

**Women's experience of pregnancy and
early motherhood following repeated
IVF treatment: A phenomenological
study**

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Table of Contents

CHAPTER ONE	1
ORIENTATION TO THE STUDY.....	1
<i>The research question, aim of the study and philosophical underpinnings.....</i>	<i>1</i>
<i>Justification for my study.....</i>	<i>3</i>
<i>Verve for commencing this study.....</i>	<i>4</i>
Professionally.....	4
Personally.....	5
<i>Presuppositions as a researcher.....</i>	<i>6</i>
<i>The physical experience of IVF.....</i>	<i>9</i>
<i>Structure of this thesis.....</i>	<i>11</i>
This thesis comprises of 10 chapters.....	11
CHAPTER TWO	14
CONTEXTUALISATION OF INFERTILITY AND MOTHERHOOD.....	14
‘Being a woman’.....	14
<i>Socio-cultural construct of infertility.....</i>	<i>18</i>
Issues for Māori.....	19
<i>The necessity for assisted reproductive technology.....</i>	<i>21</i>
<i>Theoretical perspective on ARTs.....</i>	<i>22</i>
<i>History and complexity of Infertility treatment in New Zealand.....</i>	<i>23</i>
History and funding of fertility treatment.....	23
Accessing infertility treatment.....	25
Relevant legislation	26
Socioeconomic cost of infertility treatment	28
<i>Conclusion.....</i>	<i>30</i>
CHAPTER THREE	31
WIDENING HORIZONS THROUGH LITERATURE	31
<i>Introduction.....</i>	<i>31</i>
<i>Turning to the literature</i>	<i>32</i>
<i>Experience of infertility</i>	<i>33</i>
Psychological support via the Internet.....	34
Moral dilemmas – gamete donation/embryo storage	35
IVF failure	38
<i>IVF pregnancies</i>	<i>39</i>
Maternal outcomes.....	40
Perinatal outcomes.....	42
Experience of pregnancy.....	43
Becoming attached to the baby.....	46

<i>Qualitative New Zealand research and IVF</i>	48
<i>Maternity care in New Zealand</i>	50
<i>Conclusion</i>	51
CHAPTER FOUR	53
PHILOSOPHICAL FOUNDATIONS	53
<i>History of phenomenology</i>	54
Heideggerian hermeneutic phenomenology.....	55
Heidegger's involvement with the National Socialist Party.....	56
<i>Philosophical Notions</i>	59
The Question of Being.....	59
Worlds	61
Thrownness (Belonging)	63
Moods.....	64
Time	65
Ready-to-hand.....	65
Present-to-hand.....	66
Comportment.....	67
<i>Conclusion</i>	67
CHAPTER FIVE	68
METHODS.....	68
<i>Ethics</i>	68
<i>Participants</i>	70
<i>Phenomenological interviewing</i>	73
<i>Researcher's reflective journal</i>	76
<i>Crafting Stories from Transcriptions</i>	77
<i>Interpretation of stories</i>	78
<i>Themes</i>	82
<i>Ensuring research strength</i>	83
Trustworthiness (Rigor)	83
Balanced integration.....	84
Openness	85
Concreteness	86
Resonance	87
Actualisation	87
<i>Conclusion</i>	88
CHAPTER SIX	89
PROLOGUE	89
<i>Ellie's story of the past</i>	90
<i>Introduction to the participants</i>	95
<i>Weight of sorrow</i>	98

Conclusion.....	99
CHAPTER SEVEN	101
BECOMING PREGNANT.....	101
<i>Fertility awareness</i>	101
<i>Procreation</i>	104
<i>Belonging</i>	107
<i>Failure</i>	108
<i>Success</i>	115
<i>Conclusion</i>	118
CHAPTER EIGHT.....	119
LIVING WITH DREAD.....	119
<i>Moods</i>	119
<i>Dread</i>	120
<i>Fear</i>	122
<i>Something greater</i>	126
<i>Hope</i>	128
<i>Silence</i>	129
<i>Safety and preparing for baby</i>	131
Beginning to believe	132
<i>Pretending to be 'normal'</i>	134
<i>Conclusion</i>	138
CHAPTER NINE	139
LINGERING DREAD.....	139
<i>The dream becomes reality</i>	139
Birth of the baby, birth of motherhood	139
Birth synonymous with healing.....	142
<i>Matrescence</i>	145
Emotional revelation	145
<i>Fear of the 'what if'</i>	147
<i>Comportment of motherhood</i>	154
<i>Family support</i>	156
<i>Conclusion</i>	159
CHAPTER TEN	160
ARTICULATING MEANING	160
<i>The meaning of the experience</i>	160
<i>Expanding my own horizon</i>	166
<i>Illuminating the findings within the literature</i>	167
<i>Infertility and failings</i>	167

<i>Considerations for practice</i>	169
<i>Considerations for education</i>	173
<i>Considerations for research</i>	175
<i>Being-at-home-in-the-motherless-world</i>	176
<i>Concluding thoughts</i>	177
<i>Closing sanguine quote by Ellie:</i>	179
REFERENCES	180
APPENDICES	206
APPENDIX 1: CLINICAL ASSESSMENT	206
APPENDIX 2: ETHICS APPROVAL	213
APPENDIX 3: AMENDMENT TO ETHICS APPROVAL.....	215
APPENDIX 4: INFORMATION SHEET	216
APPENDIX 5: PARTICIPANT CONSENT	222
APPENDIX 6: COUNSELLING RESOURCE	224
APPENDIX 7: TRANSCRIBER CONTRACT	226
APPENDIX 8: INVITATION TO PARTICIPATE	227
APPENDIX 9: DEMOGRAPHIC INFORMATION.....	229
APPENDIX 10: INTERVIEW PROMPTS	231
APPENDIX 11: EXAMPLE OF WORKING WITH THE DATA	233

Attestation of Authorship

I hereby declare that this submission is my work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Leona Fay Dann (signature)

Date:

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*At the centre of your being you have the answer; you know who you are
and you know what you want*

(Lao Tzu, n.d)

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Abstract

This study explored the phenomena of being pregnant and becoming a mother for the first time following repeated in vitro fertilisation (IVF) treatments (≥ 3). Readings of Martin Heidegger and Hans-Georg Gadamer provided the hermeneutic phenomenology method, a foundation in order to understand the extraordinary experience of pregnancy and motherhood for these New Zealand women.

The seven study participants were all women who had experienced repeated assisted reproductive technologies including IVF. Of the seven women six had experienced pregnancy loss directly related to previous IVF treatments. The pregnancy losses, such as nine miscarriages for one woman and another a stillbirth at 37 weeks gestation, culminated in a sense of chronic grief and sorrow.

During the first interview, between 28-30 weeks gestation, all of the participants spent significant time detailing their infertility experience. This demonstrated that the past had to be understood before the pregnancy experience could be explored. The participants' interviews, of which there were two for each woman, were digitally recorded and narratives of their experience were crafted from the recordings and validated by the women to have captured the unique experience. It is these stories that have uncovered the everyday reality of how it is to finally be pregnant and become a mother after enduring years of emotional and physical pain, compounded by financial burdening of treatment costs. The need to procreate, to belong in the mother-world and the fear of failing are dominant themes that drive the need for repeated treatment, even when required to self-fund. These women have demonstrated tenacity, losing previous pregnancies yet finding the courage to try again, to face another loss but to still try again and eventually to journey through pregnancy and the transition to motherhood.

The findings suggest that these women traverse their pregnancy experiencing a variety of moods. The mood of dread is the overwhelming mood as they endeavour to balance the effect of fear and the flame of hope. The women have become efficient at applying coping mechanisms such as the use of silence, or pretending to be what they perceive to be 'normal' pregnant or mothering women. As they transition to motherhood the shroud of fear for some wraps around the mother and newborn, yet for others over time they are able to shed the shroud and embrace motherhood. The time to transition to motherhood is experienced differently for all women, with two of the women unable to find the equilibrium of 'ease' of motherhood at 10 weeks postnatal.

This study uncovered that for these women who experienced years of infertility, treatments and failures, their pregnancy and matrescence experience is one of not-being-at-home-in-the-world.

Chapter One

Orientation to the study

“Give me children or I’ll die” (Holy Bible, 1979 Genesis 30:1)

One of the earliest written accounts of infertility is Rachel’s plea in Genesis demonstrating her desperation to become a mother. Infertility is a social construction through which it is assumed that not being able to conceive is a problem, and is one that has become increasingly medicalised. Hundreds of years since Rachel’s plea to become pregnant, women now have access to what have been constructed as appropriate courses of action in the attempt to produce biological children.

Women in New Zealand are increasingly accessing Assisted Reproductive Technologies (ART), especially in-vitro fertilisation (IVF), in order to obtain a biological child. In many instances women are requiring repeated treatments in their endeavour to achieve biological motherhood. As a consequence of the increasing access to IVF, maternity care providers need to develop an understanding of the experiences of these women in order to provide appropriate support and interventions for the women who go on to become pregnant.

The research question, aim of the study and philosophical underpinnings

What is the experience for women of becoming and being pregnant and their early mothering, following repeated IVF treatments? It is to this question that my study is focused. The aim of my research is to reveal achieving a biological child and becoming a mother after three or more IVF treatments. The methodological framework chosen to underpin the study is Heideggerian hermeneutic phenomenology, enabling women to be viewed from a more inclusive perspective than the Cartesian duality of mind-body split (Koch, 1995; Leonard, 1994). New Zealand philosophy of

midwifery encourages practitioners to provide individualised holistic care (D. Davis & Walker, 2011), therefore hermeneutic phenomenological methodology aligns well as it requires integrated wholes to be explored, an holistic approach (Miles, Chapman, Francis, & Taylor, 2013).

Phenomenology is not about producing conclusive arguments, facts or determined ideas but rather about being allusive, drawing the reader to the compelling power of the text and the analyst's reflective insights drawn from the lived experience (Bentz & Rehorick, 2008; Crotty, 2010; van Manen, 1997). The phenomenological researcher immerses himself/herself within the experience, therefore uncovering the extraordinary within the ordinariness of being pregnant and becoming a mother. Koch (1999) explains this philosophical framework, "we do not come to see how people live, but rather, we may be able to understand what it is like for them to be living their lives" (p.27).

The philosophical assumptions of Heidegger and Gadamer are appropriate for research that aims to explore and reveal the extraordinary within the ordinariness, in this case of being pregnant and becoming a mother following repeated IVF treatments. Heideggerian hermeneutic phenomenology endeavours to remain truthful to the experience itself as opposed to developing a generalised and theoretical analysis of the experience (Smythe, Ironside, Sims, Swenson, & Spence, 2008). It is anticipated, in line with phenomenological philosophy, that my research will offer primal narrations that describe in a voice previously unheard how it has been for this cohort of women (Koch, 1999; van Manen, 2007b). Heideggerian phenomenology provides the means by which the women's voices drive the analysis. The interpretative process is one of openness to possibilities and experiences. "Philosophical writing ... takes us back to a more primordial experience, and gets us thinking beyond our own horizon of knowing" (Smythe et al., p. 1395).

The insights drawn from this study will enable maternity care providers to discover and understand the needs of childbearing women with a history

of repeated IVF. Maternity care providers, predominantly midwives, will potentially be able to respond more thoughtfully, respectfully and insightfully to women in the future.

This phenomenological study offers an interpretation of the narratives of seven women who all undertook three or more IVF treatments and finally succeeded in becoming mothers. The women were interviewed twice. The first interview was around 28 weeks gestation, the second interview between 6-10 weeks postnatal. Of the 7 women, two responded to my invitation to write a reflection soon after the birth expressing how the birth was for them and how it changed the past experience of infertility. This data provided further insight and narratives that have been included in revealing the extraordinariness of their finally becoming mothers.

Justification for my study

The number of women accessing ART is continually increasing with a 47.8% rise from 2004 to 2007, and a further 9% increase from 2007 to 2008 (Wang, Chambers, & Sullivan, 2010). Of the Australasian 11,528 liveborn babies in 2008 following ART a total of 1,202 were from New Zealand fertility clinics (Wang et al.). It is now estimated that approximately 1% of all first-born babies in the West are conceived through IVF treatment (Cassidy & Sintrovani, 2008) with the overall chance of having at least one child after using one or two IVF cycles being 70-90% for women 37 years and younger (Fertility Associates, 2010; South, 2009).

Research to date (such as Cooper et al., 2012; D'Angelo, Whitehead, Helms, Barfield, & Ahluwalia, 2011; Gonzalez, 2000; McMahon et al., 2013) has focused on the positivist view regarding the treatment of infertility, pregnancy and postnatal parenting following IVF, however the objectivity of the quantitative research decontextualizes the experience (Leonard, 1989). There are no studies that identify the experience of

pregnancy and early motherhood specifically following repeated IVF treatment (\geq three cycles) from a qualitative paradigm. Braverman (2008) suggests that the women finally pregnant following three or more IVF attempts are likely to have been through an experience that has been both emotionally and financially taxing. The question is raised as to how this prolonged journey/passage toward birth and motherhood impacted on their pregnancy experience. This Heideggerian phenomenological study opens the meaning of their experience to question.

Verve for commencing this study

Professionally

I have been a midwife for seventeen years. During that time I have provided clinical care as a Lead Maternity Care (LMC¹) provider and as a hospital employed midwife for women who have become pregnant through IVF. Anecdotally I have found that these women have different requirements to women who have become pregnant spontaneously for the first time (primigravida). Some of the IVF women have required more frequent visits in order to listen to the fetal heart beat and be reassured, whilst others almost portray a sense of ambivalence not particularly interested in attending antenatal classes or preparing for their baby, a contrast to the spontaneously conceiving primigravida.

Midwifery colleagues and I have often discussed that these women seem 'different' and we wanted to know what their emotional needs were, because the women themselves were often unable to identify, or were unwilling to share, any specific requirements. Why were some women enthusiastic and others seemingly ambivalent? Why were some always

¹ Lead maternity care provider is "responsible for assessing needs, planning and providing or co-ordinating maternity care from early pregnancy until six weeks after the birth" (Grigg & Tracy, 2013, p. E61). The LMC may be a midwife, obstetrician or a general practitioner (with approved diploma).

needing to be reassured while others did not question clinical decisions and just did 'what they were told'? Perhaps this is true for non-IVF women too, and as midwives we were bringing our own presumptions to the partnership with women. As midwives we advocate for normal birth, for women's choice and making informed choices. Yet some of these women were not particularly interested in making choices or decisions.

Paediatricians also made comments over the years that they had noted that women who became mothers through IVF were over-bearing and over-protective parents. The maternal mental health nurses also made comments that women pregnant after IVF were more at risk of becoming postnatally depressed and did not adjust well to becoming mothers. It was thought that perhaps the women's dreams and expectations of motherhood, built up over the years of infertility and IVF treatment, didn't meet with the reality of a demanding and 'disorganised' newborn. Thus I wanted to find out from the women themselves something of the nature of the experience of being pregnant and becoming a mother after repeated IVF.

Personally

My husband and I have journeyed through infertility. I have experienced years of emotional turmoil, endured and placed myself through physical challenges I never thought I was capable of in the endeavour to become a mother. I have experienced pregnancies through to thirteen weeks and the grief associated with miscarriages and the shattering of dreams.

Through the years of infertility we have both come to a period of acceptance and still waters. I have personally been able to acknowledge that I have grown in a sense that I would never have experienced otherwise. Whilst I will never know what it is to be pregnant and become a mother, I have the ability to work alongside women throughout grief and empathise with them at the loss of their baby.

So whilst I appreciate my place in life I also acknowledge that this study has a purpose of revealing to me what the experience is like for these women, and may have been like for me. If I had been one of these women/mothers then I would have liked my maternity care provider to have a knowledge base upon which to provide my care. This passion is the driver for my research and is not unusual as “many academic research projects bear an intimate relationship to researchers’ lives” (Letherby, 1999, p. 360).

Presuppositions as a researcher

In line with ‘real world’ midwifery and everyday practice of reflection I have dedicated time to reflecting on the presuppositions that I bring to my study.

I revisited the journal that I wrote during the years of infertility and IVF treatment. Within this journal are written accounts of grief associated primarily with infertility but secondly with two early second trimester miscarriages. Grief, and its associated phases is not uncommon in the literature surrounding the experiences of infertility (Pawson, 2003). Revisiting my journal assisted me to identify that there is an element of coming to my study with my own ‘view’ and ‘dream’ of how I imagined I would have experienced finally being pregnant, and finally becoming a mother, after our repeated IVF treatments. These ‘dreams’, now identified and verbalised, are very important as I listen to women describe their experiences in my study.

In my clinical work as a midwife I encounter women who have finally become pregnant after repeated IVF treatment. Anecdotally I have noticed that there are two camps into which these women seem to fit; one is where the woman portrays a disassociation from or de-objectification of her pregnancy; just wanting the outcome, the baby. The other is a woman who is thriving on the experience, soaking it up like a sponge, but also protective and cautious, not wishing to ‘dream’ because she may ‘jinx’ it and not end up with a baby. I recognize that I silently wonder why the

woman 'disassociated' isn't excited and celebrating her pregnancy; isn't she finally pregnant? This bewilderment comes from my own presupposition that I would have imagined myself celebrating being pregnant, of knowing I was a mother with a baby I could feel moving in utero, even if not with a baby in my arms.

As a consequence I asked myself to write about how I truly thought I would have experienced pregnancy after thirteen weeks. When I sat and wrote I realised that whilst I may have thought in my heart how it might have been, my head was likely to have wanted to be cautious. I found that I envisioned myself being in both camps, detached yet celebratory. The words from my brainstorming clearly identified cautiousness and self protection yet at the same time wanting to experience excitement and dreams of a changing gravida body. By setting myself this challenge I was able to identify how influenced I was by working with women and therefore could not think honestly of how it would be: I was clouded by mixed experiences and my own dreams. This process assisted me to appreciate the methodology of phenomenology and the unravelling of the experience, to being open to seeing the experience, hearing the experience with fresh ears. This study will reveal therefore the extraordinariness of being pregnant, not how the world currently sees/hears pregnancy now, but how the world of pregnancy 'is' from the women who have been through repeated IVF to then become pregnant.

My personal experience of infertility treatment and IVF has informed my view of the world in a non-theoretical and non-cognitive way and my personal ontology (Leonard, 1989). It is due to this that Heideggerian hermeneutic phenomenological has formed the foundation for my study. On searching for an appropriate phenomenological foundation I identified early on that my personal experience would be unable to be separated and isolated. I recognised the ability to 'bracket' my personal experiences and prejudgements, a requirement in Husserl's phenomenology in order to view my research project objectively, as being fraught with difficulties (Bentz & Rehorick, 2008; Crotty, 2010; Kohl, 1965; Maggs-Rapport, 2001;

Paddy, 2010; Water, 2008). Whilst I have now come to an emotional field of acceptance and hence my ability to perform this study, I still readily identify with and am attached to where I have journeyed. I have chosen to declare these pre-understandings and experiences and use them to assist me in the interpretation, to understand myself as part of the process, as is an appropriate hermeneutic approach (Gadamer, 2001; Koch, 1996). "The thoughts we offer will always be imbued with who we are and those with whom we live our lives...our very understanding of the words we use has been born of our experience, our situatedness which is always/already communal" (Smythe et al., 2008, p. 1391).

I requested that one of my supervisors interview me, a suggestion made by one of my midwifery colleagues. The rationale for this was to ensure that I had grasped clearly my presuppositions. On listening to the recording of the interview I was able to identify that the presuppositions I had written were appropriate. It was through this process that I was also able to recognise that in trying to relay my story I was unable to recall exact dates of events; I was challenged to remember the events clearly. I realised that my journal of reflection during infertility, and some of the analysis that I had performed on my journal during my Doctorate of Health Science papers, had assisted me. I was able to appreciate that the hurt and sorrow that used to overwhelm my mind had been replaced with other life events; my acceptance of childlessness had emerged. Appreciating that history and events do affect the future, the relationship of my being childless was not as strong and dramatic an influence as it once had been. The wound is healing well and although I thought a portion of completing this thesis was to complete the 'full stop' of my infertility experience, I have awareness that the 'full stop' is already round and complete; for me there is a full and rewarding life without being a mother. My thinking and reflecting during this research has therefore been shaped by my personal experience. It is not divorced from my past but rather entwined in my experience.

