are removed from a woman's ovaries and are fertilized in the laboratory. Resulting embryos are then transferred into the woman's uterus through the cervix. An egg (oocyte) donation is similar to a standard IVF procedure, except that another woman donates eggs to the couple, which are then fertilized and transferred to a woman who is unable to conceive with her own eggs (Centers for Disease Control and American Society for Reproductive Medicine 2003).

Since the time of the interviews, one woman became pregnant naturally and had a baby boy, another woman had twin girls as a result of an IVF procedure, and a third couple has adopted two children from Russia in two separate adoptions.

All of the respondents and their husbands have been given pseudonyms. All of the quotes are direct quotes. Each respondent is a real person; no composites are used in this study.

FINDINGS

Biological Mothers

All of the women interviewed remembered the infertility process as a long and difficult journey, even those women who successfully became parents. Naomi, infertile 20 years prior to the interview, could still recall each painful experience as if had happened yesterday. Naomi achieved many successes in her life including completing a Ph.D. and having two daughters, but her infertility remained a central issue in her life and she still identified herself as being infertile.

For Naomi, infertility brought to the forefront some difficult decisions regarding race and class. After a painful miscarriage, she and her husband considered adoption. This was during the 1970s and her husband's openness reflected the time period: "He was perfectly willing to adopt a purple child, an orange child, an upside down child, any child, and that's when I realized I didn't want to do that. I remember telling him, and I said I'm so ashamed of myself, maybe I'm a racist, but I just want my child. I just don't know if I can deal with what would be involved in raising a child of another race or a bi-racial child. That was a very difficult thing for me--to admit it. And to say it. If forced me to look at myself in a very unique way, in a way that a lot of people for whom a lot of things, including reproduction, very easily never had to do."

Nancy did not exhibit Naomi's level of self-reflection and, in fact, was the most vocal respondent in expressing her intense struggle to have a child. Rothman's concern (2000) about the commodification of children could be embodied in Nancy's narrative. Nancy had been through it all: failed intrauterine insemination attempts, failed in vitro fertilization attempts, and even an adoption that fell through after the child had been placed with her and her husband. She was bitter and angry about the entire process, but she knew she could never go childfree. The years of medical treatments had left the couple without any money to pursue another treatment cycle using a donor egg, but Nancy was not about to let money limit her quest to have a child. Eventually they decided to borrow money from her husband's mother. Nancy's desire to have a child was so strong that even the lack of money would not stop her. She said, "I would turn tricks to get the money if I had to." Fortunately she got pregnant via the donor egg procedure that her mother-in-law had financed, and Nancy didn't have to resort to more drastic means to raise funds.

For the women who had achieved biological motherhood, most of them desperately sought a second child. Naomi reflected, "I remember thinking a lot about how I didn't want an only child. You get so selfish, first you want a child and then you've got one and you want two. I have one sister and we have always been best friends, and I wanted so desperately for my daughter to have that same opportunity. It seemed so strange that after I had one child I thought I would be satisfied, but I wasn't." Fortunately Naomi did conceive again, and her second child was a daughter as well. She felt she had given her older daughter a best friend.

For Leah, the desire for a second child came from yet another source--her son. Leah had a very difficult time conceiving but was finally successful using with an intrauterine insemination

technique. After all of that, at 13 weeks of pregnancy her cervix began to soften so her doctor put her on bed rest for the rest of her pregnancy. It was a difficult time for Leah as she attempted to work from home and prepare for the birth of her child, but she was able to have a healthy son, Damon. Three years later he started pre-school and Damon began telling Leah he wanted a baby brother or sister. "My son wants what every other kid wants, right? He wants another fire truck, he wants a baby sister. I don't know what we are going to say to him." Every time Leah took Damon to school she got all choked up. It seemed to her that all the other moms were carrying their new babies in their arms or they were pregnant. So far Leah had not been able to conceive a second child. Money was tight and she wondered whether she should pay for Damon's preschool or use that money for another intrauterine insemination to try to conceive a second child.