The physical experience of IVF

In order to unpack the meaning of the research question for this study it is essential to understand what physically and invasive procedures are involved in a single IVF treatment. For the women in this study they exposed themselves to this arduous treatment repeatedly; whilst in some instances a shortened version of the conventional IVF cycle.

IVF is a process by which the sperm and the egg are fertilised outside of the woman's body; in a laboratory rather than in the fallopian tubes (Birdsall, Ellis, Fisher, Graham, & Peek, 2009). In order for this to happen the woman must ensure that there are sufficient numbers of eggs available and mature to be collected. The maturation of multiple eggs occurs due to the woman self-administering a variety of hormone drugs by subcutaneous injection.

For the woman's first cycle clear instructions are given by the nurses at the fertility clinic regarding how to self-administer the injections (Payne & Goedeke, 2007). The first part of the cycle is termed down regulation, where the woman's own body's reproductive hormones are essentially 'turned off'. The woman then stimulates growth of multiple follicles by administering follicle stimulating hormone (FSH) injections. Throughout administration of FSH the woman must present for blood tests to check her hormone levels and for trans-vaginal ultrasound scans to monitor the number and maturity of the follicles. Generally the blood test and scanning occurs every two to three days, and if the woman's domicile is rural/remote rural this will require frequent travelling. The woman contacts the nurses at the fertility clinic the afternoon of the scan/blood test to receive instructions such as the next drug dosage or when to travel to the fertility clinic for egg collection to occur (Payne & Goedeke).

Administering the subcutaneous injections requires timing and self-control. After administering numerous injections it can become one of physical and emotional exhaustion. I clearly remember in one of my conventional IVF

cycles administering 64 injections before egg collection could occur. For some women they or their partners are unable to administer the injections, such as needle phobia, and they must seek help from others (Throsby, 2002). Administering injections also brings with it the challenges associated with timing of injections and the woman's social situation, such as women who are shift workers.

The risk with stimulating the ovaries is that of ovarian hyperstimulation syndrome, which varies from mild to severe requiring hospitalisation. Women are monitored carefully for this and receive detailed information of the signs and symptoms and where to seek help.

Egg Collection occurs via a needle that is introduced through the vagina and into the ovaries with the use of ultrasound scan to guide the needle (Birdsall et al., 2009). Each follicle is entered and the egg and follicular fluid removed, examined at the bedside by a scientist to ensure the egg is present, and then another follicle is entered (Birdsall et al.). This procedure can take up to 15 minutes to complete and whilst the woman is awake she will be provided with medication for relaxation and pain relief.

Following the egg collection the woman can be uncomfortable and she is encouraged to take simple analgesia and to seek advice from the fertility clinic as required. For some women the days immediately following egg collections can be particularly uncomfortable, feeling as though their ovaries have been vigorously punched and left bruised and extremely tender.

The woman and her partner are then at home/work waiting to hear how many of the eggs have fertilised by receiving a phone call from the embryologist the next day. The resulting embryos will be cultured for a further three to five days under carefully controlled conditions allowing for multiple cell division to occur.

If embryos are successful they will be transferred around day three to six back into the woman's uterus. Always the best embryo is selected from the total embryos and inserted using a catheter which is no more uncomfortable than a routine cervical smear (Birdsall et al., 2009). Any remaining embryos deemed suitable for cryopreservation will be frozen to wait for future thawing; if the cellular structure survives the process then potential uterine placement will occur. Following uterine placement the woman must wait for another 9-11 days to know whether the embryo has successfully implanted and she is confirmed pregnant. This can be a very long and emotionally taxing wait. Such is the clinical nature of the experience all the participants in this study have been through at least three times. This thesis goes on to address the more holistic nature of going through such repeated experiences, and then becoming pregnant.

Structure of this thesis

This thesis comprises of 10 chapters.

Chapter one, the purpose in "**Orientation to the study**" has outlined my aim, the philosophical framework and my rationale for choosing Heideggerian hermeneutic phenomenology. It also identifies why this topic is important to me personally and ought to be for maternity care providers. My presuppositions have been identified and the reflective process that facilitated their identification was included. Developing an understanding of what is entailed in the physical process of IVF was included in order to unpack the meaning of the research question.

Chapter two, "**Contextualisation of infertility and motherhood**" sets the scene by building a picture of womanhood/motherhood in New Zealand and as a result the sociocultural construct of infertility. The drive to become a mother is discussed and as a consequence the necessity for assisted reproductive technologies. The picture is further developed by understanding the history and complexity of infertility treatment in New Zealand including the socioeconomic cost of infertility treatment.

Chapter three, “**Experience of infertility, pregnancy and parenthood following successful treatment**” explores the literature. This is predominantly from the positivist paradigm where the objectivity has decontextualized the experience. I examine current available and published knowledge and identify gaps in the literature.

Understanding “**Philosophical foundations**” is the basis of chapter four, articulating the ontological and epistemological of phenomenology that frames and informs my research. I conclude that the depth of this understanding is a process of evolution as my emerging grasp is never finished and is therefore the ongoing development of my personal epistemological position.

The content of chapter five explains how I went about performing this research, this is the “**Method**” chapter. It covers ethics, recruitment of participants, interviewing, the crafting of stories and the process of interpretation. Essential to this research are the five expressions of trustworthiness explained by de Witt and Ploeg and van Manen’s principles of inquiry.

The “**Prologue**” forms chapter six and sets the scene through Ellie’s story, giving one example of the nature of the experience that comes before finally becoming pregnant. This chapter also introduces the other six participants and the highs and lows experienced through their IVF treatments. Concluding by establishing an understanding of the weight of sorrow experienced by all the women.

The findings of my study are presented in chapters seven through to nine. The women’s insights into their fertility awareness and the very core of needing to procreate are the beginning of chapter seven “**Becoming pregnant**”. They reveal that the women being-in-the-world of infertility have a sense of not belonging showing the genesis of being-not-at-home, or unsettled with their inner selves. The chapter ends with the women confirming the success of their pregnancy. With success comes hope but

the fear from repeated failures and the mood of dread compromise the celebration.

Chapter eight “**Living with dread**” follows the women's confirmed pregnancy through the second and third trimesters. The mood of dread permeates the pregnancy, where the women walk an emotional tight rope trying to balance their hope and fear.

Chapter nine “**Lingering dread**” focuses on the birth of the baby and the birth of motherhood. Matrescence² varies depending upon whether the women experienced a release of the mood of dread, or whether this mood continues and shrouds the mother and her baby. The women endeavour to establish the comportment of motherhood and to find a sense of being-at-home.

Chapter ten “**Articulating meaning**” is the clearing, where the findings from each chapter come together. The findings are linked with the current relevant literature and the overarching Heideggerian concept of being-at-home-in-the-world. This concept forms the thesis of the thesis and wraps the three findings chapters into a whole. Concluding the chapter are recommendations for maternity care providers, and also for fertility providers for women who are undergoing repetitive IVF treatments. All research needs to have limitations identified and the opportunities for further study; these are outlined in this chapter.

This research aimed to reveal the experience from a group of women who finally became pregnant following repeated IVF treatments. It endeavours to provide an understanding of how it has been for them to transition into motherhood and to give their unique experience validity in a world where becoming a mother is a somewhat taken-for-granted life event.

² “The term ‘matrescence’ has been coined to capture the experience of becoming a mother; as a sacred time of both opportunity and threat” (Smythe, Payne, Wilson, & Wynyard, 2012, p. 1)

Chapter Two

Contextualisation of infertility and motherhood

Infertility and the need for access to medical treatments have been shaped by the social construction of womanhood being linked with motherhood. In this chapter I explore what it means to be a woman, expanding to how society views being a woman, with particular emphasis on becoming a mother. I review the history and associated complexity of infertility treatment in New Zealand. The theoretical perspective of infertility treatment, including history, funding, access and relevant legislations that govern treatment are unpacked. I conclude the chapter by acknowledging the socioeconomic cost of infertility treatment.

‘Being a woman’

Asking what characteristics are associated with being a woman is essentially asking what is it to exist as a female human in the context of where one lives and into which one was born. Therefore, in the context of this study the response to the question ‘what is a woman?’ is how it is to ‘be’ or exist as a female in New Zealand society in the 21st Century.

According to Sandford (2006), Beauvoir was one of the first in western society to ask the bold question “what is a woman”? Beauvoir, in the late 1940s, was challenging what was an accepted definition that being a woman was her womb, thus viewed from the biological context of reproduction and procreation with no intellectual entity (Novitz, 1989; Sandford). Beauvoir infers it is not ‘femininity’ that changes a female to a woman, rather this change occurs due to the context/situation in which she exists. Situation “refers to the context of individual existence within and against which freedom asserts itself. One’s situation includes all those aspects of one’s existence that one did not choose” (Sandford, p. 57).

Beauvoir's above definition is similar to Heidegger's concept of thrownness in *Being and Time* (Heidegger, 1962/2008). Time is seen as a concept essential in the understanding of the person, with the sense of time having a relationship with the context where the person is currently situated. The individual's experience of the world is founded upon the context because one cannot be separated from that world (Miles et al., 2013). "Understanding the person in context is the only way that person's values and significances will be revealed. Understanding the relational and configurational context allows for a more appropriate interpretation of what significance things have for a person" (Leonard, 1994, p. 51). There are several terms for the concept of time in Heideggerian hermeneutic phenomenology, however the concept of thrownness lends itself well to Beauvoir's definition. The concept of thrownness appreciates that the person has always been situated in the world: human existence involves working out how one exists within the world that one was thrown or projected into (Heidegger, 1962/2008), "a particular cultural, historical and familial world" (Leonard, p. 47).

To be a female in New Zealand society has changed over the last century. Women prised the sole right to vote from the male hierarchy of society "like an oyster from its shell" (Davies, 1993, p. 148). New Zealand in 1893 became the first country in the world where all women had the right to vote (Nolan, 2000; Novitz, 1989). The right came about following years of suffrage campaigning for women to be respected not just as procreative mothers but also as intellectual human beings. Despite the acquisition of the right to vote women continued to have a major focus upon home and family life and to be dependent upon the male breadwinner (Nolan; Novitz). Changes occurred during the 1940s when a lack of workforce (men were overseas fighting) saw the government actively encouraging women into paid work. Indeed this gradually became compulsory so that by 1944 all women aged between 18-40 years had to register for 'man powering', although married women with children were generally an exception (Nolan, 2000). When the men returned the government developed an official campaign in an endeavour to attract women back

into their homes to free up work for the male breadwinner (Nolan, 2002; Novitz).

The Government's luring of women back into the pre-war societal gender order settled well for many women who returned to domesticity and the confinement of their homes (Nolan, 2000). It is suggested that a return to traditional femininity transpired (Brookes & Tennant, 1998). The media and politicians focused on the traditional family; the occupation of a housewife was the "apotheosis of womanhood" (Nolan, 2002, p. 64). Young females growing up in the 1950s and 1960s were taught that to be female meant that they must be attractive to men; that this required time and devotion to their husbands and children at the expense of any external interests, resulting in their being the 'eternal woman' (Brookes & Tennant; Novitz, 1989). The genesis of the 'eternal woman' was derived from 1940's pamphlets for girls informing them about menstruation but including the social script around females adopting practices to make them attractive to men (Brookes & Tennant). There remained a strong culture that being female meant 'being the womb', with commencement of menses viewed as positive, demonstrating that 'she' was now a woman. Women returned to a life where motherhood was the ultimate experience and life was one of docility (Oakley, 2005).

However, there were women who wanted to retain their paid employment and associated independence. This desire was supported by a shortage in the public services which required more workers than the male workforce provided, and successfully promoted married women into waged work (Nolan, 2002). The 1913 marriage bar, which required married women to leave the workforce, was revoked and women were encouraged to return to occupations such as nursing and teaching (Nolan, 2000). As a consequence, increasing numbers of married women began working outside of the home and according to Bean (2005) developed a sense of self fulfilment and self realisation. In the 1960s and 1970s in the wake of the oral contraceptive and the opportunity for newfound career access

where in the past access was restricted to women, women fought for increased opportunities to work (Gibbs, 2010).

For these women their strength came from the feminist movement which began to question motherhood and unpaid work in the home as the only life experience (Oakley, 2005). The emancipation that began in the 19th century was further fuelled by the independence from men that women experienced in the 1940s and their desire to take control of their destiny from the subordination of men. The second wave of feminism's focus was the creation of autonomy for women to express who they wanted or desired to be, rather than living in subordination (Coney, 1993; Segal, 1991). According to Segal, the catalyst was to challenge the societal 'normal' view of gender ideologies, creating a new dyadic between men and women, as well as women and the world in which they lived. An aphorism of this wave was that women could do everything that men could do, in their search for a relationship built on mutual obeisance. An example of one of the aims of this movement was women's right to choose not to be a mother, and the access to legal abortion. An era emerged in the 1970s where for the first time women had possibilities of having control over their procreating bodies (Coney). "Women were able to imagine a life that included both a family and a job, which changed their childbearing calculations" (Gibbs, 2010, p. 6).

Now in the 21st Century some women identify themselves as professionals and establish career pathways before contemplating the priority of motherhood (Bean, 2005; Ng & Ho, 2007). Women's engagement in the workforce has increased exponentially. In 1942 a Wellington study found 17-25% of mothers were working outside of the home (Nolan, 2000). The 2006 Census found that 71.05% of women in two parent families work either full or part time (Statistics New Zealand, 2006). So whilst women enter the workforce and develop professional careers, they inevitably balance this with motherhood. The axiology of womanhood in New Zealand reveals that there remains a discursive construction that motherhood equates to womanhood. Motherhood remains the dominant

discourse providing women with a sense of completeness and purpose (Payne & Goedeke, 2009). Although some women are childless by choice there is the societal acceptance that motherhood constitutes womanhood which is the norm in New Zealand society (Morton, 2012).

Returning to the question “what is a woman”, in New Zealand in the 21st century she is to some extent whatever she wishes to be. These wishes will be dependent upon her ethnicity, culture, beliefs and values; but her status is still centred on her reproductive ability, she remains the ‘womb’ and the mother of the children that she bears. There remains the underlying destiny that she is a female and therefore ‘should’ become a mother; that her experience of matrescence results in her ability to “successfully combine competing responsibilities of family life, paid employment, self and other” (Thomas, 2001, p. 104). Society continues to expect “real” women to have children (Letherby, 1999), with women frequently experiencing negative perceptions when they identified they had chosen to be childless (Morton, 2012). Despite feminists’ attempts to reconstruct this identity it remains popular in media and within varying sectors of society with women being discriminated against based on whether they have had children or not (Letherby, 1999; Morton; Novitz, 1989; Riley, 2008).

Socio-cultural construct of infertility

Infertility is a socially constructed term given to an individual being unable to achieve what is socially/medically defined as a norm of being healthy. As a consequence medicine has constructed medical courses of action (Greil, Slauson-Blevins, & McQuillan, 2010; Lesnik-Oberstein, 2007). New Zealand women are therefore not different to the majority of women in the industrialised world where to procreate is the normal societal expectation of adulthood. Through such pronatalism infertility is constructed as a disability (Cassidy & Sintrovani, 2008; Ulrich & Weatherall, 2000). New Zealand women from a very early age are aware that their biological

make-up relates to their potential inevitability of reproduction (Batty, 2002): it is biological destiny for women to reproduce. In New Zealand society there is a subtle but popular lexicon that motherhood equals womanhood. Unless a woman has become a mother she is less than a 'real' woman. A review of New Zealand popular media found an emphasis for women with infertility to persist and persevere in their need to become mothers. "The primary goal for women is to have a child; the primary role portrayed for women is to mother, with limited options for women to occupy any other positions" (Payne & Goedeke, 2009, p. 3). An excellent example of this is my recent examination of 10 frequently purchased magazines (November 2013); nine out of the 10 all had a heading on the front page about becoming a mother, or about a particular baby. The underlying belief that motherhood provides women with a sense of completeness and purpose in their lives remains a dominant discourse (Fry, 2001; Letherby, 1999; Riley, 2008; Ulrich & Weatherall). For the women who face fecundity issues with potential to not produce their own biological offspring the 'social stigma' is debilitating. Pawson (2003) suggests that these women may become desperate and vulnerable.

Issues for Māori

Assisted reproductive technologies such as IVF have the potential to raise particular issues for Māori, the indigenous people of New Zealand. Fertility and the ability to produce children and maintain the iwi and hence the whakapapa (ancestry) is taken seriously (Glover & Rousseau, 2007). Genealogy is of utmost importance for Maori as the offspring are the whānau (family), sub-tribe (hapu) and iwi (tribe) (Ulrich & Weatherall, 2000). Māori women become mothers at an earlier age (median 25 years) than women of other ethnicities (Ministry of Health, 2012), thereby reducing their need to access ART for age related infertility. However, the impression that Māori have less infertility issues has been challenged by Hiroti (2008) due to the documented fertility rates of Māori decreasing from 6.18 births per woman in 1962 to 2.94 births per woman in 2007. At

present there is a dearth of information available on the prevalence of infertility amongst Māori or the causes of infertility (Glover & Dyall, 2008). A recent research project working with Māori communities to develop an understanding of the issues associated with infertility has to some extent assisted in filling this information void (Reynolds et al., 2010). There is a limited amount of data on the fertility services or outcomes for Māori. What is available is that in 2008-2009 Waikato and Wellington Fertility Associates provided 11-12% of first specialist appointments to Māori and between 5-7% of the IVF cycles over that period were for Māori (Reynolds et al.). For those who access ART and conceive children through the use of gamete donation, whakapapa of the donor continues, whether known or not, with a change/loss of the traditional whakapapa. Whakapapa according to Glover and Rousseau (2007) forms an important part of the person and is made up of both parents' identities. These identities together make up the Māori notion of life or tinana. For Māori therefore the 10% that use donor gametes or surrogacy within their hapu maintain their iwi and therefore their whakapapa and "their ascent to an eponymous ancestor" (Daniels & Douglass, 2008, p. 141). It is the value placed on whakapapa that made counselling compulsory prior to any decisions being made regarding embryo donation (Daniels & Douglass). Peek (personal communication, October, 14, 2013) suggests other barriers for Māori accessing treatment are the unfamiliarity of treatment and the non-eligibility due to high BMI. Whilst the attendance at first consultation is 25-30% equal to Europeans the access to IVF was disproportionately low and needs further investigation (Peek, 2010, 2013).

For Māori unable to spontaneously conceive there has historically been the ability to raise children outside of the immediate whānau (family) (Reynolds & Smith, 2012). Māori tikanga (custom) facilitates the informal adoption (whangai) of a baby between whānau and remains common practice to address infertility (Reynolds & Smith, 2012; Ulrich & Weatherall, 2000). The opportunity to parent, facilitated by this custom, may alleviate the need for infertility treatment, but due to the informality of these arrangements it is difficult to quantify.

The necessity for assisted reproductive technology

Procreation is constructed as a fundamental human desire of most couples and is no longer confined to heterosexual couples (Inhorn & Birenbaum-Carmeli, 2008). Just as humans have the liberty to decide with whom they cohabit, and who their sexual partners are, now there is an increasing liberty for people other than heterosexual couples to seek parentage through the use of ART. Single women and lesbian couples have taken up assisted reproductive technologies as an alternative route by which they can pursue parenthood. Similarly these cohorts of women may seek IVF when they have been unable to conceive using alternative informal means. The introduction of ART has resulted in infertility being a condition not purely identifiable with heterosexual couples. Gay or lesbian couples or single women accessing ART could be conceptualised as infertile, as although they may be physiologically fertile it is the absence of the appropriate gamete that renders them infertile and therefore are termed 'socially infertile'. As a consequence the traditional heterosexual and nuclear family has been transcended by the creation of a non-traditional family through technical means resulting in a change in the conventional cultural view of the family form (Inhorn & Birenbaum-Carmeli, 2008; Michelle, 2006).

While infertility is predominantly viewed as a medical issue, when the layers are 'peeled away' infertility becomes multi-factorial. The social, political, economic and legal issues are entangled within the values of each society and culture. Sexual practices, infectious diseases, occupational and other environmental factors have all had cumulative effects on fertility. Deferring childbirth has also increased the incidence of infertility with the older woman having biological factors reducing her ability to conceive (Robertson, 2002). Increasingly, male causes of infertility are the drivers for women accessing ART. For example the use of intrauterine insemination (IUI) due to mild to moderate sperm problems (Birdsall et al., 2009). Key causes of infecundity are well documented with 40% attributed to female infertility, such as ovarian ageing and tubal damage due to

sexually transmitted infections (Ziebe & Devroey, 2008); 40% is attributed to male infertility predominantly sperm problems (Birdsall et al.) and 20% to both members of the couple (Cassidy & Sintrovani, 2008). As a consequence there have been increasing demands on ART practices worldwide and this industry has grown extensively (Hammarberg, Fisher, & Rowe, 2008; Robertson; South, 2009; Svensson, Connolly, Gallo, & Hagglund, 2008; Ziebe & Devroey).

Theoretical perspective on ARTs

While the cause of infertility may involve both partners, as Throsby (2002) points out, often ARTs involve the woman's body. Therefore feminists have theorised about ARTs and women. For example liberal feminists advocate for women to have unimpeded access to professions such as researchers and physicians and under this mandate promote ART as a woman's right to choose to be consumers of these treatments (Cussins, 1996). Conversely, some radical feminists would see ART as patriarchal where the male dominated medical profession, threatened by women's understanding and relationship to nature and hence women's fecundity, are able to dominate the deficiencies of nature and take control over women (Bunkle, 1994; Michelle, 2006; Payne & Goedeke, 2009). The latter feminist view sees the objectification of women undergoing ART treatment in a negative light, holding ART treatments responsible for the "subjugating and disciplining effects of reproductive technologies on women's bodies and lives" (Cussins, p. 576). The liberal feminist, according to Cussins, views the increasing choice of ART treatment available to women today as favourable.

Post-structuralist feminists argue that women are not always powerless and unable to practice acts of dominance. Rather women should be encouraged and supported to make decisions that enable individuality and consideration of the determinants of benefits and risks (Payne & Goedeke, 2009). These feminists recognise that there are indeed aspects of ART

that are positive, such as the transformation to the conventional meaning of reproduction, for example, women who choose not to marry being able to become biological mothers (Michelle, 2006). However, post-structural feminists also recognise that power relations within ART are highly complex and fraught psychologically due to the 'power over' properties involved in the implementation of treatment. Women undergoing ART battle throughout their treatment with the transfer of power from their 'biological right' to conceive to the power that the ART specialist and/or /technologies have in assisting in the production of a 'biological' pregnancy.

History and complexity of Infertility treatment in New Zealand

History and funding of fertility treatment

The first New Zealand IVF birth occurred in 1983 (Murray, Hutton, & Peek, 2005). It is now estimated that approximately 1% of all first-born babies are conceived through IVF treatment (Cassidy & Sintrovani, 2008) with the overall chance of having at least one child after using one or two IVF cycles being 70-90% for women 37 years and younger (Fertility Associates, 2011; South, 2009). According to Fertility Associates (2010), a leading New Zealand treatment provider, about one in five couples will experience difficulties conceiving with approximately 60% of them seeking medical advice. The number of women in New Zealand and Australia (only combined Australian statistics are available) who gave birth as a result of ART has increased from 2083 in 1991 to 9984 in 2007 (Farquhar, Wang, & Sullivan, 2010). The number of ART procedures increases by 10% per year on average in New Zealand, accounting for an estimated 2.0% of the total children born in New Zealand (Wang et al., 2010). Whilst pregnancy rates are substantially higher than they were a few years ago, there are still women who require repeat treatment cycles.

Public health funding in New Zealand is sourced from a variety of avenues including tax funded revenue, local authorities, not for profit agencies,

health insurance and 'out of pocket funding' (Morgan & Simmons, 2009). Initially IVF was provided free to the public through tertiary hospitals, for example, Auckland Hospital Board poached funds from elsewhere in the hospital system (Batty, 2002). Changes as a result of the health reforms and the introduction of the purchase/provider-orientated market in 1993 (Morgan & Simmons), resulted in privatisation of several IVF clinics (Coney, 1995).

At the time privatisation of infertility clinics occurred, there were concerns expressed regarding potential vulnerabilities, closures, and compromised quality of care (Coney, 1995). Infertility groups were concerned that quality of the service might result in the services being vulnerable to closure. Hospitals were concerned that they would lose accredited Obstetric registrar training if there was no access to infertility training. It appears that those concerns have not come to fruition. South (2009) states that publicly funded treatment now amounts to around \$10 million a year. Privately funded treatment totals a similar amount. Whilst waiting lists increase to at least 12-18 months for public access to IVF in New Zealand (South, 2009), 50% of treatment remains publicly funded with 50% funded 'out of pocket' (Farquhar et al., 2010).

Therefore, women requiring IVF treatment must navigate an arduous path to comprehend how to expedite treatment, often including the generation of adequate funding, all in addition to the emotional and physical stress of being infertile. Couples in New Zealand can have initial consultations and tests in the public hospitals but many treatments are carried out under contract in the private sector. Consequences are potential vulnerabilities and inequity of access due to the cost of private treatment, whilst developing what could be perceived as a more 'boutique' style infertility treatment service. The consumers of ART therefore could be viewed as potentially becoming vulnerable, in that the cost of private treatment could continue to rise in order to ensure sufficient dividends to the investors of these clinics.

The funding for ART, which includes IVF, comes from the Ministry of Health for public cases, or 'out of the client's pocket' and/or in rare situations Accident Compensation Cooperation. Currently there are numerous issues related to access to IVF, including concerns regarding the health literacy of the population and therefore health care disparities (Hasnain-Wynia & Wolf, 2010). The strict criteria that dictate if couples are eligible for free funding or not are restrictive (Allan, de Lacey, & Payne, 2009; Farquhar et al., 2010; New Zealand Herald, 2006). In addition, there are currently no health insurance companies in New Zealand who pay for IVF. There are also geographical access issues with the only available treatment centres being located in five large metropolitan cities where tertiary care is available (Allan et al.). Health Insurance companies view fertility treatment as being highly elective and "given its highly elective nature, it can be too expensive, particularly if people were going for repeated treatment" (New Zealand Herald, p. 3).

Accessing infertility treatment

To access publically funded IVF cycles in New Zealand couples have to meet specific criteria as defined in the clinical priority access criteria (CPAC) see Appendix 1. In 2000 the Health Funding Authority (HFA) attempted to resolve existing inconsistencies in funding and access to IVF. Increased funding allocation (increase of \$3.7 million), amended the service specifications for treatment contract holders and introduced the national referral guidelines and the CPAC (Batty, 2002). Whilst the CPAC provides guidelines on decision-making regarding treatment, Batty argues that there was little or no attention paid to the values that underpinned the criteria:

The limited public consultation and the subsequent lack of responses in relation to selecting the access criteria and the allocation of 'values', undermines the validity of the CPAC and called into question how reflective of the wider community's social values the criteria are. (p.141)

The introduction of the CPAC was to do with health sector reforms and constraints that the government needed to implement due to over-spending in health. The CPAC was one of the rational and transparent tools implemented in order to make the hard prioritisation decisions for most major conditions as it 'scores' patients in terms of their need for treatment (Morgan & Simmons, 2009). The CPAC continues to be a rationing strategy in 2013.

The CPAC focuses on: exclusion factors for access to treatment, modifying factors for access to treatment (for example, Body Mass Index (BMI) range of 18-32) and calculation of the priority score (for example, history of smoking, blood results, age and probability of conception without treatment). All couples are scored according to the criteria and if they score 65 or above the couple are eligible to access publicly funded treatment (Fertility Associates, 2011). The introduction page to the criteria (Appendix 1) reads "we see these criteria as an essential step in establishing the level of funding needed for infertility treatment and request that Health Practitioners, working with them, use the criteria with diligence and honesty". Whilst the CPAC endeavours to focus on maximising benefit, the direction to "use the criteria with diligence and honesty" does introduce a degree of subjectivity to what is an otherwise objective screening tool where health practitioners' values could potentially underpin the scoring. Ultimately there are many within the population who will not meet the criteria thus highlighting the question of inequality of access to ART; but just like all health care in New Zealand, there is no automatic right to treatment (Morgan & Simmons, 2009).

Relevant legislation

Prior to the enactment of the Human Assisted Reproductive Technologies (HART) Act reproductive treatments and research in New Zealand was mostly the result of self-regulation by health practitioners involved in ART (Peart, 2006). The only legislation dealing with reproductive technology in

New Zealand prior to the HART act was the Status of Children Amendment Act 1987 (Johnson & Wallace, 2004; Peart, 2006).

The HART Act (2004) was enacted to provide a legislative framework regarding prohibition of some procedures, approval of others and ethical review and evaluation of yet others (Daniels & Douglass, 2008; Henaghan, Daniels, & Caldwell, 2002). The overarching aim was to govern the future treatments with regards ethical decision making, spiritual and cultural perspectives of society and the future resulting offspring (Daniels & Douglass, 2008).

Within the HART Act is the requirement that both ethics and advisory committees be established (Allan et al., 2009; Peart, 2006). The Advisory Committee on Assisted Reproductive Technology (ACART) was established as an independent advisory committee that sits between the government and the people of New Zealand developing advice and guidelines to regulate ART. Therefore it is this committee which determines policy on ART in New Zealand rather than Parliament, although ACART must undertake extensive public consultations before issuing or completing policies/guidelines (Advisory Committee on Assisted Reproductive Technology, 2010; Peart, 2006). The other key functions of ACART are to monitor the outcomes of ART procedures, established procedures and research developments (Advisory Committee on Assisted Reproductive Technology, 2010; Henaghan et al., 2002; Peart, 2006).

An Ethics Committee on Assisted Reproductive Technology (ECART) was also established to liaise with ACART reviewing any applications for human reproductive research and assisted reproductive procedures that were not already established (Henaghan et al., 2002). ECART also reviews previous approvals to monitor progress and procedures performed (Ethics committee on assisted reproductive technology, 2004).

Resting behind the HART Act and providing some governance to ART in New Zealand is the Human Rights Act (HRA) 1993 and in a broader sense

the New Zealand Bill of Rights Act (NZBORA) 1990. Both prohibit people's discrimination regarding restricted access to ART, such as single women and couples with disabilities (Fong, 2003). "The liberty to procreate may be brought within the right not to be deprived of life, NZBORA 1990, section 8, if procreation is considered in legal terms an essential element of life" (Fong, p. 3). "The HRA and NZBORA are not to be breached when making evaluations for exclusions" (Fong, p. 13). The HART Act has a responsibility to remain within the boundaries of the HRA and NZBOFA. The only guidelines in the HART Act on restricting access to ART is from the platform advocating for the unborn child, of the prospective parents inability to parent and concerns regarding the general well-being and safety of the potential child (Fong; Peart, 2006).

Socioeconomic cost of infertility treatment

As stated above, infertility clinics are now predominantly privately run clinics that also have contracts with the District Health Boards (DHB) for the provision of tertiary infertility treatment. The public funding covers the most appropriate treatment which could include insemination with partner's sperm, donor insemination, IVF, IVF with sperm microinjection, egg donation and surrogacy (Fertility Associates, 2011). If couples do not become pregnant from their first cycle of publicly funded treatment they may be eligible for a second cycle. Once the public funding has been used the couple are left with no other option than to pay 'out of pocket' if they wish to continue their pursuit of biological parenting. Thus, such couples face on-going anxieties about accessing funds privately to pay for treatment and in some instances financial pressure may result in them deciding about ceasing treatment altogether (New Zealand Herald, 2006).

Women who become involved with IVF treatment face a flux of emotional needs with this being accentuated in repeated treatments "the low success rate and the repetition of the invasive procedure is an additional source of demand and distress" (Cassidy & Sintrovani, 2008, p. 5). For those who continue treatment and pay 'out-of-pocket' the cost may become an

influence on the meaning that they give to their pregnancy and forthcoming child.

There are women/couples for whom public funding is either not available at all or the bid for funded treatment has been unsuccessful; and therein lies the question of generating funding. Some couples will be able to 'pay out of pocket' but others will require financial support in the form of loans with the long-term prospect of having a loan and no baby. Couples who have had to pay for four cycles are likely to have spent over \$60,000 (South, 2009). South (2009) provides examples from couples of their financial sacrifice in order to have 'one last attempt' at bringing home their biological child. Whilst women/couples struggle to cope with the emotional and physical turmoil of infertility and ART they have the added strain of raising capital and debt repayments. Baker (2004), in her study aptly labelled 'the elusive pregnancy' found that the male partners in the relationship found the high financial cost of IVF a concern, with some of the participants having bank loans to pay for the treatment. Baker also found another financial burden was often that women's normal functioning was interfered with due to treatments, which included the income from paid work. It was estimated in England that women undergoing IVF may miss up to 23 hours of work during the treatment cycle resulting in a significant loss in earnings, approximately € 596 (Metwally & Ledger, 2011).

All the women who participated in this current research would have had to pay at least one cycle of IVF. Indeed some would have paid for multiple cycles. For those who could access publicly funded cycles this often comes with a delay, and some couples choose to pay 'out of pocket' rather than wait.

For the couples who seek on-going fertility treatment and have no or limited access to funds there is the potential for 'reproductive migration' across the Tasman to Australia. Australia offers uncapped infertility treatment (Farquhar et al., 2010) and there is anecdotal evidence that

couples move so they can have improved access to fertility assistance. (New Zealand Herald, 2006). Women are also travelling further afield to undergo IVF treatment (Grunwell, 2010).

Conclusion

Women over the last century have been able to define what constitutes 'being a woman' influenced by the feminist movement and advanced fertility treatment. For women who choose to pursue a career, or who delay childbearing, waiting for the right time/partner, there remains a draw to fulfil society's expectation of becoming a mother. The conventional family structure has changed and transcended from the traditional family through to the family form now constituting traditional heterosexual couples through to same sex couples and single women.

Society's expectations, in addition to women/family desires for procreation, have together been drivers for the birth of infertility treatments; with the associated complexities for access and a significant portion of the public health dollar spend. However, there remains a socioeconomic cost for women/couples who in their pursuit of biological childbirth incur debt to access treatment in New Zealand and increasingly abroad. Having constructed the context of infertility and motherhood it is important to explore the literature to examine how the fiscal and emotional costs impact upon a woman finally pregnant and what research knowledge is available regarding her experience.

Chapter Three

Widening horizons through literature

Introduction

Anyone coming to the literature brings their own historicity shaped by prior ontological and epistemological understandings (Dickinson, 2004). Regarding text this becomes a springboard of thinking, showing me what I already know, resonating (or not) with my opinions, and drawing me to new questions. Therefore literature becomes a partner in my journey of thinking and discovery (Smythe & Spence, 2012).

The main recommendation for hermeneutic literature reviewing is not to present the reader with a report of the literature but rather to incite thought (Smythe & Spence, 2012). Heideggerian hermeneutic phenomenology focuses on the whole rather than the Cartesian duality of mind-body split (Koch, 1995; Leonard, 1994). The literature that is available, of which selected articles have been reviewed, is situated predominantly within the objectivity of science rather than the duality of the mind-body. This milieu of literature will have influenced my pre-judgements and my epistemology, as it inevitably has for other health practitioners who provide maternity care. Heideggerian hermeneutic phenomenology recognises that there is a process of transcending towards a clearing where a primal phenomenon can be revealed. Whilst the purpose of this chapter is a review of the literature directly related to this study, it is also a process through which I have widened my horizons to come nearer to the clearing, to the openness and opportunity to listen to the women's primal voice. My quest was to let "the possibility of phenomena" (Figal, 2010, p. 39) emerge from their voices, my own thinking and to develop further my awareness through analysis or discrimination of the given (Heidegger, 1962/2008).

The literature review initially draws the reader into the holistic perspective of what it is to experience infertility and moral dilemmas, acknowledging

the psychological impact of treatment and failure. I have had to expand my reading to include journals from psychological, anthropological and sociological databases in order to capture literature to stimulate thought and seek answers to questions that arose during my study. In the rapidly changing world of ART, where scientific discoveries are constantly being sought, it is imperative to acknowledge the traditional quantitative framework specifically related to IVF. This forms the biomedical portion of this chapter. This is followed by literature that focuses on the experience of a pregnancy after IVF, including a review of the qualitative research available in New Zealand regarding IVF. The chapter concludes with a review of the maternity care available in New Zealand.

Turning to the literature

When looking to understand the experience of infertility, pregnancy and becoming a mother it becomes apparent that the majority of the research available is quantitative. Although there is some salient qualitative studies that reveal the complex issues related to ART. The studies are global which demonstrates the growing global access and requirement for ART treatments (van Balen & Inhorn, 2002). While there is globalisation of ART there remains inequity of access to treatment, especially in the non-western world (van Balen & Inhorn). "The silence surrounding infertility in resource-poor countries may also reflect a tacit eugenic view that the infertile poor are unworthy of treatment" (Inhorn & Birenbaum-Carmeli, 2008, p. 179). According to van Balen and Inhorn high-tech ARTs are being introduced in developing countries but often to elite segments of the populations causing frustrations to those less fortunate. When resources are limited, such as in some third world countries, to invest in reducing the maternal and neonatal mortality as a priority, rather than spending on ART, is understandable by most except perhaps the infertile women. In New Zealand there are restrictions to accessing ART, as we have seen in the previous chapter; all of the women in my research have self-funded a minimum of one IVF treatment cycle whilst some funded all their cycles.

Experience of infertility

There is a body of knowledge that endeavours to explore how it is for women/men to be identified as infertile and the associated sequelae. Health practitioners covering the wide spectrum of the infertility continuum seek knowledge in order to provide appropriate and sensitive care. Therefore literature is available in journals from social sciences, anthropology, psychology and mental health nursing to identify a few. This literature seeks to convey that the experience of infertility is one of perpetuating psychological, physical and emotional turmoil and distress (see for example, Bleil et al., 2012; Hinton, Kurinczuk, & Ziebland, 2010; Morshed-Behbahani, Mossalanejad, Shahsavari, & Dastpak, 2012; Moura-Ramos, Gameiro, Canavarro, Soares, & Santos, 2012; Papaligoura, Papadatou, & Bellali, 2012; van Balen & Inhorn, 2002).

Valentine (1986) almost 20 years ago, and eight years following the birth of the first IVF baby, performed semi-structured interviews to explore the emotional impact of experiencing infertility from the perspective of being a social worker working with these families. She identified key psychological findings: infertility is an active crisis state, involves multiple losses, multiple sources of stress and a variety of methods of coping. Valentine stated that little was known at the time about how couples respond to the “narcissistic hurt that accompanies fruitless effort to conceive and bear a child” (p.68). She concluded that infertility is not a pathological event but rather an expected emotional experience when one is unable to parent or reproduce. Twenty years later I have to ask myself if her concluding statement is time specific or has this changed now in the 21st century?

In the previous decade “scholars treated infertility as a medical condition with psychological consequences rather than as a socially constructed reality” (Greil et al., 2010, p. 140). Now in the 21st century Greil et al, in their review of recent literature, conclude that researchers are more aware of the importance of identifying the social contexts, and social scientific frameworks essential in providing psychological counselling.

Since the insightful paper by Valentine her key topics have been expanded further regarding the social stigma perceived by involuntary childless women. The salient social isolation and the transformative role of various emotional supports are key themes (Allison, 2011; Benasutti, 2008; Eugster & Vingerhoets, 1999; Gonzalez, 2000; Hinton et al., 2010; Imeson & McMurray, 1996; Letherby, 1999). “Many couples challenged with infertility often find themselves isolated and marginalized in a child-centred society that is acutely ignorant of the impact of infertility” (Benasutti, p. 52). Benasutti’s phenomenological study involved four women and aimed to ascertain the deep and accurate understanding of the experience of infertility. Benasutti identified a need for the genuine accounts of lived experiences to inform clinicians, particularly counsellors, who work with these couples, stating that the impact of being infertile is more likely to produce psychological stress than the actual cause of infertility. Her focus was on improving the knowledge base for couple counsellors in order that they could assist future infertile couples to resolve their crisis and to foster stronger relationships. She believed that the resolution of the infertility crisis could be less tumultuous if the couples promoted effective communication and listening within their relationships.