As an African American woman Leah was the one respondent who most clearly understood the race, class, and age-related constraints of infertility and medical treatments:

> *I really think the media portrayal of infertility is wrong. African Americans are at a higher incidence of infertility and you never get that from the media. You don't get decent health care. The doctor said to me, "If you weren't the person you are, and you didn't have health insurance, you'd never have gotten the care." For me being African American, all you see is the pregnant teenagers. Once I started talking about my own infertility I was amazed at how many of my friends suffered from it, too. Biologically the best time to have a child is in your early twenties, but most people don't have the economic means to support a child, you don't have a life partner then, and they don't want you to be an unwed mother, so what are your options? If I had only known.*

Adoptive Mothers

The women who eventually adopted children didn't choose that option initially. They all attempted to have a biological child first, and for some, the decision to adopt was a process involving many steps or stages that transpired over many years. Their decisions to adopt were agonizing and required deep introspection, as a mutual decision between them and their husbands. After arriving at the decision to adopt, other difficult decisions had to be made: would it be an international or domestic adoption; how old a child did they want; what race or ethnicity did they prefer?

The decisions first required closure with infertility treatment. Martha had been through cycle after cycle of infertility treatment, but desperately wanted to be a parent. Someone in her local RESOLVE chapter told her to write a letter to her unborn child. Martha spent two hours writing this letter, sobbing the whole time. But it was a catharsis that helped her through the grieving process. Her husband, Frank, never grieved, at least not openly, but he quickly agreed to proceed with an adoption. Although Martha was still very emotional during the interview, she shared her letter to her unborn child with the focus group. The following selection addressed her attempts to bring closure to having a biological child:

> *Now the time has come to say STOP and move on with our lives. Stop the treatments, with their accompanying physical and emotional pain, stop the inability to have control over our becoming parents, stop the monthly disappointment, and focus on what's most important: creating a family. And so, we are moving ahead with our efforts to bring children into our family through adoption. And now that we've been thinking about it for*

so long, it hurts a lot less to know that you will never be with us, because we know that we will have a family.

There will always be a little part of me that aches for the loss of the chance to have you be a part of our lives. But when I feel that pain, I know that I will be able to look at my child and say, "I wouldn't have had it any other way, because if I had given birth to a child, I wouldn't have had you."

After the letter writing, came the educational process of adoption for Martha and Frank: classes put on by adoption agencies, extensive research, and the home study. Martha and Frank were very proactive in finding a birth mother. They sent out mass mailings to everyone in Martha's choir, everyone in their law firms, everyone on their Christmas lists. Eventually it was their local adoption agency that found them a birth mother who delivered twin boys. At long last Martha and Frank were finally parents.

Sarah's narrative was more compressed than Martha's. After Sarah had been through an ectopic pregnancy and had to have a Fallopian tube removed, she decided immediately to look into adoption. She was 37; her husband, Dan, was 45. Sarah and Dan moved quickly to the option of adopting because they were concerned they would not be able to adopt a child if agencies considered Dan "too old." They attended an international adoption session with an agency that promoted an adoption program in India. After seeing pictures of a little Indian girl with her American parents, Sarah and Dan were smitten. The adoption wasn't easy, though, and it wasn't quick. After nearly two years, Sarah flew to India to bring home Cynthia. Once in India, all went smoothly and Sarah returned home in a few days with two-year old Cynthia.

Even after Sarah made the transition to motherhood, she still expressed remorse that she wasn't able to have a biological child. "I still missed out on pregnancy. We went to a play group and the women would be trading pregnancy stories. They wouldn't even think about it when it is perfectly obvious that my child is adopted. They didn't think. I would have to get up and leave." Although Sarah was by all standards a nurturing mother, she still saw herself as marginalized and not a biological mother.

Age was also a critical factor in the adoption process for Eunice and Roy. They had attempted to overcome Roy's infertility through two surgeries, but after a few years they called it quits. They chose not to use donor sperm for a variety of reasons. But by then Eunice was 38 and Roy was 41. Several adoption agencies, including the one affiliated with their church, turned them down for an adoption. They found one agency that guaranteed a child, but it cost $35,000, which was not economically feasible for them.