Throsby (2004) suggests that for some women pretending to be a ‘career girl’ protected against unwanted fertility questioning. This strategy implies that it was easier for women to cope with social critique regarding voluntary childlessness than managing the knowledge of IVF treatment/failure. For some women/men finding strategies to cope may be by accessing counselling outside of the home; for others psychological support may be sought through the Internet.

Psychological support via the Internet

The use of the Internet for support by IVF women/men appears to be increasing and in conjunction with this is the ability to research the lived experience of infertility (Hinton et al., 2010; Isupova, 2013; Toscano & Montgomery, 2009). The most recent study by Isupova used a

combination of hermeneutic and ethnography of communication methodologies to understand the lived experience of infertile Russian women. Her study revealed the social isolation Russian women experienced and the strategies they enact during IVF treatment. The study found that support available via the virtual meetings reduced the women's silences as they sought to share with people who had the same experiences. The women reduced other real world relationships that provided unwelcome advice and "psychologically painful attitudes" (Isupova, p. 6). The risk with chat room culture is the reinforcement that only those who have experienced can understand, raising the potential that those accessing internet support also isolate themselves from 'outside' world relationships (Hinton et al., 2010).

Moral dilemmas – gamete donation/embryo storage

Experiencing infertility and accessing IVF treatment brings with it a variety of moral dilemmas influenced by the woman's social context. The use of a donated oocyte or sperm can result in a family being created that consists of a genetic parent and a social parent (Bos & van Balen, 2010). Since 1983 there has been the option of conception using donated oocytes for women who access IVF treatment with no eggs or poor egg quality (Birdsall et al., 2009; Bos & van Balen, 2010). The use of donor sperm has been available for intrauterine insemination and more recently IVF when the male is found to have no viable sperm (Choy & Ellsworth, 2012), or when a single woman is accessing treatment. Whilst donor oocyte/sperm may increase the opportunity of IVF success, it brings with it the emotional challenge of the child's biological identity.

Some of the women in this study had to abandon having biogenetic offspring and had to use egg or sperm donation. This made me question the impact on their relationship with the subsequent child. Would their relationship to their unborn baby be different, or do all women have cautious relationships due to their relentless quest to get pregnant? Is there an ongoing relationship with the donor woman? Inhorn and

Birenbaum-Carmeli (2008) suggest that there is a 'hybridised fusion', an allegiance between women. Indeed the women in my research who received donor eggs referred to ongoing relationships with the donor women. Inhorn and Birenbaum-Carmeli are convinced there is a destabilisation in family dynamics: "ARTs are applied to an ever-expanding range of people and problems, they are unsettling core notions of kinship and undermining the traditional family by introducing a whole range of quasi-, semi-, or pseudo biological forms of parenting" (p.182). The experience of infertility is deeply entwined in the personal grief of one's fecundity, and for some the added dimension of grieving their biological relationship with the potential offspring.

There have been concerns expressed for families created through IVF and donated gamete (Bos & van Balen, 2010). Concern is for the child when they are not informed regarding their conception and biological makeup. Another concern is regarding the parents relationship to a non-gamete child and whether they feel less positive toward the child, especially when donated sperm was required in place of the father's sperm (Golombok et al., 2006). Bos and van Balen in their systematic review in 2010 analysed the results of empirical studies that focused on childrearing and the psychosocial development in families formed through ART. From the studies they reviewed (29 publications) they found there was no difference in the parent-child relationship in families created through reproductive technologies and those of natural conception. They found in general the families from ART were shown to be more positively motivated parents, possibly linked to the high motivation required to undergo ART. Bos and van Balen did not expand on if or when the child was informed of its genetic lineage, but rather focused on the psychosocial development of the children. For couples who became parents at an advanced age it has been disproven that there is a negative impact on the child's wellbeing by being raised by older parents (Greenfield, 2011).

Counselling is essential prior to accessing donor oocyte/sperm to ensure the donor is well aware of the risks associated with IVF (Birdsall et al.,

2009; Throsby, 2004). For either sperm or egg donation, if donated after August 2005, all donors in New Zealand must be identifiable in line with the open adoption practices (Birdsall et al., 2009; Daniels & Douglass, 2008). All parents and/or the child are able to access this information through the New Zealand Births, Deaths and Marriages Department as the fertility provider notifies the Department of the donor demographics when a birth has occurred.

Women/couples accessing IVF who have successful egg retrieval and fertilisation may have remaining frozen embryos following the completion of the treatment cycle and their 'take home' baby. They then must face the moral dilemma with regard to what to do with the remaining embryos. Fertility counsellors have an integral role to play in this decision-making especially regarding donation of the embryo (Goedeke & Payne, 2010). Endeavouring to understand the meaning that couples place on their frozen embryos has been one of interest and research (de Lacey, 2005; Goedeke & Payne, 2009). It is appreciated that this meaning has a direct influence on the destiny of the embryo, whether that be discard, donation for other medically diagnosed infertile couples (Goedeke & Payne, 2010) or donation to scientific research (de Lacey, 2005, 2007; Lanzendorf, Ratts, Keller, & Odem, 2010). When embryo donation occurs in New Zealand, ECART require counselling for both the couple donating the embryo and the recipient, as well as police checks of the recipient(s) (Birdsall et al., 2009; Daniels & Douglass, 2008; Goedeke & Payne, 2010). All counselling must be culturally sensitive of those involved, essential to ensuring Maori whakapapa tradition is recognised (Glover & Rousseau, 2007). Based on the principle that the best interests of the child will be provided for the donor couple and the recipient couple are required to meet prior to transfer of the embryo (Daniels & Douglass). When the replacement of frozen embryos without a viable pregnancy completes a treatment cycle, a sombre question is yielded regarding ceasing or continuing the hope-disappointment cycles

Infertility discourses often refer to participation in IVF treatment by using the hegemonic metaphor “IVF as lottery” (de Lacey, 2002). The implication with this metaphor and the associated discourse is that it raises the ideas that continued participation will bring success. At some stage either the women ‘win’ the lottery and become mothers or construe that the lottery is no longer worth the investment and cease treatment. De Lacey (2002) argues that applying this metaphor opposes the women into those who become mothers (winners) and those that do not (losers). De Lacey suggests that those women who did not become mothers resisted being labelled ‘losers’, and that health practitioners should assist in the deconstruction of “negative stereotypes of infertile women as ‘obsessed’ and ‘compulsive’”(p.50).

IVF failure

IVF failure and the decision to cease treatment has also been a topic of interest. There is suggestion that there needs to be a higher profile of IVF failures in order to improve the social awkwardness surrounding the failures (Throsby, 2004; Williams, 2013). Williams cites American author Miriam Zoll who recently released her book titled “*Cracked open: Liberty, failure and the pursuit of high-tech babies*”. Zoll (2013) described in her book (viewed on line) the visceral reality of ART failure that is more common than treatment providers would have society believe. She unpacks the emotional consequences that women face following repeated treatments in an un-regulated American industry where society is led to believe success is prevalent.

The phenomenological study by McCarthy (2008) identified that participating women adjusted to ceasing treatment by re-defining their sense of self. Even so they continued to have a sense of being incomplete. “The sense of being out of synchronization with life’s patterns and failing in one’s anticipated contribution to society highlight the void that is created when the hoped-for child is not part of a woman’s life” (McCarthy, p. 321). Stopping treatment is associated with feelings of guilt

and failure which impact negatively on the woman's self-esteem (Throsby, 2004). Even 20 years after ceasing treatment and despite having fulfilling childfree lifestyles, Wirtberg, Moller, Hogstrom, Tronstad and Lalos (2006) in their qualitative study found such women were able to clearly remember their infertility experience. This study identified that the crisis of the experience may remain potentially for the remainder of the woman's life. Studies have found that women who underwent IVF treatment and the associated psychological implications of stopping treatment did identify that the experience had added to their personal growth. Transpersonal descriptions such as spiritual growth, relationship growth, and improved relationship with families are all identified as benefits of surviving treatment (Benasutti, 2008; McCarthy, 2008; Metwally & Ledger, 2011).

IVF pregnancies

With my commitment to ensuring I was keeping up to date with the IVF literature, in 2011 I developed an on-line journal alert system using the CINAHL Plus and PsycINFO databases. I set up the alert to occur weekly using key words IVF and in vitro fertilisation; the key words were open to maximise the alert system. In addition to the literature that has been made available to me through the alerts was the realisation of the global industry and vast amount of research being driven by this need for ongoing development in ART. It is also a topic that features regularly in newspapers around the country and media globally, such as the recent (2013) expansion of ICSI and removal of genetic material to ensure specific inherited genetic conditions are eradicated in the human lineage.

I became increasingly aware of the literature being produced that encompasses the woman's psychological wellbeing such as the mental health of the woman who becomes a mother following ART and the literature that is focused on the outcome of the baby that resulted from IVF, such as temperament and long-term mental health (see for example McMahon et al., 2011; McMahon et al., 2013). Questions arose in my

mind surrounding the quest for research to identify whether women who became mothers through ART were different; whether the baby produced as a result of ART was different to the baby produced through natural conception. I wondered why the research world thought that this needed to be so. Or was the need to prove that the outcomes were no different for these women and children? I was stimulated by these studies because as I became embroiled in the women's stories/experiences I was interested to see if their outcomes were similar or not to those in the literature. Women pregnant through donor egg also featured regularly in literature articles (see for example de Lacey, 2007; Gurtin, Ahuja, & Golombok, 2012; Wanggren, Alden, Bergh, & Skoog Svanberg, 2013). The relationship between the donor and the birth mother intrigued me, knowing that some of my participants fitted this description. I also became aware of the vast amount of literature that demonstrated becoming pregnant after ART carried risks; that heightened risk assessment and management of these pregnancies became a dominant theme. There is a plethora of empirical evidence that demonstrates there is an increased risk to maternal and perinatal health following IVF treatment compared to women who conceive naturally (Jackson, Gibson, & Y, 2004; Mukhopadhaya & Arulkumaran, 2007; Talaulikar & Arulkumaran, 2012).

Maternal outcomes

The increased incidence of complicated pregnancies may be due to the IVF process itself, complicated by multiple pregnancies or due to the underlying reasons for the infertility, for example maternal age and elevated blood pressure (Mukhopadhaya & Arulkumaran; Woods, 1997). A recently reported Swedish study evaluated the outcomes from IVF by reviewing 25 years of data (Kallen et al., 2010). Most notable had been the purposeful decline in the multiple pregnancy rates, by introducing single embryo transfer, with the associated reduction in maternal and neonatal complications. Women with multiple pregnancies have complications at least twice that of singleton pregnancies; complications such as anaemia, hypertension including pre-eclampsia, premature births,

haemorrhage and operative births including caesarean sections (Allot, Payne, & Dann, 2013). Pregnant women following IVF are also at heightened risk of venous thrombosis, especially in the first trimester (Henriksson et al., 2013). Whilst the absolute risk of pulmonary embolism in the first trimester is low, it is a condition difficult to diagnose and associated with maternal death (Henriksson et al., 2013). Fertility clinics have endeavoured to further reduce the maternal and neonatal risks in New Zealand by restricting the number of embryos replaced with the direct consequence being a reduction in multiple pregnancies and the associated complications (Murray et al., 2005).

Risk assessment in pregnancy is a common practice model and is applied to all pregnant women, although this is heightened for ART pregnancies. Finely woven, from the very beginning of any treatment is the concept of risk in ART pregnancies. The CPAC (Appendix 1) is essentially a risk based assessment tool, ruling out the women with high risk factors where their probability of a successful pregnancy is reduced, and thus not a cost effective use of the tax dollar. Even when IVF is successful and women do become pregnant the concept of risk continues. With the increased risk of miscarriage they are exposed to repeated blood testing in the first trimester and then offered the national maternal serum screening to detect the risk of fetal abnormality (offered to all pregnant women in NZ). If the screening result is high risk then the follow up is a diagnostic amniocentesis, bringing with it the risk of miscarriage. It is the only definitive test for abnormality prior to offering termination.

Once the women progress to the second trimester the risk of miscarriage has subsided, but as their pregnancy progresses their LMC remains on guard aware that these 'types' of pregnancies are at risk (Kallen et al., 2010; Sazonova, Kallen, Thurin-Kjellberg, Wennerholm, & Bergh, 2011). Practitioners are encouraged to identify why the woman required ART as the risks to the pregnancy associated with the underlying medical condition are important factors to consider in the pregnancy (Allot et al., 2013; MidCentral Primary Policy Group, 2010; Talaulikar & Arulkumaran,

2012). With the emphasis on risk it made me realise that the practitioners themselves may share the woman's concern about how the pregnancy will progress, and that the perpetual heightened awareness of risk may well impact on the management of the pregnancy/birth.

Perinatal outcomes

Singleton pregnancies following ART do have an elevated risk of pregnancy complications for both the mother and the potential for adverse outcomes for the infant (Talaulikar & Arulkumaran, 2012). There is a disproportionally higher incidence of premature births for women who have undergone IVF, even when the pregnancy is a singleton (Filicori et al., 2005). Singleton infants following IVF have associated complications such as decreased fetal growth and small for gestational age compared to spontaneous conception (D'Angelo et al., 2011; Pandey, Shetty, Hamilton, Bhattacharya, & Maheshwari, 2012). A retrospective observational study comparing IVF conceived fetuses with spontaneously conceived fetuses identified even at 12 weeks gestation the crown-rump measurement was smaller in the IVF fetuses (Cooper et al., 2012). The suggestion from these findings is that the underlying infertility pathology may have a larger impact than IVF techniques on fetal growth. Reviewing four years of Swedish data specifically investigating the outcome of singletons following IVF continues to add to the Swedish IVF evaluation (Sazonova et al., 2011). Sazonova et al., identified that specific maternal characteristics affected the obstetric outcome in a negative manner. Specifically of note was the women's smoking status, their BMI, whether they were primigravid and the years of infertility. The women accessing IVF funded treatment in New Zealand already have to have addressed their lifestyle factors such as BMI and be non-smokers thereby increasing the opportunity for positive outcomes.

There have been suggestions that there is an increased risk of autism spectrum disorders (ASD) in children conceived through IVF. Conti, Mazzotti, Calderoni, Saviorzzi and Guzzetta (2013) performed a

systematic review of the literature in order to compare the methodologies and thereby develop a conclusion regarding this suggestion. On review of the seven observational studies there was found to be no evidence to support the suggested relationship between ASD and IVF conception.

On-going research into the maternal and perinatal outcomes following ART continue and are required to ensure the long-term safety of these technologies (Metwally & Ledger, 2011; Nygren et al., 2011). An example is the recent literature focusing on the thawing technique of cryopreserved embryos and the impact of varying thawing techniques on the obstetric and prenatal outcome (Liu et al., 2013). This article demonstrates the on going quality improvement that is being sought with IVF technologies.

Women who are well informed, for example via internet searching, may well be very aware of these risks. Access to the internet does come with risks both in regard the information shared in chat rooms and the degree of truth posted on sites (Parsell, 2008). The LMC may also be shaped by 'risk' thinking, balancing keeping the pregnancy as normal as possible with the perceived risks may mould the management of the pregnancy (Allot et al., 2013). I wondered if the LMC shared the risk thinking regularly with the woman and what effect this had on how the woman viewed her pregnancy; did this add to her dread/anxiety? Therefore, I would postulate that these IVF women may have elevated anxieties throughout their pregnancies as a consequence.

Experience of pregnancy

The literature suggests that the women and their partners/husbands who finally achieve a pregnancy would experience periods of anxiety during the pregnancy. Previous descriptive literature through the decade of the mid 1980s to 1990s surrounding the topic of pregnancy following IVF identified a theme of tentative pregnancies. With the objective to develop some understanding of the women's experience of pregnancy following IVF treatment, van Balen, Naaktgeboren and Trimbos-Kemper (1996) and

McMahon, Tennent, Ungerer and Saunders (1999) undertook similar studies. In the control group participants in van Balen et al's Dutch study were from two midwife practices where the women planned to birth at home. A second group were IVF women under obstetric care who were planning to birth in hospital and a third group were women who had long standing infertility but who had conceived spontaneously, cared for by obstetricians, and planning to birth in hospital. Van Balen et al's research question asked how the successful IVF couples evaluated their previous IVF treatments/investigations and the pregnancy and birth for which they had long striven. In Van Balen et al's study the IVF women viewed the birth as more exceptional than the fertile women; this maybe because of the value the IVF women placed on the safe birth of the long awaited baby. The IVF women reported complications during their pregnancy more often than the fertile women. Of the IVF mothers 42% complained of minor or major complications during pregnancy compared to 23% of the fertile mothers. It is worth noting that the IVF mothers were older (mean 33.3 years) than the fertile mothers (mean 27.6 years) and as a consequence the age may have been a factor in the perception of pregnancy complications. In addition to the age difference the IVF and previously infertile mothers were under the care of obstetricians as opposed to the younger women (spontaneously conceived) who were under the care of midwives and birthing at home. What constituted complications is not expanded on other than women perceiving their pregnancy as less thriving (no definition was provided to this statement). Van Balen suggests that the IVF couples report more complicated pregnancies due to the unresolved psychological stress experienced through their infertility, leading to high levels of stress experienced in the pregnancy.

McMahon, Tennent, Ungerer and Saunders (1999) in their Australian mixed methods study asked the question whether the experience of pregnancy differed for the woman following successful IVF pregnancy compared to the woman with spontaneous conception. The women were all recruited through an obstetrician at the same hospital as the IVF clinic. The purpose of the McMahon et al study was to describe the pregnancy

experience for women post IVF treatment. They also wanted to investigate whether women's infertility strategies, such as controlling their emotions, continued with them throughout their pregnancy. McMahon et al., sought to ascertain if their experiences of IVF pregnancy were different to the control group. Questionnaires were used to assess the women's childbearing attitudes and neonatal perception. In the qualitative interview component of the study the women were asked to "describe conversations they had with their baby" (p.348). In addition they were asked whether they had prepared a nursery for the baby and scored their response on a 3-point scale.

The IVF women denied the significance of problems in the pregnancy and were less likely to seek information. They also viewed their pregnancy as a less relaxed process influenced by the infertility experience. Women who had multiple IVF treatments (that is two or more) identified their pregnancies as being a positive and fulfilling experience. In comparison the women who had become pregnant on their first treatment, and the control group, did not necessarily endorse pregnancy in this manner. McMahon et al made a salient closing statement:

It is important that health professionals understand that adjustment to pregnancy and parenthood may take a different course for IVF women and that models of 'normal' adjustment to pregnancy and motherhood derived from studies of naturally conceiving women do not necessarily apply to this group. (p.335)

Sandelowski, Harris and Holditch-Davis's (1990) study, which used grounded theory methodology and repeated in-depth personal interviews, concluded that pregnancy identity was more complex after IVF than spontaneous conception. The couples were interviewed twice in their homes using probing techniques for clarification and to encourage elaboration. The transcripts were analysed for content and categorised using techniques from Lincoln and Guba to ensure the study's rigor. The content of these interviews included in the paper is minimal with very little

of the couple's voices coming through; no essence of the experience is portrayed.

Toscano and Montgomery (2009), using a phenomenological methodology, accessed data from the virtual communities in order to convey the lived experience of women who were pregnant post IVF treatment. They found that the experience of trying to achieve a pregnancy was an integral part of their participants' experiences and thus was included. The key themes identified were: preconception turmoil balanced with hope but which included such stresses as financial, marital and psychological; conception with cautious joy whilst balancing fear and uncertainty; belief in a higher power and magical thinking; sorrow; birth synonymous with healing; breaking the silence through connection and sharing experiences. The web community provided a forum for shared experiences and therefore support, seeking impartiality and a feeling of virtual-social inclusion. The very last words in this article have been included here for the purpose of enhancing how common infertility is "We attended our first IVF orientation...I couldn't believe my ears when the orientation announcer mentioned there are 100 couples attending this function. And here I thought there would only be a few of us suffering from infertility" (Toscano & Montgomery, p. 1035).

Studies continue in order to try and understand how the women experience their pregnancy and adjustment to motherhood (Bracks-Zalloua, Gibson, & McMahon, 2010; Cox, Glazebrook, Sheard, Ndukwe, & Oates, 2006; Hammarberg et al., 2008; McMahon, Gibson, Allen, & Saunders, 2007). The studies have also expanded to include the development of the mother-infant dyad commencing in utero and the effect on the postnatal parenting relationship and temperament of the baby.

Becoming attached to the baby

For the IVF mothers there is a cautiousness in the relationship to their in utero baby (McMahon, Tennant, Ungerer, & Saunders, 1999). For the IVF

woman finally pregnant I began to wonder if 'falling in love' with her in utero baby, defined as intense emotional attachment by McMahon et al., (2011), is different to the woman who became pregnant spontaneously, or following a first IVF treatment. Would the women after repeated treatments have a different relationship with their in utero baby? These thoughts led me to a plethora of articles with regard to attachment to the baby in utero, and taking this concept further to the effect that the pregnancy attachment had on the baby's temperament.

With up to 15 per cent of Australian couples experiencing fertility problems and many requiring ART such as IVF to conceive (Bracks-Zalloua et al., 2010) it is not too surprising that there is a significant amount of research related to IVF. I read through many articles related to this topic (Fisher, Hammarberg, & Baker, 2008; Gibson & McMahon, 2002; Gibson, Ungerer, McMahon, Leslie, & Saunders, 2000; Hjelmstedt, Widstrom, & Collins, 2006; Hjelmstedt, Widstrom, Wramsby, & Collins, 2003; Kikkert, Middelburg, & Hadders-Algra, 2010; McMahon et al., 2011, 2013) with headings such as 'antenatal mood and fetal attachment after assisted conception'; 'the mother-child relationship following in vitro fertilisation: infant attachment, responsivity, and maternal sensitivity' or 'patterns of emotional responses to pregnancy; experience of pregnancy and attitudes to parenthood among IVF couples'. The literature I read surrounding this seemed equivocal such as Hammarberg, Rowe and Fisher (2009). They suggest that the ART mothers perceived their infant's temperament to be to be less difficult than from the spontaneously conceived mothers perception; that idealized expectations of pregnancy for women conceiving through ART may leave them vulnerable in their adjustment to early parenthood. McMahon et al (2013), in their prospective study, reassure IVF parents that antenatal anxieties were not associated with more difficult infant temperaments. Other study findings suggest a direct link between prenatal maternal anxiety and neurological development of the child (Kikkert et al., 2010). The more I read the more I became aware that the evidence was open to variable interpretation. I was mindful of the research limitations, especially some fundamental principles of validating empirical

evidence. Of those critiqued, few reported any power calculations in order to demonstrate adequate sizing of the sample or acceptable response rates. Others had poorly matched groups and inadequate or no follow up of participants. The use of questionnaires and telephone interviews with Likert scale responses did not convey the depth of the experiences. I was left with the question in my mind about how the women in my research would describe the relationship between themselves and their unborn baby and how the relationship changed, if it did, when the baby was born.

Qualitative New Zealand research and IVF

Interestingly, there have been two New Zealand qualitative studies performed regarding ART. Both of the studies described below are focused on the psychological impact of infertility and the need to seek ART. Motivated by the need to develop a positive feminist discourse regarding infertility, Ulrich and Weatherall (2000), analysed interviews with 19 women and identified the following three discourses. The first was the rationale for wanting children: the women viewed pregnancy and motherhood as a natural instinct, of being biologically predetermined. They also viewed motherhood as a stage in the development of a relationship with their partner. For some women the concept of never having children prevented them from entering a relationship with anyone for whom children were not a priority. It was also noted that women viewed motherhood as a societal expectation with the genesis from early socialization of girls. For some women the active reproductive decision to have children demonstrated choice and not a predetermined natural instinct, assuming that choice would mean success in conceiving.

The second discourse related to the reality of motherhood: it was identified that motherhood, for women who had conceived through medical intervention, was not what they had imagined it to be. Women described the unexpected challenges of being mothers, and these were in contrast to what they had understood motherhood to be. The women had thought that motherhood would be straightforward but found the reality of

motherhood being hard work. Nothing like the 'breeze' they had thought it would be.

Finally the third discourse described the language of infertility in the context of the experience. Women demonstrated a clear understanding of the constructed nature of infertility. The women were dissatisfied with infertility being referred to as a problem, implying some remedy or ability to be clearly fixed.

Ulrich and Weatherall's study is meaningful, insightful and thought provoking. They made the following statement..."Western discourses of motherhood as an inevitable outcome of a woman's biology, as living up to social expectations and as a pinnacle of an intimate relationship obscure the personal, social and economic experiences of having and not having children" (2000, p. 333). Their identification of the various discourses regarding motherhood and infertility in New Zealand in 2000 I believe remain evident in 2013 with motherhood being the status important for a woman's completeness. Their paper concludes with recognition of New Zealand women who have involuntary infertility, acknowledging their ability to inform society with regards motherhood and infertility through their experiences of grief, confrontation of loss and their personal feelings of failure. In concluding their paper in this manner they offer a different construction to women who experience infertility and do not become mothers. They identify/recognise these women as survivors and the valuable asset they provide to society.

A further New Zealand study was performed in 2004 with the aim of examining the meaning attributed to infertility and the awareness of choices of infertility treatment (Baker, 2004). Whilst this paper is informative, especially the stories of the men and the women, the methodological trustworthiness is open to question. For example, I found it noteworthy that there is no elaboration on the research method applied,

especially with regard to the Treaty of Waitangi³ given that there were Maori participants. Of the 24 participants some had already become parents but were with new partners. Others had become parents following previous medical treatment, whilst others had been accessing treatment without pregnancy. Less than half the women who participated were in satisfying jobs or had careers and it was for these women especially that lineage, as well as femininity, was associated with parenthood. Baker found that it was predominantly the women who wanted to continue accessing treatment as opposed to the men. The men were concerned with the wellbeing of their partners, the huge financial burden of treatment and the preoccupation that conception had on their lives. Baker does challenge the role of reproductive technologies in prolonging the yearning of parenthood and the delaying of women “getting on with other aspects of their lives” (p.40). Baker carefully highlights the significance of the perspective of couples that are unable to have children, even following ART, and the difficulty these couples experience in a society where the construct of ‘normal’ is parenthood.

Maternity care in New Zealand

The New Zealand maternity system “is arguably one of the most woman-centred national maternity systems in the world” (Grigg & Tracy, 2013, p. e63). It is founded upon the tenet of continuity of care facilitated through the ‘Section 88’ maternity legislation (Ministry of Health, 2007). All women in New Zealand (with residency) have access to free maternity care (Ministry of Health, 2011a) and the choice of a LMC, irrespective if their pregnancy is the result of IVF or not. Some may choose to have a private obstetrician as their LMC for which there is a cost (Birdsall et al., 2009).

³ The requirements of the Treaty are that participation, protection and partnership must be included in ethics applications for New Zealand research.

Women who choose to have care by a midwife LMC do so for the articulated practices of partnership and continuity of care which are provided by one midwife through the entire spectrum of pregnancy and postnatal (Frohlich, 2007; Grigg & Tracy, 2013; Guilliland, 2009; Pairman, 2004; Surtees, 2004). An IVF pregnant woman will choose an LMC whom she identifies as being best able to provide appropriate support and visits of reassurance (Guilliland, 2009; McMahon et al., 1999; van Balen, Naaktgeborne, & Trimbos-Kemper, 1996). The updated Primary Maternity Services referral guidelines no longer recommend women pregnant following IVF have a consultation with an obstetrician during their pregnancy (Ministry of Health, 2011b). Just as for all pregnant women, careful in-depth health history taking and referring to the appropriate specialists is important (Allot et al., 2013). Women who are pregnant following IVF face increased risk of adverse pregnancy outcomes as described previously. Whilst the perinatal adverse outcomes are related to premature birth, low birth weight and plurality of the pregnancy, it is due to these risks that anecdotally obstetricians imply women should be under medical care (Mukhopadhaya & Arulkumaran, 2007; Ziebe & Devroey, 2008). However, some women, who are finally successfully pregnant following IVF may also have complex co-morbidities, such as essential hypertension or pre-existing diabetes, and therefore by current guidelines are recommended to be accessing obstetric care (Ministry of Health, 2011b).

Conclusion

The holistic experience of infertility, including the moral dilemmas and the psychological impact of treatment/failure have been identified, predominately through the positivist paradigm. The harsh reality of treatment failure and the sense of repeated treatment gambling accentuate the social isolation experienced by women/couples. Increasingly psychological support is being accessed via the Internet to assist with the chronic sorrow and social isolation.

Women who do finally conceive through IVF are fortunate in New Zealand to receive their maternity care from health professionals in arguably one of the best maternity systems in the world (Grigg & Tracy, 2013). Women are able to choose the LMC they identify as the best health practitioner to provide their individualised maternity care. With the emphasis on pregnancies after IVF often being viewed as high risk the question arises as to whether the women's holistic needs are provided for. This research endeavours to reveal such insights.

Heidegger believed that the enigma of human existence and therefore human experience was lost in twentieth century science (Steiner, 1991). This chapter, has to some degree, provided an example of Heidegger's perspective as demonstrated in the dearth of qualitative research and in the methods applied within the positivist paradigm. Braverman (2008) suggests that qualitative research is imperative to developing an understanding of the experiences and perceptions of women and men following IVF treatment in order to provide appropriate support and interventions. Whilst there is some qualitative literature involving New Zealand participants, there remained the need to focus solely on women following repeated IVF treatments, especially with the burgeoning demand for IVF in New Zealand. This current research reveals the experience of repeated treatment/failure and the impact this has on the pregnancy; able to be revealed because it is founded upon a methodology that listens to the experience and unravels the extraordinary in the ordinary as detailed in the methodology chapter.

Chapter Four

Philosophical foundations

“In order to understand ourselves we have to look at how we exist” (Polt, 1999, p. 44)

Phenomenology is not about producing conclusive arguments, facts or determined ideas. It is rather about drawing the reader to the allusive power of the text and the analysts reflective insights from the accounts of lived experience (Bentz & Rehorick, 2008; Crotty, 2010; van Manen, 1997). As a phenomenological researcher I seek to uncover the extraordinary within the ordinariness of the participants' experience of being pregnant and becoming mothers. Koch (1999) explains this philosophical framework, “we do not come to see how people live, but rather, we may be able to understand what it is like for them to be living their lives” (p. 27). Heideggerian hermeneutic phenomenology has informed this research inquiry, an appropriate philosophical framework which enables the women to be viewed whole rather than as the Cartesian duality of mind-body split (Koch, 1995; Leonard, 1994).

Understanding and articulating the ontological and epistemological underpinnings of phenomenology have been essential to frame and inform this research (Crotty, 2010; Koch, 1996; Leonard, 1989; Maggs-Rapport, 2001; Norlyk & Harder, 2010). I have come to appreciate that developing an understanding of phenomenology is a process of evolution, as my emerging grasp is never finished: My personal epistemological is continually developing. Developing an understanding of Heideggerian hermeneutic phenomenology supports my view of the world and my sense of being-within-the-world. It is generated from the linguistic and cultural traditions that I was born into, enhanced by my life experience thus far. My personal experiences of infertility treatment and IVF have informed my view of the world in a non-theoretical and non-cognitive way forming my personal ontology (Leonard, 1989). This chapter describes the

philosophical foundations and notions that have underpinned and formed the foundation to this study.

History of phenomenology

For hundreds of years, from Plato and Aristotle, philosophers have asked questions regarding who we are in the world, questioning the sense of being. The phenomenological movement is framed upon these earlier philosophers and is associated with Hegel [1770-1831] and Brentano [1838-1917]. Husserl carries the crown of being referred to as the founder of phenomenology (Crotty, 2010; Dowling, 2011; Paddy, 2010; Sokolowski, 2000).

Husserlian phenomenology requires researchers to 'park' their life world and natural attitude in order to interpret the experiences with a neutral mind state (phenomenological reduction), from a temporary separate life platform free of suppositions (Dreyfus, 1987; Walters, 1994). The utilisation of phenomenological reduction assumes that this would provide a view of the world without any presuppositions, hence discerning the world anew without influence. As a result the researcher would be able to experience the meaning of an experience as it occurs in consciousness without presupposition influence (Dowling, 2011).

Heidegger was a student of Husserl and indeed his major work is a "reinterpretation of phenomenology and its method" (Walters, 1994, p. 13). Heidegger disagreed with Husserl's phenomenological reduction, believing that we exist in the world and are consequently influenced by that existence. Human beings are unable to stand outside of the world and reduce their lived experience, as that is part of being in the world (Harman, 2007).

I recognised my personal ability to render a 'phenomenological attitude', to bracket my experiences and prejudgements in order to view the research

from a neutral mind state, as being fraught with difficulties. I chose to declare these prejudgements and experiences and have used them to assist me in interpretations of the women's stories; and also to understand myself as part of the process, as is a hermeneutic approach (Gadamer, 2001; Koch, 1996). Part of performing this research has been declaring myself-in-the-world and the involvements I bring of a woman who experienced first-hand three IVF treatment cycles (my personal ontology and epistemology). As a midwife I provide care for both women who conceive spontaneously and those who conceive through IVF. I recognise that the needs of the latter are different to women who conceive spontaneously or through their first IVF cycle.

Heideggerian hermeneutic phenomenology

Heideggerian hermeneutic phenomenology has its roots in theology and the analysis of Biblical text in order to provide understanding and meaning to others (Bentz & Shapiro, 1998; Crotty, 2010; Gadamer, 2001; Leonard, 1994). Hermeneutics is the theory and practice of interpretation leading to an understanding, whilst recognising that there are no such things as un-interpreted phenomena (Leonard; van Manen, 2007b). Heideggerian hermeneutic phenomenology engages in the interpretation of what is 'already' shown in factual life (Hatab, 2011). It is the process of reflecting and writing, reflecting upon the text provided and writing until such time that the fullness of the phenomenon is revealed. "The hermeneutic circle is a circulation between language and lived experience that cannot presume to offer fixed truths or objective explanations" (Hatab, p. 88), with the ultimate aim to become more fully who we are (Koch, 1996; van Manen).

Heidegger's approach extended the hermeneutic methodology to one that recognises that interpretation is not divorced from one's experiences. Rather the interpretation of the experience in question will be moulded and informed by the experience the researcher brings to the interpretation (Koch, 1996; Leonard, 1994).

Thinking does not happen as a mechanistic process divorced from being in the world. Rather thinking is lived, breathed, and dreamt, felt, run-with, laughed and cried. It arises from all that has come before in one's life, both the remembered and that which is known without knowing. (Smythe et al., 2008, p. 1390)

Heidegger's involvement with the National Socialist Party

It is important to note that I bring my own epistemology of the era of the impact of the Nazi party through the lens of my paternal family. My father lived in a Nazi occupied country; his mother was German and his father Dutch. During the Nazi occupation his family (my lineage) had a significant change in status from that of respected wealth to the demise of their income, the destruction of factories leading to the eventual desperation of every day existence. Due to this family history I have always taken an interest in this era, in my need to understand my family ontology and the immigration to New Zealand. What I do appreciate is that in this the 21st Century it is impossible to understand the depth of the fascist movement and the fear that people had at the time. I am mindful of the extremes to which people went in the desperate need to survive, including the risks undertaken to assist others to survive (for example my grandmother being German was able to hide people of other ethnicities within their home) and the risks of denouncing the fascist movement.

Times were turbulent in the 1930s and 40s for people living in Europe, recovering from the First World War and the depression. History of this period of time is well recognised as the Nazi ethnic cleansing resulting in mass extermination of the Jewish blood line, including other minorities such as gypsies and homosexuals (Solomon & Higgins, 1997). Heidegger, unlike some of his colleagues (for example Gadamer), joined the National Socialist Party and although this was only for a 12 month period it has led to significant discourse as a consequence (Solomon & Higgins; Water, 2008; Wolin, 2004; Young, 1997).

Heidegger was living and creating his philosophy in the midst of this European dictatorship. The theoretical underpinnings of Heideggerian philosophy deem it contradictory to separate Heidegger the man and Heidegger the philosophy from the ontology of the time (Young, 1997). Therefore each student who studies Heideggerian philosophy must engage in the reality that Heidegger did join the National Socialist Party and must individually decide if there is any relationship between the philosophy and fascism (Polt, 1999).

What is fact is that Heidegger did indeed join the party on the 1st of May 1933; twenty three days later he presented his inaugural Rector's speech. He was actively involved for a period of twelve months, the same length of time as holding the position of Rector before standing down (Harman, 2007). From here there is a dichotomy of beliefs. For some there is the suggestion that Heidegger joined the party in order to provide some protection to the university community from political control and to protect the Jewish and anti-Nazi faculty from oppression (Young, 1997). This would fit well with the facts that Heidegger did have some close relationships with colleagues who were Jewish, namely his lover Hannah Arendt (Polt, 1999). His resignation was due to his refusal to comply with the purging of those deemed politically unacceptable; he became an open critic which resulted in him being viewed as an expendable professor (Young).

Others suggest that Heidegger joined the party as he genuinely believed an opportunity existed in this dictatorship for ontological revolution of the German people (Bambach, 2010). Following events of the First World War there had been many changes in European identities. The National Socialists were intent on uniting the German people and rejecting individualism favoured by the greater community (Young, 1997). There was the idea that one leader would re-establish the German identity making the decisions for the people (volk) (Young). Heidegger intended that he would be the philosophical leader of the National Socialist party, to lead the re-awakening of the volk, and when this did not occur he resigned

from his Rector position and returned to his writing and teaching (Bambach).

Harman (2007) analysed Heidegger's short interlude with the party and suggests that he joined the party purely for the opportunity it provided for enhancement of his philosophy. Lang (1996) suggests that Heidegger was vain and only interested in his personal development "and a desire for philosophical glory" (p. 109) that joining the party would bring. Bambach (2010) supports Lang's inference by describing Heidegger's failings as "staggering and his unwillingness to honestly address his mistakes constituted insularity at best and prideful arrogance at worse" (p. 114). Heidegger's followers, many of whom are Jewish, remain dedicated to his philosophy and are of the opinion that there is no relationship between fascism and Heideggerian philosophy (Harman; Polt, 1999).

The true reason for Heidegger's short interlude with the party is unlikely to ever be known. Intensive interrogation following the war by the Allies concluded with the label 'fellow traveller' therefore recognising him as a follower although not an extremist (Harman, 2007). Whilst Bambach (2010) suggests that his responses were egregiously inadequate there remains no direct relationship between his philosophical thoughts and anti-Semitic statements (Polt, 1999). Perhaps as Young (1997) suggests he demonstrated political naivety by his short interlude with the party. However, from the many readings regarding his involvement it is the view of Heidegger's silence post war when questioned that causes the most disquiet. In *Being and Time* Heidegger refers to silence as an important component of discourse and that "discourse is the Articulation of intelligibility....hearing and keeping silent are possibilities belonging to discursive speech" (Heidegger, 1962/2008, p. 204). Heidegger suggests that keeping silent strengthens what one has to say "in talking with one another, the person who keeps silent can 'make one understand'" (Heidegger, 1962/2008, p. 208). The question remains: was his silence in relation to the atrocities because he had no words that could adequately

explain or excuse them or, was the silence his protection from disclosing his involvement within the party.

My conclusion to his involvement in the Party is that firstly I inadequately understand the context of the time. Those that did (namely the Allies) examined Heidegger and he was spared execution (Harman, 2007). Secondly, my commitment to Heideggerian hermeneutic phenomenology and the underlying philosophical concepts leads me to believe that I should not separate the man from the philosopher, endorsed by Young (1997). I have reconciled using Heidegger's philosophy by remaining attuned to any nuances within his work that display any propinquity to anti-Semitic or fascist considerations and have yet to find any that are disquieting. Heidegger was passionate that humans should not take their being-in-the-world for granted, but rather that we should appreciate our existence for the opportunity it offers. In this quest he developed philosophical notions that have become the framework to inform phenomenological methodology.