Roy and Eunice had given up on adoption when an aunt of Eunice's called with news of an acquaintance who had just found out she was pregnant, but had children in their teens, and felt she just couldn't take on another child. Eunice and Roy quickly consulted lawyers in their state and in the aunt's state. When Brian was born four months later, Eunice and Roy spent two weeks with Eunice's aunt while the parental rights were terminated. Then Eunice experienced a new challenge. Both she and Roy worked full-time in very demanding positions, and it wasn't at all clear what kinds of family leave they would be allowed to take. For awhile they alternated taking days off at work, then Roy's parents came and stayed with them for three months to take care of their new grandchild. In spite of the logistical difficulties, Eunice and Roy delighted in the addition of Brian to their family and easily made the transition to parenthood.

The Wannabe Mothers

Not all women in this study had made the transition to motherhood, but the women who were still in the process of trying to become mothers offered a great deal of insight into the process. The wannabe mothers were homogenous in the extreme desire to become a mother, but the women were heterogenous in almost every other way. The first group was women had just started treatment and still had high hopes; the second group had experienced failed in vitro attempts but were still hopeful; the third group consisted of respondents who were at the end of their treatment and about to make the decision to adopt or to be childfree. In the quotes that follow, it is apparent that optimism for being a biological parent fades with the length of treatment, but for some women it is replaced with optimism that an adoption will occur.

Claire was representative of the first group of women just starting treatment. She was 32 and had first confronted difficulties conceiving a child a year and a half earlier. She and her husband, Sam, had gone through tests and evaluations, and she was just starting with the low end of treatments. Claire was starting to see the world of women around her a bit differently: "I look at couples with twins and wonder if they went through infertility treatment. I notice babies more; I notice pregnant women more. There are days I tell my husband I saw five pregnant women today. It's hard. We had sort of a baby boom among our friends. I really am happy for them, it's just hard for me to express that I'm happy for them." But Claire expressed her optimism, "We really feel like we're in control of this process. Maybe it's because we haven't gone very far down the road. We're just starting this [infertility treatment] and we really hope it doesn't come to IVF. I don't think there's any reason for us to give up hope."

At the time of the interview Ellen had not conceived a child and she was still uncertain about her future. She was in the middle group of having had failed treatments, but was still extremely hopeful. Ellen was conflicted about her desire to be a biological mother, balanced with her overall goal of having a child. She highlighted what several respondents had expressed in other interviews: "I think infertility is a long journey. We know we'll only do a couple of IVF cycles; we're clear on that. We've talked about adoption. My husband is extremely supportive of adoption, even more than I am. I really want to experience pregnancy. I'm still at that point; at this time I want to do anything I can to achieve a pregnancy. You can never close that door."

Karen was in the same focus group as Ellen and was about at the same stage of disappointment with treatments to date, but was more proactively seeking an adoption. She was very strong in her desire to be a mother. Early in the interview she described her decision to adopt: "I thought I didn't want to adopt, but we decided that we really wanted to be parents. We saw no way we were going to conceive because we had three things wrong with our reproductive systems. It [infertility treatment] was closing one door and [adoption was] opening another. It was not difficult to make that decision. I had such a negative experience [with infertility treatment], it wasn't hard to close the door." But later in the interview, her statements reflected some regret in not being a biological mother. Karen admitted: "I'm a big clothes horse and I stopped shopping for clothes when we started trying to get pregnant because what I wanted to do was have this marvelous maternity wardrobe and not feel any guilt about it. But then I didn't shop for clothes for two years and that turned out to be punishment that I couldn't shop for clothes. Finally I decided to buy some clothes. I was looking in the mirror at my teeth and

wondering if my kids will have my teeth. Then I realized no, they won't. These are some of the losses."

Catherine was in the last group of wannabe mothers. She was a successful writer with a very emotionally supportive husband. At the time of the interview she was just completing what she had determined would be her last cycle of treatment based on her physical limits and their financial resources. Catherine had always thought children would give her life a sense of completion. When she realized that she might never have children, she wondered what would give her life greater meaning. "Infertility has made me realize that my career does not mean that much to me. I enjoy my work, but is that all there is...making money? If I don't have a child I need to find some social cause or become a foster parent--something that will give my life meaning."

Catherine also reflected on her immortality and the loss of a grandchild for her mother who was 78 at that time. "I wanted to have somebody else to love and to create a new person. It made me think about when my mother dies I won't have a child to replace her. It has made me afraid of growing old alone. I am afraid of the future now. It has made me think about loneliness and aging. When I die, I want to know that somebody who maybe looks a little like me or who will be like me will connect some of my life with theirs."

Like Catherine, Mary still had not completed grieving or accepting that she wouldn't have a child. "I feel like I shouldn't still be grieving, but I am. I understand it takes time. I just can't believe it's not going to happen. I wanted to be pregnant, breast feed, and everything. You know, I never wanted to know this much about all of this [reproduction]. I never wanted to be so educated about this. Talk about taking away all the spontaneity. It's such a bizarre way to live."

The Childfree

Elise was the only respondent who had made the definitive decision to be childfree. Although several respondents were on the cusp of making the decision, Elise was the only one who stated she knew she would never be a mother. In her late thirties, Elise was finally at peace with her decision to remain childfree. Elise's only remorse was that she had gotten pregnant before she and Jack married, but felt they were not ready to take on parenthood at that point in their lives. Together they made the mutual decision to terminate that pregnancy. Soon after they married, they started trying to get pregnant. Elise had four miscarriages over 18 months, but no doctor could determine the cause for the miscarriages. They had a minimal health insurance policy and no resources to pay for an in vitro procedure.

Elise also knew she wanted a child only if it was her genetic child. "It was clear to me that I only wanted MY CHILD. I was only willing to make those sacrifices and changes to my marriage and changes to my life if it was my child. I decided it was healthier to admit that. But at some levels it was a grieving process when it became very apparent that our biology had failed us."

They decided together to remain childfree after realizing that so much of their life together was focused on their infertility that it was overwhelming all other aspects of their life together. "Infertility was everything we talked about, it was always on our minds, it was the sub-text of everything we were doing and that has an effect."

Matthews and Matthews (1986) proposed a framework emphasizing the social processes that involuntarily childless couples must go, which included: reconstructing reality, transforming identities, and making role adjustments. Of all the respondents, Elise was the one who most

closely followed the process described by Mathews and Mathews. Moving through this grief process of infertility was accentuated by the death of her sister who died in her early twenties, just after Elise experienced the miscarriages. Her grief compounded, Elise stated, "It is useful to know that you can't just decide everything about your life. Life doesn't always go along with you."

Jack and Elise lived in Atlanta and were self-employed in a business from the time they married up through the time Elise's sister died. Soon after the death of her sister, Elise was offered a job in Washington, D.C. After much reflection she accepted the position and moved to Washington. Through her new job, and with the support of a new network of friends, she created a new identity for herself.

Elise was very fortunate that her marriage survived not only infertility, but also a commuter marriage. Jack had to stay in Atlanta to run their business, but they decided that it was in the couple's best interest-- as well as Elise's --to take the position in Washington. The couple spoke on the phone daily and saw each other two weekends a month. Elise insisted that their marital relationship was strengthened by infertility, and could now withstand living apart for a few years.

Elise acknowledged that there might always be lingering doubts in her mind about their decision not to adopt, but for now, she was eager to close out that chapter and focus positive energy into her marriage and her career. The decision to be childfree left her without the role incompatibility experienced by Eunice, and without the strain on resources experienced by others who pursued multiple rounds of IVF and/or adoption.

DISCUSSION AND CONCLUSIONS

The current analysis extends Greil's (1991) research on infertile women by disaggregating infertile women by reproductive outcome. This allows us to illustrate the diversity and commonality of the experiences of infertile women as they seek to become mothers.

While the women interviewed had varied physical characteristics and different personality traits, all of them shared one thing in common: tenacity. These women were resourceful, persistent, and driven to achieve their goal of having a child. After suffering an initial set back of finding out that they (or their husband) had an infertility diagnosis, these women all initially embraced modern medical technology to assist them in bringing home a baby.

The mothers who did have a biological child shared a positive attitude toward the medical profession, even those who eventually conceived their child naturally. The women who had one biological child and wanted a second child were the most favorable toward assisted reproductive technologies and still held high hopes that they would conceive a child. All of the women related that the infertility treatments and diagnostic tests were painful, invasive, and, at times, humiliating. For the most part, though, the women felt they had been treated fairly and in a dignified manner by the reproductive endocrinologists, who were sincere in helping them achieve their family-building goals.