Philosophical Notions

The Question of Being

The concept of Being is pivotal to Heidegger's philosophy. Heidegger was concerned that the scientific world could give answers to the questions such as what a dog is, but could not tell how or why human experience as a whole mattered. He was concerned that we were living in a world where science and technology was the focus rather than the concept of being (Heidegger, 2001). His concern was the objectivity of society where "one only listens to what makes noise, so one only counts as being what works and leads to a practical, useful result" (Heidegger, 2001, p. 118) as opposed to valuing the concept of being: being-with-each-other and our way of being-towards-one-another in the world (Steiner, 1991). In Heidegger's (1962) book *Being and Time* he wanted to develop a descriptive understanding of the concept of Being, of the relationship to

being-in-the-world, which he termed Dasein. Translated from the German 'das Sein', Dasein literally means everyday human existence, a non-conscious matter (Dreyfus, 1991; Leonard, 1989). "Dasein must always be seen as being-in-the-world, as concern for things, and as caring for other [Daseins], as the being-with human beings it encounters, and never as a self-contained subject" (Lang, 1996, p. 159). Heidegger fundamentally sought to develop an understanding of the way in which "the human being, Dasein, actually is in order to appropriate the possibility of understanding its Being" (McKenzie, 2008, p. 573).

Heidegger recognised that we all have our own ontology of the concept of being (using a small b) to mean something that actually physically exists, which is different to the concept of Being (capital letter B) to mean actual existence. In this it is meant the manner in which human beings exist (Being) rather than what they actually are (being) (Large, 2008; Paddy, 2010).

The course of everyday activities and practices of Dasein is characterised by the concept Being-in-the-world. Its everydayness means that it is so close and well known to human existence that it is overlooked (Heidegger, 1962/2008). It is to this end that Heidegger has used the term Dasein "liberating us from a dead ontology preventing us from experiencing our world as it appears rather than as we think it should" (Large, 2008, p. 27). This recognises there are components of the past and also the future that together provide ways in which each human individual identifies experiencing his/her world. Therefore my understanding of Dasein is the being of Being, unique and different for every individual. The Being is always with me "because my Being is mine, it is always an issue for me – it is the special way of being that Heidegger calls existence" (Polt, 1999, p. 49).

In the context of this research I am focusing on the manner in which women who are finally pregnant following repeat IVF treatment experience **their** world being pregnant as opposed to **that** they are a pregnant

woman. “When we designate this entity with the term Dasein, we are expressing not its ‘what’ (as if it were a table, house, or tree) but its Being” (Heidegger, 1962/2008, p. 67).

A key word is the use of ‘in’; the world is ‘in’ one’s existence and one exists ‘in’ the world or to dwell in the world (the being there of existence) (Crotty, 2010; Inwood, 2000; Polt, 1999; Sokolowski, 2000; Water, 2008). The use of the world ‘in’ does not refer to being physically inside something but rather that of being alongside (Large, 2008). Human beings are primarily a part of a world that is familiar and that they know their way around in-the-world (Inwood, 1999). They never exist alone but are always part of a context that they find themselves in, this is Being-in-the-world (Paddy, 2010; Ruin, 2010).

Worlds

The reference of worlds is not the geographical world as in that on a map, but rather as Large (2008) explains, it is the intelligibility in which equipment and others make sense and therefore have a presence. All human beings are born into a world where there is a set of relationships that are meaningful, with practices and languages. My world is intimate to me as a human being, it is so much a part of my everydayness and so comfortable that it generally causes me no concern. “World according to Heidegger is a priori...it is given in our cultural and linguistic practices and in our history” (Leonard, 1994, p. 46). By living within the world that we are thrown into (by birth) we absorb and are shaped by the culture, values, languages and family traditions, not in an objective and cognitive way but rather by way of interaction and immersion (Leonard). Our individual worlds are constructed by the past and influence the current and the future existence of ourselves in our world. The world that we individually live in is a world of potential and possibility with aspects that we may share with others in the sense of common culture, experience and language.

Those women who have lived the experience of being unable to conceive are the only ones who can truly understand the world of infertility. Language is the tool used to express an understanding and interpretations of the world; it is the shared discourse between human beings that demonstrates a shared intelligible world (Large, 2008). Women were able to share openly with me during this research for we were able to communicate with each other demonstrating a meaningful and common world. The women did not feel that they would have been able to share as deeply with a researcher who had not shared in the same infertile world, that their interviews would have been more prosaic as a consequence. “I must live in my world before I can know it in its limited way” (Large, p. 57).

In order to develop an understanding of the experiences of women pregnant after repeated IVF treatment one has to appreciate and understand the individual worlds that constitute the women’s worlds. Each participant experienced infertility and finally pregnancy influenced by the cultures, family traditions, languages and expectations of her world and of the world they identified that they should belong in. “Understanding the relational and configurational context allows for a more appropriate interpretation of the significance that things have for a person” (Leonard, 1989, p. 46).

“Dasein’s existence is understood in terms of possibilities...how we face our possibilities and what they might mean to us is always going to be deeply personal” (Large, 2008, p. 36). Human beings are therefore able to define their own possibilities within the individual world. All humans have the opportunity to make a stand about their own existence, to make decisions; this is what differentiates a human from an animal.

Within the world are a variety of concepts important to Heideggerian philosophy some of which are important to this research and are introduced here but expanded on in the findings chapters.

Thrownness (Belonging)

The concept of thrownness involves identifying where one exists within the world that one was thrown into. Our human existence involves understanding the cultural, familial and historical particularities that one was thrown into (Leonard, 1994). "Thrownness describes an aspect of Being-in-the-world where we find ourselves coming from the past into the future" (Paddy, 2010). The notion of thrownness is "finding ourselves in a particular nexus of cultural, familial, and situational practise and meanings and out of this thrownness we have to take a stand on ourselves (Leonard, p. 54). The world establishes potentials for whom a person can or cannot become. Whilst each of the participants constitutes and defines her own world there are constraints to that world by way of her inherited languages, values, culture, purpose and history. All of the women in this research undertook IVF hoping that success would transpire and that each of them would be able to identify themselves in the world that included a woman's biological life purpose, to be a mother.

So whilst we all individually experience 'Being-in the world' we have multiple facets of the world that we encounter throughout life. I live in a world where I am a professional woman, I make valuable contributions to society but it is a different looking world to the 'conservative' world I was thrown into from birth. I thought that while I was a professional woman I wanted to also be a mother, to be part of the mother-world where family traditions and cultures deemed I should belong. After being unable to achieve a biological pregnancy through repeated IVF treatment I (together with my husband) made the decision to accept that we were thrown into a different world, a world where other human beings live who have been unable to become parents.

The personal mission of completing this research has been a cathartic experience because it has made me realise that I belong in a world where I am valuable and worthwhile. My existence in the world I related to was challenged but as a result I now know the world I belong in and have a

personal sense of place. It is this needing a sense of place that drove the participants in this research; they were unaware that there was a world different to the mother-world (the world where I personally exist). This is a world that exists and with which other humans share the same language and experience, where the sense in the present is not separate from our history and traditions but was and is directly affected by those experiences.

Moods

Heidegger says that moods are always present before one cognitively discloses the mood. Moods are defined as “a unique and primary way of disclosing Dasein’s Being-in-the-world” (Smith, 1981, p. 211). Being-in includes two moments: one of understanding (the mood) and the second of finitude both are characterised by speech. There are some moods, such as anxiety, when the familiarity of everydayness collapses and as a result Dasein becomes uncomfortable in the world and the individual’s world becomes decentred (Inwood, 1999).

A mood is an attunement that is disclosive of the whole of being. It is because of these moods in which, as we say, we are this or that (that is, bored, happy, and so forth) we find ourselves in the midst of the whole of being, completely pervaded by it. The affective state in which we find ourselves...discloses, according to the mood we are in, the whole of being. (Smith, p. 216)

Women who participated in this study experienced a variety of moods. The predominant mood that permeated their experience was that of dread and the effect it had of fearing failure, failure of treatment through to the ‘what if’ of something occurring that would endanger their newborn. Whilst dread was dominant there was some balancing of this mood with that of hope and the celebratory opportunity that success brought to the experience.

Time

Time is a way of Being and is a measurement of change in its very broadest sense (Large, 2008). Time always involves the three-fold structure, that is past, present and future (Harman, 2007). “Both projection and thrownness are at work whenever we are absorbed in a present state of affairs” (Polt, 2010, p. 71). Therefore, at any moment in time we are influenced by the future and the past. Even if we were to draw a line and mark present time, as soon as it marked it becomes past time and the rest of the line becomes future time. Humans therefore have an ontological understanding of time that we have been taught since time started for us individually.

The concept of time is referred to as lived time, a term Heidegger called temporality. Lived time will be slow when a person is anxious (as experienced by the women during their IVF treatment) but speeds up when enjoyment is being experienced. For example, when listening to a speech time stands still when we are disinterested, or bored; if the speech is exciting the time flies by quickly. According to Harman (2007) there is an “ambiguous way that time is already at work in our environment before we have noticed it at all” (p. 27). It is subjective time in contrast to the objective clock time by which we live the inauthentic everydayness of life (Large, 2008). Heidegger preferred to assign the measurement of time by the use of an environmental reference, “when the sun rises, it is time for so and so” (Heidegger, 1962/2008, p. 465). For the women the sun rose and set many times whilst they awaited motherhood; they experienced the ‘slowness’ of time.

Ready-to-hand

There are particular elements in our lives that we do not need to pay any attention to, they are ‘just there’. Heidegger refers to this as being ready-to-hand. It pertains to the primordial relationship that we have with things (Mitchell, 2010). They have a deep seated, habitual element to their

presence so that our everyday living becomes circumspective, we do not pay them any attention (Harman, 2007; Stapleton, 2010; Walters, 1994).

Applying this concept of ready-to-hand in order to grasp Heidegger's meaning is important. In my later years as a LMC I became aware of heart palpitations when I had been working for long periods of time without a break. I had never ever thought about my usual heart rhythm, my heart worked and I didn't think anything of it. Suddenly, palpitations made me aware that there was something unusual in the way my heart patterns occurred and this changed from never paying attention to the physical presence of my heart to suddenly being aware of how important it was. "When things fail us, we appreciate their importance" (Polt, 1999, p. 78)

Present-to-hand

When the habitual equipment of life changes from the background of everyday use and become conspicuous they are termed present-to-hand, they have become cognitive. Equipment that is present-to-hand comes from what was ontologically ready-to-hand (Heidegger, 1962/2008) but because something has changed its existence is no longer deep seated it is now an object in view. The element in view, or conspicuous, will not revert to being ready-to-hand as the awareness will remain. Termed by Heidegger as present-to-hand it is the deep and personal way that we are each able to talk about our personal existence as mine.

Relating this to the example above, the palpitations that occurred changed my previous ready-to-hand appreciation of my heart to now always being aware of my heart and attuned to changes in the pattern. I would never now not be 'in tune' with changes of my heart rhythm whereas previously I paid no attention to it because it was 'just there'.

For the women who want to conceive but seem unable to there is a change from their knowing they are female to becoming much more aware of their reproductive cycle. With ongoing fecundity they then become so

familiar with their reproductive physiology that they will never be able to return to their previous un-in-tune reproductive awareness.

Comportment

In our everyday going-about all human beings have a manner that is unconscious to the individual. Whilst this is not individually identified it is perceived by those with whom they interact (Dreyfus, 1991; Giles, 2008). Others are able to identify what is individually important to each of us by the manner in which we demonstrate our being-in-the-world; we are constantly comporting to something (Heidegger, 1962/2008). “He basically comports himself to other beings and to himself and that this is only possible on his part because he understands being’ (Lang, 1996, p. 153). When the women in this current study became mothers they endeavoured to comport themselves in a manner that they identified was the ‘way’ to be a mother. Yet, a way of being is always infused with a mood.

Conclusion

This chapter has developed an essential framework upon which this study has been founded. My understanding is based on the historical construction of phenomenology, recognising Heidegger’s involvement in the National Socialist Party and thereby forming an acceptance that in the 21st century it is difficult to appreciate and make a concrete decision regarding his rationale for his involvement. Developing my understanding of phenomenology has underpinned and informed this research, essential to provide trustworthiness and validity.

Key Heideggerian philosophical notions have been introduced and will be linked into the findings as I offer interpretations of the lived experience for these women finally pregnant following repeated IVF treatment and their matrescence. The next chapter takes these philosophical principles and combines them with the practical approaches in describing the ‘how to’ of the research process that I applied.

Chapter Five

Methods

“We do not come to see how people live, but rather, we may be able to understand what it is like for them to be living their lives”

(Koch, 1999, p. 27)

This chapter exposes the steps that were undertaken, guided by Heideggerian philosophical underpinnings, in order to best answer the question: ‘What is the experience for women of becoming and being pregnant and their early mothering, following repeated IVF treatments’?

Van Manen (2006) warns of the dangers of applying a ‘method’ for the potential to “hollow out our understandings and cuts us off from the deeper sources of meaning” (p. 714). I have been mindful therefore of there not being any fixed method but rather a process of trusting and believing. The understanding of interpretive or hermeneutic phenomenology can only be obtained by actually ‘doing it’ with the tradition of this philosophy providing the principles (Koch, 1995; van Manen, 2007b). I have been guided by the historical authors and the practical approaches described by van Manen that are underpinned by the philosophical principles of Heideggerian hermeneutic phenomenology (Koch, 1995, 1999). My reading of Heidegger and Gadamer has continued throughout the interpretive process in order to identify notions that resonated with the emerging findings and provided assistance to inform the analysis.

Ethics

With the contact details for recruitment of participants planned to be coming from Fertility Associates, National Ethics Approval was required. Approval was sought and gained in February 2012 (Appendix 2). When it later became apparent that there was potential for ‘word of mouth’ recruitment, a variant to the ethics approval was sought via

correspondence with the Chairperson of the Central Regional Ethics committee, and granted in May 2012 (Appendix 3).

Fertility Associates ensured that the potential participants had indicated their consent for their involvement in research on their original treatment consent form prior to forwarding their details. It was important that this occur to ensure that the women's autonomy was upheld. The opportunity to withdraw at any time was made clear on their initial information sheet that they retained (Appendix 4). At the first interview the women chose their pseudonym; signed their consent form (Appendix 5) and were reminded that they had the option of withdrawing if they did not wish to participate or continue participating.

From the commencement of this research I have always been aware of the privilege of women sharing their stories with me; of the passion and enthusiasm that they brought to the research. Therefore I had an overwhelming responsibility to also protect the women. It was essential that women's anonymity and confidentiality was maintained and this formed an important part of the ethics application. Protection of the women's psychological wellbeing was also a major focus, identifying that for some women the interview could generate previous unresolved concerns. A list of counsellors was completed and left with each participant should support be required (Appendix 6) and the consent process included approval for me to contact their LMC should I have extreme concerns regarding their wellbeing (Appendix 5).

The transcriber signed a confidentiality agreement (Appendix 7) prior to commencing her contract. As the transcriber was previously employed in a woman's health area of the local hospital, she was familiar with many of the medical concepts that arose. She was also aware that she could discuss her emotional concerns if any emerged during her transcribing. She did pass comment that she found typing the postnatal interviews cathartic, especially when hearing the mother talk to the baby or the baby making noises.

Participants

As the aim of my research inquiry is to reveal the nature of the experience of achieving a biological child and becoming a mother after repeated IVF treatments, a definition of repeated IVF was required. There were two important facets surrounding my decision to define 'repeated' as three or more cycles of treatment.

Firstly, there is a dearth in qualitative literature that focuses solely on women following repeated IVF. I suggest that these women have an intense desire to become biological mothers that drives them beyond recurrent attempts at treatment, different to women for whom success at IVF comes relatively quickly and smoothly. During their years of treatment there is often the grief associated with forgoing biological identity as in order to conceive the use of donor gamete may be necessary.

Secondly, any woman meeting the criteria for this research inquiry would need to be pregnant following a third or more IVF treatment. The third cycle is about everything they have been through, including the associated cost of paying out-of-pocket for at least one of their treatment cycles (if not more).

Women who were excluded from participating in this research were those for whom articulating in English (verbal and written) was difficult, or women who had previously been mothers as they already had experience of early mothering.

It was anticipated the participants would be invited through Fertility Associates who are the contracted tertiary care providers for IVF in the Central Region of New Zealand. At the very genesis of this research I made an appointment with the Medical Head of Fertility Associates to discuss with him the research I proposed. He was supportive and asked for a copy of the research proposal, which he presented to his colleagues on my behalf. General agreement and support was given to assist me in

the recruitment of participants, acknowledging the need to enhance their understandings of the infertility experience from the qualitative paradigm. Throughout this study I have continued to update the Medical Head on my progress.

I decided early on that limiting to a specific geographical area would reduce the cost of my transport to attend the interviews. I was prepared if recruitment was restricted to extend the geographical area but this was not required. Whilst these interviews could have been facilitated through an electronic medium such as Skype, I thought it would be most beneficial to interview the women physically face-to-face.

Each month I was sent an Excel spread sheet that contained the names, addresses, and IVF history of women who had in that past month had a confirmed pregnancy following three or more IVF treatments. The women were then sent a letter of invitation (Appendix 8) to be involved in my research along with the information sheet (Appendix 4). If there was no contact from the women then I made contact via the phone after four weeks. A vicissitude to the recruitment strategy transpired when a midwife asked me if I required participants, as she was aware of a woman keen to be involved. An effect of this probe was that my recruitment strategy became via Fertility Associates and via 'word of mouth'. I made the decision to accept 'word of mouth' recruitment due to Fertility Associates having some initial concerns about recruiting sufficient numbers of participants.

A total of ten women were invited to participate with two women declining for reasons such as fatigue or not being interested. One woman who had agreed to participate miscarried at thirteen weeks gestation. The recruitment process resulted in seven women participating, less than the number approved through the ethics application but the depth of their interviews justified ceasing recruitment. In qualitative research determination of sample size is not solely the number of participants that is important but rather the depth and quality of the data obtained (McCarthy,

2008; Water, 2008). The decision to have only seven participants was for two reasons. First it took four months to recruit the participants and a further eleven months to collect the interview data. Second as the interviews were performed and the narratives crafted a decision was made that the richness and quality of each woman's experience were such that a larger number of participants would not add to the understanding of the experience.

Demographic information was gathered from each of the seven women at the time of the first interview (Appendix 9). Of the seven women who did participate five were ≥ 39 years of age, one was between the ages of 33-38 years and another was 27 years of age. Four of the women had accessed public funding for their two approved IVF cycles. One didn't access the funded cycles she was eligible for due to the length of the waiting list but rather chose to self-fund. All women self-funded at least one IVF cycle; one funded three cycles, one funded four cycles and another five cycles. Of the seven women five experienced miscarriage following previous intrauterine insemination (IUI) or IVF treatments, with one woman experiencing nine miscarriages. Another woman also experienced a termination of pregnancy at 20 weeks gestation due to a congenital abnormality being non-compatible with life and a final woman experienced a stillbirth at 37 weeks gestation (following her third IVF treatment). Therefore of the seven women only one had not experienced a miscarriage or fetal demise following IUI or IVF treatment. All six women had experienced varying degrees of grief associated with their long sought after pregnancy and the resulting miscarriage(s). Two of the women had also previously experienced multiple IUI cycles prior to commencing IVF. All seven women had a minimum of three IVF cycles with some having up to five cycles. Two of the seven women, after many IVF cycles, chose to access donor eggs and were successful with pregnancies following this change in treatment. One woman required sperm donation after her husband was diagnosed as azoospermic.

Of the seven women three, Stella, Jean and Olive (pseudonyms), chose to have a LMC who was a midwife. Stella chose her midwife following a friend's recommendation, but important in that decision was that the midwife confirmed that she had previous experience providing maternity care to women who had undergone infertility treatment.