The respondents did not hold this same positive attitude toward insurance companies. Even the families who had health insurance that included infertility treatment were frustrated in the limited coverage and the red tape they had to go through to get reimbursed. For the families without health insurance or those whose policies didn't cover infertility, there was anger, outrage, and empty bank accounts. One respondent was a physician herself and was able to get medical

care through professional courtesy, while one respondent was able to get infertility treatment at a naval hospital since her husband was in the armed services. But as difficult and painful as all the infertility treatments were, all of the respondents vocalized a sentiment that it was the treatment by their insurance companies that was most degrading and lacking of compassion.

All of the women relied on a variety of informal support systems through the attempted transitions to parenthood. The marriages of these women not only survived this ordeal, but for many, it was strengthened. Extended family gave many of the respondents emotional–and often financial--support. For some women, their parents and siblings were incredibly supportive. Other women chose not to share their personal trials and tribulations with their families, or the families actually made the situation more difficult for the respondents. Some women sought out support groups such as RESOLVE, but others found that their issues and concerns were too private to be shared outside their familial and social circles.

The women who went on to adopt a child all had to bring closure to their medical treatment first, but not all the women had completed that stage. Given the current availability of medical options and a large choice of infertility clinics in the Washington, D.C. area, it was very difficult for the respondents residing in that metropolitan area to decide to stop treatment. They were tempted to continue treatment because there was always one more new treatment on the horizon, or a different clinic with high success rates. Grieving was a necessary stage for the women before they could move on to adoption, but the grieving period varied tremendously in length for individual women. Some women still didn't know which avenue to pursue and were pursuing an adoption while continuing medical treatment. They kept hearing stories of the

mythological woman who adopted a child and miraculously found out she was pregnant the next month.

The adoptive mothers were thrilled to have children, and for all of them, they could not imagine life without that child or children. There was some level of regret among many of the respondents, such as not being able to breast feed or go through pregnancy, but those regrets faded over time as the children grew and adoptive mothers were confronted with fewer mothers of playmates who were pregnant or nursing.

More research needs to be done to determine the similarities between those who choose to be childfree and women who are voluntarily childless. Some childfree, infertile women may be "postponers" (Rovi 1994) who were ambiguous about the their reproductive intentions or the timing of having children during their earlier reproductive years. Those women may be similar to voluntarily childless women who were also uncertain about their reproductive intentions at some point in their reproductive life, but eventually choose not to have any children.

But some infertile childfree women had positive intentions throughout their reproductive lifetime and only chose to be childfree when they knew their emotional and/or fiscal resources were strained to the point of no return. These women had positive reproductive intentions when they started the journey toward motherhood, but along the way they accepted a negative outcome. There was still regret among these women that they would never have a child, but they were able to balance that regret with the knowledge that they had tried to become a mother and that it was time to move on.

Interestingly only Eunice spoke of the incompatibility between mother and worker roles as has been described by Rindfuss and colleagues (Rindfuss and Brewster 1996; Rindfuss, Brewster,

and Kavee 1996). This may have been because the questions asked of the focus group members emphasized the time period between the infertility "diagnosis" and the point when a child joined the family or the couple decided to not have children. As might be expected, the respondents fell into a variety of categories for employment status at the time of the interview. The majority of the respondents who had young children at home had quit their jobs and had not resumed working outside the home. For instance, Martha had been a successful attorney, but was quite content at the time of the interview to be at home with her adopted twins. Naomi, who had experienced infertility 20 years earlier, stayed at home with her daughters when they were young. After the girls started elementary school, Naomi completed her Ph.D. and secured a faculty position at the university where her husband was on the medical faculty. If the mothers with young children in this study could be reinterviewed in 20 years, several of them may follow Naomi's pattern of re-joining the work force (full or part-time) once their children get into school.

It would also be interesting to determine if infertile women who go through so much to become mothers are more likely than the general population to stay at home with young children. The infertile women may be older, may have fulfilled (early) career aspirations, and may have resolved role incompatibility earlier in their lives. That is, the infertile women may have decided at the time of starting infertility treatment and/or the adoption process that they were privileging the mother role in their desire to go forward with treatment/adoption. Thus, after overcoming the odds to become a parent, they were less ambiguous about their roles and less likely to experience role incompatibility as women in the general population.

Another possibility to explain the lack of reported role incompatibility is that infertile women who seek treatment and/or adoption are predominantly upper-income women who have

the economic means to be at home with their young children or to have full-time help to care for their children if they do return to work outside the home.[1] Rachel--whom we met in the prologue--had a nanny at home for her two children. She resumed working full-time soon after the birth of her first child, continued working through all of her subsequent surgeries and infertility treatments, and then returned to work soon after the birth of her second child. She was busy, but did not speak of any conflict between her mother and working roles.

The infertility treatments altered the daily lives of the women, and especially affected their relationships with their husbands. Andrews, Abbey, and Halman (1991) found that fertility problems increased marital conflict, with stronger effects for wives than husbands. There was no question that infertility had been very stressful for women interviewed here, and that it had an effect on their marriages. One respondent spoke of the marital tension: "His way of relating was of ignoring it [infertility] and not talking about it, and my way was to talk all the time so we were butting against each other. How could I talk all the time and he not hear it?"

For some women, though, the experience of going through infertility treatment strengthened their marriage. Greil (1991) described this as a result of the shared experience of infertility, when two people experience a crisis and interact intimately with one another. One woman noted that in her short marriage she and her husband had been through more than other people who have been married 20 years go through. Another respondent stated that once they were through the infertility treatments they were much closer and more intimate, as though they'd been through a war together.

The respondents in this study echoed Greil's finding (1991) that infertility resonated more for women than for men. Alana, a "wannabe mother," described some of the physical and

emotional strains of infertility: "Carl never would know how to react, but he'd be Pollyana-ish about it. He would be totally oblivious to when my period was supposed to start and here I'd been through living through all of this. He still smokes. I told him once I was pregnant no smoking in the house. I'd think here I am giving up this or that and he wasn't making any sacrifices. I found him not reacting and not being supportive like I would want him to be. When my period would come, I'd tell him to say 'Sorry Alana' and leave it at that. I told him not to be Pollyana-ish."

Several respondent credited RESOLVE for assisting in communication between spouses, and others had sought counseling. One person confessed, "I don't know how you can go through anything like this and not be changed, whether it is positively or negatively or whatever. It has had both positive and negative effects on our marriage. We go to a counselor and it's a good thing for our marriage. We love her. I think infertility can really hurt your marriage or bring you closer together. We understand each other in a different way; we appreciate each other's needs."

The women who had completed their family building–either with biological or adopted children--and those women who had chosen to be childfree were the ones who could see that their marriages had been strengthened by the process. It was the "wannabe mothers" who reported the most marital strain related to the treatment and/or adoption process. They were very specific in pinpointing the sources of disagreement. Alana was very open to adoption, while her husband was not; he wanted to have a biological child or none at all.[2] Leah had gone by herself to RESOLVE meetings that included men and women. The men there helped her understand her husband's reactions to the entire process better, even though he refused to go to the meetings with her. Leah and her husband's marriage reached an equilibrium after the birth of Damon, but

now they were experiencing marital discord again because Leah wanted to have a second child and her husband didn't even want to try for a second child.

The one common theme among all the respondents was that infertility had become the central issue in their lives. While the women might use any number of adjectives to describe themselves--short/tall; skinny/fat/; blonde/brunette–the one word that they identified with as infertile. Even women who had completed their family-building goals, still saw themselves as infertile. The experience for these women was so deeply personal, lasted for such a prolonged period of time, and was such an affront to their biological desire to procreate, that they were never able to successfully put it behind them. While some regrets faded over time for the two women who had experienced infertility 20 years earlier and had both become mothers–one with biological children and one with an adopted child--infertility resonated with them so deeply that they both cried during the group sessions recalling the pain they went through to become mothers.

The introspection that all of these women had to face during the transition to motherhood was difficult. However, there were unexpected and beneficial side effects to that introspection: it made the respondents question their values and assist in making them more thoughtful parents. When Claire saw a frustrated mother hit her child in a grocery store, she thought: "I could never hit a child like that. My child is a gift."

ENDNOTES

[1]The infertile women in this analysis are not representative of women with infertility (Chandra and Stephen, 1998) but are more representative of a select group of infertile women who seek treatment who are older, non-Hispanic white, and have a high income (Stephen and Chandra 2000).

[2] Eventually Alana won him over and they adopted two Russian daughters who are adored by both parents.

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