Stella and Olive both affirmed that the decision for a midwife LMC was not difficult feeling they didn't need the extra reassurance of an obstetrician. Jean (27 years) chose to have a LMC midwife because in her mind once she was pregnant she was 'normal'⁴ and that indicated midwifery care as acceptable. Jean however found it difficult choosing a midwife and in the end decided to tell a friend she was pregnant in order to be recommended a midwife. The four remaining women all went with obstetric care, one engaged in private care and the three others hospital care.

Birth outcomes varied for the seven women. Three women chose elective caesarean sections, Cola had a complication of paralytic ileus requiring urgent abdominal surgery and 24 hours in the intensive care unit. Jean had her labour induced for cholestasis at 36 weeks gestation and had a normal vaginal birth. Jane had a spontaneous labour which failed to progress (no augmentation was trialled) and resulted in an emergency caesarean section. Of the six women interviewed postnatally all attempted to breastfeed their babies: three required extensive input from lactation consultants. At 10 weeks postnatal five babies were fully breastfed.

Phenomenological interviewing

Phenomenological interviewing is asking the participant to tell her story; it is crucial therefore that the interview style promotes openness. It also

⁴ The women saw themselves different always to others, they identified other women as 'normal'

requires the interviewer to be cognisant of the participant's body language and to concentrate on attentive listening (Koch, 1996). Asking the woman to tell me her story was accepting that for her the story was the way that she constructed her existence at that moment in time (Koch, 1999). Questioning participants in hermeneutic phenomenology can adopt an approach that is conceptual, theoretical or historical in order to explicate the meaning and to assist in understanding the lived experience (Dowling, 2011).

As I had not previously been involved in interviewing for research I wanted to prepare myself to ensure no opportunity was lost. Being a midwife I was mindful that I had already developed an ability to extract stories from women in an unobtrusive manner and to be a patient listener. Yet I wanted to critique my own ability to perform this task prior to interviewing my participants. I approached a midwife member of staff who was 30 weeks pregnant and asked her if she would be willing for me to interview her. The midwife agreed. I attended her home and interviewed her using the recording device on the laptop and the digital Dictaphone. Using these devices in a practice interview ensured I knew how to use them and provided the opportunity to listen and reflect on my interview style. The midwife was also able to provide me with feedback about how she felt the interview progressed. I had thought that I may have interjected but on listening to the recordings this wasn't the case. I did however provide verbal agreement on occasion and therefore learnt that this was something I needed to be mindful of.

All the women who participated in my research were interviewed face-to-face between 28 and 30 weeks gestation in their own homes. I had with me key questions (Appendix 10) I could use as prompts to ensure the women's focus remained true to the inquiry but I rarely needed to use these prompts. Women were so eager to share their story that they often only really required an initial question to continue to tell their story in whatever way they desired. From reading about interviewing for phenomenological research (Koch, 1996; Norlyk & Harder, 2010; van

Manen, 2007b) I appreciated that it was essential to have a sense of openness; “an openness that trusts the ‘whole being’ of the researcher will be caught up in the play of the conversation in a manner that is in keeping with the study” (Smythe et al., 2008, p. 1392). I implemented this by ensuring that prior to attending each interview I had a period of quiet time to contemplate the interview ahead, to prepare my mind. During the interviews themselves I taught myself to listen attentively and not to be distracted. Occasionally when I heard a concept that I wanted the woman to expand on I would revisit by phrasing “tell me more about...”. More often than not the interview would have ebbs and flows, quiet times and at times tearful times but these were all important components of the women’s experiences.

Toscano and Montgomery’s (2009) study found that there was a process of psychological healing at the time of the baby’s birth. They suggested that interviewing women post delivery might not yield the same descriptive information as the real time or narrative story format that the women created themselves. Hence all of the women were given a journal with a statement in the front of the journal reading “congratulations on the birth of your baby. This journal is to offer you the opportunity to record your thoughts soon after your baby is born. How was the birth? How is it to have your new baby at home with you now? What feelings have you experienced?” Women all had the option of participating in this portion of the research, whether they chose to or not, they retained the journal for their own use. For the women who completed the option they copied the journal entry and gave it to me at the postnatal interview, retaining the journal. To audiotape a reflection and send it to me was also an option. I chose not to interview them in person at this early time postnatal; respecting the privacy of this time and not wishing to be an intrusion on long anticipated moments. Of the seven women who participated in my research two completed this option.

Six of the women were re-interviewed face-to-face between 6 and 10 weeks postnatal. Due to one of the seven women moving to Australia at

32 weeks gestation (Olive) and despite arrangements that her postnatal interview would be organised via email and held through Skype, she was lost to follow-up. Once again at the interviews I had with me key prompts (Appendix 10) and rarely used them.

All of the interviews were recorded using an electronic device downloaded onto my laptop and also on my I-pad. Additional recording using a digital Dictaphone was undertaken as extra back up. The interviews were emailed through to the transcriber on the same day and were typed verbatim.

Toscano and Montgomery's study (2009) commented that women found it difficult to be open and frank with the 'fertile world', that is interviewers who have had children without IVF. Due to my personal experience of infertility and coming from the 'infertile world' I hoped this would add to the interviewing, and was my rationale for including my infertility experience in the information sheet. As explained in Chapter Four, women commented that they felt it was easier to share their experience because they knew I had "been there". This supported Toscana and Montgomery's (2009) comment on frankness and honesty due to sharing the same-world as the participants.

Researcher's reflective journal

I kept my own reflective journal that I completed following each interview. These journal entries consisted of comments made by the woman prior to the interview commencing or after the conclusion but were none the less felicitous insights. According to Koch (1996, p. 179) "Incorporating journal data provides a rich context". "The hermeneutic process, therefore, should include the researcher's personal reflections as sources of insight about the phenomena" (Walters, 1994, p. 140). I commented on the woman's physical demeanour that may have changed during the interview and which paid homage to her experience. "Qualitative research explores

human behaviour and the search for understanding through people's actions" (Maggs-Rapport, 2001, p. 375). My observations of the participants' actions, recorded in my journal, assisted in improving my understanding of the complexity of the experience and the woman's being-in-the world. "To understand a person's behaviour or expressions, one has to study the person in context, for it is only there that what a person values and finds significant is visible" (Leonard, 1989, p. 46).

Crafting Stories from Transcriptions

Once the interviews were transcribed they were returned to me via email. I appreciated the approach described by Caelli (2001) and Paddy (2010) that it was important to send back to my participants a narrative that they could understand; I firstly needed to craft stories from their transcripts. Caelli refers to these as "narratives of experience" (p. 278) and each individual transcript required time and thoughtful application. Each transcription I read through carefully, then I identified and thoughtfully removed portions of the transcription that were not essential to the focus of my research including any tautologies. To perform this I firstly had two identical transcripts on the computer screen, one of which I labelled 'narrative'. On this I very carefully identified and highlighted sections that wandered away from the topic the woman was discussing, I then deleted the highlighted sections. I re-read the remainder to ensure that I had not removed any parts that changed the meaning of the topic under discussion. This was a time consuming and piecemeal approach, taking sentences and paragraphs at a time. Using many of the women's verbatim words, as much as possible, the story was reconstructed (example in Appendix 11). Most parts of the eventual narratives were intact and unaltered whilst some had words inserted to link sentences. Grammar was altered as required and the husband's/partner's/health professionals' names were replaced by generic descriptors such as partner, midwife or obstetrician. As in oral story telling and the weaving in and out of topics, the narrative was cut and moved about in order to keep topics together

and afford conclusions. I was able to check the narrative with the original transcription that remained on the screen contemporaneously. It was a difficult process to remove portions of the transcript, as they were all valuable in their own right, even if not directly related to the research. I ensured that the crafted stories remained evocative and as true to the transcription as possible. I read the stories out loud to ensure their eloquence, a process that was essential to ensure appropriate structure of sentences and expressive storytelling. I revisited them again after several days prior to emailing them on to each participant for validation, an approach recommended by Caelli and van Manen (2007b).

Each participant was given the opportunity to read and inform me if my crafting into narrative had retained the same meaning as their experience (Caelli, 2001). Caelli suggests that this enables the participant to read and embrace their experience. Further, it was an opportunity for them to choose to delete or change sections of the data. Of the seven women three chose to make some simple changes to their narrative; indeed they added to the depth of their experiences by often inserting singular but strong words. An example is Jane who added into her narrative the word always *“I’m very much on the conservative side with everything. Always thinking just in case....”*. A couple of the women chose to meet with me to go over some of their narrative and to confirm the minor changes. All of the women valued their narratives and have kept them as an account of their experience of becoming mothers. *“I have just been re reading your narrative this arvo, it is 'better than fine' and you have captured the experience incredibly well. I love how you have crafted what I've written/said. Thank you” (email from Ellie).*

Interpretation of stories

After the women had confirmed that each narrative was an accurate account of their personal experience I interpreted the narratives. Initially I read the narratives and interpreted purely what was written on the paper,

the primary interpretation. Van Manen (1997) refers to this as the informational content, as if the public were to read and understand this narrative just as they were to read any other material. “First view the text, may operate on a literal meaning, that is what the words mean, what the story line is or what people are trying to tell one another or us” (Koch, 1999, p. 27).

Initially when reading and listening to the first narrative, Ellie’s, I struggled to burrow deeply to reveal what she wasn’t saying, to find what was buried beneath the words she used. I kept hearing experiences that Ellie’s described that I personally had experienced; such as wearing a mask out of the house, pretending to cope and that all was well when inside you felt emotionally broken. All I could hear Ellie saying was what she actually voiced. I couldn’t break beyond the experience as told because it was so close to my own. My supervisors quietly led me by suggesting that I park Ellie for a while and start with another narrative, but using some key questions. It was after I followed their gentle advice and ‘trusted the process’ that I was able to reflect and identify my own experience tangled within Ellie’s. I had to respect that this was my historical horizon (Gadamer, 2003). “To acquire a horizon means that one learns to look beyond what is close at hand – not in order to look away from it but to see it better, within a larger whole and in truer proportion” (Gadamer, p. 305). My own story and the understandings deeply embedded with my thinking, rather than getting in the way, would assist to produce a more meaningful result.

When Ellie’s experience of infertility treatment became suffocated by that of my own, it was important for the rigor of this research that I recognised that my presuppositions were dominating my interpretation. This ensured that I was able to develop a technique that facilitated open interpretation of the stories of others whilst respecting my own historical experience. I spent time re-reading about interpretation in order to understand better the art of listening to the language. I referred to numerous journal articles by Koch (1995, 1996, 1999), van Manen (1997, 2006, 2007) and a variety of

others who had written on 'doing' hermeneutic research (Maggs-Rapport, 2001; Norlyk & Harder, 2010; Smythe et al., 2008) and once again became deeply immersed in van Manen's (2007b) book *"Researching Lived Experience"*. I developed an understanding that I had to read, to sit quietly and reflect on the words the women were using, that introspection was essential. I needed to listen for the deep tonalities of the language, that according to Van Manen (2007b) often falls out of our familiar range of hearing. I taught myself that interpretation, along with writing, required attunement, reflexivity, forbearance as well as committed, uninterrupted time. I taught myself the rhetorical hermeneutic process "composing linguistic transformations is not a mechanical process. Rather, it is a creative, hermeneutic process" (van Manen, 2007b, p. 96). Through this my own story still had its sacred space deep in my being, but a clearing was made to draw the stories of the other women alongside it, to listen to stories other than my own.

I moved on to the narrative of Jane and used these key questions:

- What is she really saying here?
- What's between the lines?
- What might this be about?
- Am I adding to the woman's insight?

I also removed myself from the distractions of home choosing to spend a minimum of four uninterrupted hours in the quietness of the public library. These techniques were a panacea for me in that I was thence able to uncover what was below the surface of the spoken language. "Rather than creating knowledge, the aim of hermeneutic inquiry is understanding...as we interpret, we reach for an understanding that satisfies our experience" (Koch, 1999, p. 26). I applied these techniques to all of the interpretations including returning to Ellie's, endeavouring to analyse as the narratives were constructed with concurrent interviewing. The antenatal narratives were analysed first and then I moved onto the postnatal narratives as they became available.

Interpretation continued with the discovery of each woman's particular passages and a sense of what her words, silences, tears and laughter meant. In some instances I read and questioned sentences, and yet in other passages it involved several sentences. Following this process was in line with van Manen's (2007b) three approaches toward uncovering themes described as:

- (1) the wholistic or sententious approach
- (2) the selective or highlighting approach
- (3) the detailed or line-by-line approach.

In such a way I identified key experiences in the women's passages and then wrote notes and paragraphs that I believed captured or questioned the experience. I applied all three approaches at different times, to different narratives. Often the notes I wrote were scribbles and concepts with the more writing and re-writing leading to my interpretation of themes or notions. My aim was to elucidate the deep essential experience of being pregnant following repeated IVF attempts and the early experience of becoming a mother; I had to keep this in the forefront of my mind (Norlyk & Harder, 2010). These experiences were key because if they were removed from the narrative the experience changed completely because the meaning of the experience would become hidden. This is one of the principles that van Manen (1997) describes as guiding the enquiry in order to ensure that the true phenomenon of the experience is revealed.

I was aware that there were potential times of epiphany. I recall the first time this occurred, the true realisation that I had interpreted that which was hidden. "We experience an epiphanic moment when a text suddenly speaks to us, when it addresses us in a manner that validates our experience, when it conveys a life understanding that stirs our sensibilities, when it pulls the strings of unity of our being" (van Manen, 1997, p. 366).

I also sought conversational input from midwifery colleagues articulating to them my interpretations of women's experiences. This collaborative

conversation would involve me describing a woman's narrative and then my interpretive ideas followed. Dialogue with colleagues was a process of sounding out my thinking referred to as the art of testing (Gadamer, 2003). I found this process of testing challenging but also affirming in many instances and very worthwhile. I recognised that my mind was constantly thinking, reflecting, and processing my research, especially in moments of quiet contemplation such as cycling or running. I learnt to accept that the permeations in my mind would come spontaneously, that there was no linear process and therefore I was never far from a recording device be it electronic or pencil and paper. My research became a personal living experience with my topic of passion burgeoning.

Themes

As I interpreted the women's stories and as I began writing the early concepts of my findings (example in Appendix 11) I became aware of connecting themes. Themes such as fear and hope connected the different women's stories. The more I developed this thinking and reading the more my desire to grasp an understanding of the philosophical notions that related to the themes came to light. As I immersed myself in Heideggerian writings I began to understand particular philosophical notions and could begin to relate the women's experiences to parts of Heidegger's philosophy. I found this provided a solid foundation upon which the interpretations and then the findings chapters could be framed.

This was how the findings chapters emerged. It became clear that the experience of infertility treatment framed how the women experienced their pregnancy and early mothering; this had to be a findings chapter. The second and third findings chapters were very clearly developed from the themes that linked the stories and how the experience of pregnancy and mothering was interwoven with the grief and sorrow of infertility. At the conclusion of the draft findings chapters there was still the need to express more clearly the infertility journey. It was then that it became clear

that the reader would need to have a prologue, a chapter that framed the experience before the reader could embrace the findings chapters with sufficient understanding of the importance of the infertility experience. This is how the prologue and Ellie's un-interpreted story came to be part of this research.

Ensuring research strength

Trustworthiness (Rigor)

Phenomenological research attains trustworthiness through the applications of the epistemological and ontological foundations that inform this paradigm (Koch, 1996; Maggs-Rapport, 2001). In the positivist paradigm of research trustworthiness is identified as rigor, a term problematic in phenomenology as it is at odds with the philosophy (de Witt & Ploeg, 2006). In phenomenology, where the use of language should not be conflicting with the ontological foundations, the term trustworthiness is appropriate (Walters, 1994). Koch suggests that soundness occurs in phenomenological research by the inquirer performing excursions into the philosophical literature. According to Norlyk and Harder (2010) research strength (trustworthiness) is obtained through attention to the philosophical underpinnings and how these are implemented throughout the phenomenological study. Hermeneutic phenomenological research attempts to uncover the concealed meaning that is embedded in the lived experience, explained in its detail and description, providing trustworthiness (rigor) through the distinction of moral and spiritual senses (Maggs-Rapport; van Manen, 2007b). "A good phenomenological description is collected by lived experience and recollects lived experience – is validated by lived experience and it validates lived experience" (van Manen, p. 27).

The knowledge from this research is made legitimate through the trustworthiness that I have endeavoured to provide. I have detailed my situatedness throughout this research in order to promote an

understanding of my participation in and through the research, a process endorsed by Walters (1994). By being included in the research, rather than as a third person, as in Husserlian philosophy, my being-in-the-world has assisted with the interpretation and the development of graced moments (Walters). “A hallmark of phenomenological research is graced moments, when there is a shared sense of belonging to the insight that seems to go beyond what was said, yet is felt and understood as ‘being true’ (Smythe et al., 2008, p. 1396).

In order to ensure trustworthiness to my study I have focused on the five expressions detailed by de Witt and Ploeg (2006). I recognised their ability to guide me in how trustworthiness could be interwoven through the process of continual application. The five expressions are: Balanced Integration, Openness, Concreteness, Resonance and Actualisation. The five expressions of trustworthiness also interrelate with the processes described by van Manen (1997) that assist phenomenologists in becoming sensitive to principles of inquiry.

Balanced integration

There are three characteristics to balanced integration that have been adopted throughout my research. Firstly it is about the appropriation of the philosophy and the research question. Heideggerian philosophy fits well with the quest to reveal the extraordinariness of achieving a biological child and becoming a mother after several IVF treatments. The concept of Being is pivotal to Heidegger’s philosophy, the concept of being-with-each-other and our way of being-towards-one-another (Steiner, 1991). The philosophy fits comfortably within my clinical practice as a midwife, which is defined as ‘being-with-woman’.

Secondly, balanced integration is about “in-depth intertwining of philosophical concepts within the study methods and findings” (de Witt & Ploeg, 2006, p. 224). Heideggerian philosophy focuses on Dasein, and what is the meaning of Being. As I progressed through the interpretations

and developed the findings chapters I sought to identify central Heideggerian concepts that linked with the interpretation of the women's experience (Paddy, 2010). I endeavoured to weave the philosophical notions together with the women's stories, adding to the interpretation whilst being mindful to not detract from the experience.

Thirdly there is a careful balance between the voice of the women, Heideggerian philosophical explanations and my own presuppositions. There were times during the interpretation and the writing of the findings chapters that my own experience had to be recognised for the significance it brought to the study. Smythe and Spence suggest:

Through being in the world, we acquire an orientation that is interwoven, inseparably, with our history and culture. We inherit traditions, both formally and informally, through language and the process of socialisation that mean we cannot stand outside the phenomenon in question because embedded in us are understandings derived from these previous experiences. (Smythe & Spence, 2012, p. 13)

I was mindful of my own ontology and epistemology, writing transparently about the interplay of my own experience with that of the women's stories. As I interpreted and wove in the philosophical notions I turned to the literature and wove through the findings current knowledge and evidence. The resulting constructions are the fusions of the women's voices; literature; the notions of hermeneutics underpinned by Heideggerian philosophy; and my own understanding and prejudices (Koch, 1996; Norlyk & Harder, 2010) resulting in a work that I believe is both readable and alive.

Openness

Openness and balanced integration are expressions of trustworthiness of the research process; the actual 'doing' of phenomenological research (de Witt & Ploeg, 2006). In order to be a phenomenological researcher I had to ensure I had adopted an approach that was consistent with the inquiry. Leonard (1989) identifies that the integrity of phenomenological

research is maintained when the researcher “does not become enmeshed in the study and thus unable to distinguish his or her own response from what the text is saying” (p. 53). I have attempted to ensure openness by declaring my presuppositions on entering the inquiry and have comprehensively explained this in Chapter One, and referred to potential influences in chapters as they became obvious. I have included in the final chapter my being-at-home-in-the-motherless-world in reference to the thesis of the thesis. I endeavoured to maintain an attitude of openness during the interview as evidenced in the detailing of my interview technique.

I have also detailed any changes that occurred throughout the research, the change in recruitment and ethics approval for this change is one such instance. I am confident that changes and rationales that have been required throughout the research are auditable and visible to the reader who will be deciding if this research is believable (Koch, 1996).

Concreteness

Ensuring that the findings have been written in a manner that the reader develops a concrete identity with the context and experience in the phenomenon is an essential element of trustworthiness. Concreteness is referred to as life-world by van Manen (1997), and by Koch (1996) and Leonard (1989) as credibility. They are terms employed to provide a true value in the evaluation of qualitative research. It is the ability of the reader, through his or her own experience of the life-world, to be able to recognise the context and experience. “Hidden meaning embedded within the words of the research participants” (Maggs-Rapport, 2001, p. 380) have been revealed in a manner that is identifiable of the experience.

There were opportunities to articulate some of the conceptualised themes with the women such as when I met them to go over their narratives. I was able to hear their thoughts on these concepts. When I spoke with Jane about the sense of belonging she sat quietly and then looked directly

at me and replied, *“that is actually very true, I had never thought about it like that before”*.

Resonance

My aim was to reveal the extraordinariness within the ordinariness of the experience, allowing the reader to encounter a resonated connection with the findings. Referred to earlier in this chapter, it is the moment in time when the reader is in-tune with the experience and is able to relate to the experience as being true (Smythe et al., 2008). Van Manen (1997) refers to these moments as ‘epiphany’, stating they may be so strong in their intuitive grasp that they may stir the very centre of our soul. “The special effect that phenomenological tone aims for is epiphanic; it is meant to touch our understanding of life’s meaning that we experience meaning in life” (van Manen, p. 364).

I have taken opportunities to present my research to health practitioners, but in particular to midwives. Following these presentations there have been midwives who have come forward and acknowledged the findings to be congruent with their practice experiences. The findings presented connected the midwives with the context of the provision of the care that IVF mothers needed, when the midwife knew the women needed something extra but couldn’t place specifically what that care needed to look like.

Actualisation

Phenomenological interpretation is never completed, there is always the opportunity in the future for further interpretations to be obtained, to further seek understanding. According to de Witt and Ploeg (2006) it is this future opportunity that provides the trustworthy expression of actualisation. This current piece of research is never completed but always opens to future interpretation by readers, a limitless time does not exist. Actualisation was important as I wrote the final chapter, the thesis of the thesis. I took comfort knowing that there will always be a future for ongoing

interpretation from the women's stories that hold overwhelming depth of experience of infertility, pregnancy and motherhood.

Conclusion

This chapter has demonstrated the 'workings' of this study, the detailed process that I undertook in which to seek to answer the question of the experience of pregnancy and motherhood following repeated IVF treatment. I have explained the nature of phenomenological interviewing, crafting of stories and interpretations leading to the identification of themes.

I have always acknowledged that I brought to this research my own presuppositions from my experience of infertility and repeated treatment. In this chapter I have ensured that transparency of my experience and any interplay with the participants stories has been identified and appropriately acknowledged. The application of the phenomenological framework by van Manen and de Witt and Ploeg (2006) has ensured trustworthiness and creditability was at the forefront of my mind as I progress through the study.

The interweaving of the women's hidden experience; the Heideggerian philosophical notions and the available literature are explicated in the three findings chapters. However, before entering the findings firstly the reader must experience a taste of the infertility journey expressed by Ellie in the next chapter, the prologue.

Chapter Six

Prologue

“Dasein possesses what is past as a property which is still present-at-hand and which sometimes has after-effects upon it”

(Heidegger, 1962/2008, p. 41).

The women’s need to express their journey and the importance of the past affirmed Heidegger’s notion that freeing ourselves from the past is not a matter of disowning it, but rather to make its possibilities our own (Large, 2008). Belonging to “the very Being of human beings [is] that we are always captured and enslaved by our past”(Large, p. 12).

I have chosen to share one participant’s story about her experiences preceding this pregnancy in full. This was the first story I heard during the data collection for my study; I invite you to share the impact of that experience. I follow Ellie’s story with a brief glimpse into the experiences of sorrow and loss of each of the participants.

Attending the first interview it quickly became clear that Ellie needed to share the past. Ellie was unable to even begin to share her story of the current pregnancy until she had described the experience of the emotional roller-coaster journey she had been on. This was the same for all the women. The women’s present situation and experience was coloured by the past; they could not tell the current story without telling the previous story.

Everything that went before a pregnancy is a part of the now. Ellie’s story is offered for the reader to hear the heartache that is demonstrated by the woman’s words. It, along with the overview of the other participants stories set the scene for the following findings chapters that specifically address the research question ‘What is the experience for women of becoming and

being pregnant and their early mothering, following repeated IVF treatments?’

Ellie’s story of the past

I guess the big thing is, as with everybody, often when you are a teenager or in your early 20’s, you think you’re going to meet your handsome prince and have 2.5 children and a white picket fence by the time you’re 25 or 30. I didn’t meet my husband until I was 31.

IVF wasn’t such a huge shock to me because prior to meeting him in the late 90’s, I had an emergency appendix removal and they said to me afterwards that I had PID [pelvic inflammatory disease]. At the time they alerted me if I wasn’t pregnant within six months of trying, to come back and see somebody. Then in 2007 I had my tubes removed and for me emotionally that was huge. I cried a lot of tears over that one. Lots of people used to say to me “I know someone who has had IVF and they got their baby and then their body knew what to do and they got pregnant”. I’m like, oh my goodness; this isn’t going to happen to me. It was a real grieving process because I realised there’s absolutely no way that I can get pregnant naturally. That was really tough. It wasn’t something that played on my mind a lot, but it was something that I was aware of. There had always been this fear I guess, or this slight shadow that we might have problems.

We got married and decided we would start referrals to specialists because we knew that there were going to be problems as I’d been off contraception for two years. So, we got referred and we finally got our first IVF in April 2008, three years later. I must have been 36, so we used my eggs; they thought they’d be fine. They harvested seven eggs... none of them fertilised, so that was it. That was the one cycle we paid for. At our follow up visit, they basically said ‘we can’t use your eggs. You won’t be able to apply for funding unless you use donor eggs’. I thought ‘for God’s

sake, this is ridiculous...how on earth...I'm never going to have my own biological child'.

That was really hard too because you think with IVF they'll still be mine. We might not get around to getting it the same way as everybody else but at least it would be our child. And so that was another huge barrier to overcome and we kind of dithered for quite some time.

Finally in early 2009 I put an ad together on the computer for a donor and did nothing with it. A couple of weeks after that my friend rang me and said "I have a friend who is really keen to do egg donation, I'll introduce you to her". Then, my mother rang me and said "your cousin is very keen to donate her eggs for you". My cousin was living in Australia so we brought her over to New Zealand and she got all checked out – all good. She was young with great eggs, all the rest of it. But as it happened she didn't respond well to the drugs. So we had only one egg to be harvested and hopefully it would fertilise. So once again that was devastating.

I think I was out walking when I got the phone call and there I was walking down the street absolutely bawling my eyes out. I was bawling my eyes out because I felt awful for her because I knew she was going to be devastated and I felt awful for us. Once again it was that whole 'what on earth have we done wrong to be on the wrong side of the statistics again?'. You read about it in the information books that sometimes people don't respond to the drugs but you never hear about it. Well I'd never heard about it prior. So, that egg was harvested, it fertilised beautifully and it was put back in three days later but I didn't get pregnant. So, that was really tough because there was the whole family connection and she was the ideal donor. She was crook afterwards. I was worried that I had ruined it for her and that she'd never be able to have another child. It was hideous. It was very stressful and it was very hard on me and very hard on her. So that was our second attempt. That failed miserably basically and we were devastated.

You look back at what we'd done, the spectacular, against the odds failures. We needed to just rule a line under it, so we kind of got to the point where we said okay we'd put the house on the market. [If] we can't have a baby then I'm gonna have paddocks. So that was basically what we decided to do.

Then, one day the phone went and it was the woman who had got pregnant before she could be our donor originally. She said "I've just heard what happened, I'm going to do it for you". So, as you can imagine it was like...you know what's it's like once you've made a decision and you think right, we've made this decision. We angsted quite a bit, the two of us, over whether to go with it or not. Basically the thing that swung it was the fact that we wouldn't have to pay for it. We still had another fund of IVF up our sleeves and we're like, well this is the universe trying to tell us something as well because we hadn't gone to her, she had come to us. So, she did it. She got really crook. I was freaking out because she was so sick. She was crook and it was my fault. I was beside myself. I was like God, what do I do? Once again, the guilt was huge. I was very stressed out. There were lots of tears. Then, the egg harvest came and she had quite a few follicles but they only got six eggs. I think about four fertilised and one made it enough to be put back. What a huge celebration, our miracle, finally we were pregnant. I can remember going through each of the blood tests and it was just like...it was perfect. Everything worked out perfectly...I used to joke with my doctor about boringly 'normal'.

It was so boringly normal, everything was always perfect and obviously it wasn't perfect. I got to my 38th week visit to my LMC, it was a Wednesday morning and I was joking about the boringly 'normal', and he examined me saying "your baby's partially engaged, that's good, but it doesn't mean anything is going to happen in any great hurry".

On the Thursday night we went to some friends not realising it was actually a surprise baby shower. It was all the people whose kids I'd taught and people that I'd made friends with before I resigned in 2006. I thought if

we were going to be putting all this money, time and effort into doing IVF I don't believe that I could have coped with the stress of working full time. I didn't think it was fair on the class to be their teacher full time and to be coming and going. We got home and had all these amazing gifts and we were just blown away by people's generosity, most of them knew it was the miracle baby. We went to bed and I can remember my husband lying there with his hands around my tummy and he was like I can feel the baby moving and it was like Wow, that's really cool...by just after 7am the next morning there was no heart beat, there was no baby.

I don't remember that day. No, that's a lie. I remember bits of it. For us, once again, back on the end of the statistics. I'd never ever heard of anybody not getting to full term and not having their baby. You hear of people who lose their babies to cot death or are really prem and they die, but I'd never ever, ever, ever heard of somebody having a stillborn baby so late. It was hell. There is no other way to describe it. It was absolute hell.

She was born on the Saturday morning about 2.57am. It was a very difficult labour, and long apparently but I was none the wiser. It was like, even though it was hell and it was devastating it was like...she was perfect in every way except she was...she wasn't alive. When she came out she had the rosebud lips, she was still warm, she was still slightly pink. It was very hard to believe in those first minutes that she wasn't alive because she looked so perfect and there was still that 'high', that rush of emotion, we were so proud, and we're so clever, all that sort of stuff.

By 7 o'clock that same morning my husband turned to me and he said "we've got to do it again". It was funny because I was feeling the same way. I said "I totally agree with you but how on earth do we potentially put our donor through that again". We needed to wait to decide whether it was just the emotion or whether we really did want to do it again.

She was born on the Saturday morning and we came home Sunday night and we had her christening/funeral on the Tuesday and then she was cremated. I didn't want visitors other than family and I specifically told people that, which was very assertive of me because normally I wouldn't. I didn't want people handling my baby and seeing my baby because I didn't think it was respectful to her to have people coming in looking at her. When she came back from the autopsy she was wrapped up in a pink blanket, it was kind of round, I would never have picked it but that was beside the point. We slept with it after she was cremated for quite sometime because of the smell. I only washed that blanket a few weeks ago, it became our smell not her smell and we knew the smell had gone...the most beautiful thing was my husband actually started that.

Finally I asked her [the donor] a few months later and she was like "I've been trying to work out when the best time is to tell you that I'm more than happy to do it again". I was really worried that she might get sick again. So, there was a whole pile of stuff we had to check out and we also needed the autopsy results back and the green light. When they came back it was inconclusive, they can't rule the line whether cholestasis was what killed her or not but I believe it is. We hadn't told anybody about the cholestasis, except my best friend. That's just the one thing, when people ask us do we know why she died, we just say it was inconclusive. I think if we started going down that whole track it would just make it hard enough even for us to understand. There are just some things you don't want to talk about with people. We just decided we'd keep that bit quiet but it's added a whole other element of what a huge big gamble it is.

When I discovered I was pregnant this time I was very excited, absolutely petrified, relieved...

Introduction to the participants

All of the women had similar stories to tell to Ellie and so I have provided a overview of each of them in order to acknowledge the highs and lows of their infertility experience.

Jane was 39 years of age at the time of her interview. She had experienced three IUI⁵ treatments, one miscarriage and this pregnancy was the result of her third IVF. She had already experienced not becoming pregnant, then the joy of successful pregnancy, only to lose that precious baby:

When I suddenly lost my pregnancy symptoms and when it was confirmed I remember the feeling of devastation and being right back at square one.

For all the effort, and the subsequent painful loss, Jane felt she was making no progress towards becoming a mother. Jane and her partner had chosen to self-fund their treatments rather than wait for public funding. Perhaps her age had given her a sense of urgency.

Jean was 27 years of age at the time of her interview. She knew that due to her husband's cystic fibrosis having children naturally would not be an option. Jean thought that because she was young becoming pregnant would be straightforward and was surprised when the first IVF cycle failed. They celebrated the success of the second IVF treatment but quickly went onto mourn the miscarriage:

It was a real disappointment to find we didn't get pregnant with the first cycle, but then it wasn't quite as awful as getting pregnant and losing the baby.

Jean and her husband quietly mourned their loss choosing to not widely share the pain. Several months later Jean and her husband decided to self-fund a third IVF cycle believing it was worth trying again:

⁵ Intra uterine insemination

It was quite difficult going through it the third time, particularly emotionally, because you sort of think 'well we got pregnant before but is it...are we going to get pregnant again, or what are our chances?'

Tess was 43 years of age at the time of her interview. Tess and her partner had no other option but to self-fund their four IVF cycles due to her age. Tess was 37 when they started to try and conceive seeking advice after 18 months and a further 18 months of investigations to confirm a diagnosis of unexplained infertility. She conceived following the first IVF cycle but miscarried:

The first cycle I ended up with a positive pregnancy...I thought at the time it was all too easy...I miscarried around week 10.

Tess went on to conceive following a thawed embryo replacement. Sadly due to a congenital abnormality in the fetus she chose a medical termination of her son at 20 weeks gestation. Tess expressed her grief openly with friends/family. She spent time reading and understanding the grief process so that in time she and her partner were ready to embrace IVF treatment again. Following genetic counselling that confirmed 75% chance of the condition not recurring they decided to recommence treatment. The remaining grief from the loss of her son added to the difficulty in dealing with the unsuccessful second IVF cycle. Success followed by miscarriage again with the third cycle, she finally conceived with the fourth IVF cycle. Tess was cautious as she waited for confirmation mid-second trimester that the fetus did not have the same congenital abnormality of her son.

Cola was 46 years of age at the time of her interview. She had started IVF treatment when she was almost 42 years of age. Due to her age Cola and her partner knew they would need to self-funded any IVF cycles. She had experienced a total of six IVF cycles when I met her. Along with those cycles were conceptions but very soon after miscarriages, a total of nine miscarriages.

We did five cycles and frozen eggs...the majority of the time it was 'Yes, you're pregnant' ...but no it never carried on.

Cola and her partner were determined in continuing with treatment despite the number of cycles, including the highs of success and the lows of miscarriage:

I'm a firm believer that you don't want to do a little bit and then two years down the track think 'Oh gosh, if I'd only just hung in, one more time'.

Olive was 39 years of age at her interview. Before Olive could access IVF treatment she had significant lifestyle changes to make but was committed to achieving these goals. She had several unsuccessful cycles of clomiphene before progressing to IVF treatment. She was able to access public funded cycles twice but neither of these cycles were successful.

The fact that the second cycle didn't work either was even more devastating...the next one we would have to pay for and it might not work.

Following saving and borrowing funds they were able to self-fund their third IVF cycle. Olive did everything she could, including accessing alternative medicines such as acupuncture and Chinese medicine to ensure she gave this cycle everything she could. Olive, who had never experienced the high of IVF success, was celebrating her pregnancy from the moment that she knew she had conceived. She believed celebrating was important:

I said if this is the only chance I'm ever going to have to be pregnant in my life, I'm going to enjoy it, I'm not going to spend my days thinking it's not happening or trying not to think about it or be all down! I wanted to be as happy and as positive as I can, I'm pregnant and I'm happy about it, I wanted to shout it from the rooftops! I thought if something's going to happen, it's going to happen regardless of my mental state or how I feel.

Olive and her partner moved to Australia when she was 31 weeks gestation for her husband's employment. They were anticipating the birth of a baby boy.

Stella was 33 years of age at the time of her interview. Following investigations for infertility Stella and her husband were shocked to find they would require sperm donation. Stella underwent four unsuccessful IUI treatments:

We did four rounds of that, we kind of did it month after month but that didn't work. We thought IUI would be fine but we got to the end of the four rounds and then realised we were going to have to go on to IVF treatment. We didn't ever suspect that we would need to get to IVF.

Stella celebrated conceiving with the first IVF treatment but sadly miscarried. The second cycle was unsuccessful and so they decided to self-fund a third cycle.

It had been six rounds of things before which had been disappointment after disappointment.

Stella was determined that despite the disappointments they would try again but she would access acupuncture before the treatment and would be more conscientious with her drug regime. They were cautiously optimistic as they entered this pregnancy due to previous loss but hoping they would meet their longed for baby.

Weight of sorrow

All of the women who participated in this study had faced years of sorrow. Sorrow due to their infecundity; sorrow due to their repeated failings at ART and for six of the women sorrow over pregnancy loss(es). "Entering repeated treatment cycles leads to a recurring pattern of expectation, anxiety, and grief that accompanies the loss of hopes and dreams when treatment cycles fail" (Harris & Daniluk, 2010, p. 7).

Any human being who faces sorrow has become attuned to internal passion regarding their existence (Sipiora, 2012). "In sorrow we are attuned to a rupture, a break, a being cut off from someone or something

that was close or dear to us. The laceration is of us, of our existing, our being-in-the-world as relatedness to things and others” (Sipiora, p. 259). These women spent years undergoing repeated ART treatments, including IVF, and in so doing the weight of sorrow was not a one off laceration, but became a deep sorrowful ravine. Their attunement to sorrow discloses their grief over the loss of the future dream and the reality of the infertile past, leaving them alienated in the present where they are unable to visualise possibilities. Heidegger states “one’s own potentiality-for-Being is disclosed in such a way that one’s Dasein always knows understandingly what it is capable of” (Heidegger, 1962/2008, p. 336). The women experienced repeated failings and chronic sorrow culminating in a laceration to the very core of their existential; fundamentally a laceration to their Dasein.

Sipiora (2012) suggests that by humanities embracing sorrow it in turn empowers us to respond in an appropriate manner to that particular sorrow that we are facing. By embracing the sorrow and disappointments the women still clung to a fragile thread of hope; they continue treatment in the effort to enter the dreamed-for-world of motherhood. When they achieved their successful pregnancy their previous experiences of infertility and pregnancy loss required validation at the time of interview before they were able to share the experience of successfully being pregnant.

Conclusion

Ellie’s story and the brief glimpses of the other women’s stories are evocative; they demonstrate the flux of emotional, physical and financial costs accentuated by repeated treatments, which impacted upon the meaning that they now give to their pregnancy and newborn. The deep emotional pull of the potentiality of motherhood, for all the women, was the driver for repeated IVF treatment despite miscarriage, stillbirth and failed treatments.

The stories interpreted in the following findings chapters describe their experiences of being on an emotional roller coaster. Losing previous pregnancies yet finding the courage to try again, to then face another loss, but still to try again and eventually to journey through pregnancy and the transition to motherhood.

Chapter Seven

Becoming pregnant

“I think people have felt that she is extra special, we felt that she is extra special... all babies are special but we’ve had quite a journey to get here”
(Stella)

When I was studying to become a midwife seventeen years ago a question was posed to the midwifery tutor “is a pregnancy following IVF more special than a spontaneously conceived pregnancy”? The midwifery tutor replied, “all pregnancies are special and all women should be viewed as such”. As a consequence of my own repeated IVF treatment, and as a midwife I started to question the midwifery tutor’s response. This chapter uncovers the experience of trying to get pregnant, to the moment of success.

Having listened to the stories of these women it is now my belief that whilst every pregnancy is special in its own right, a pregnancy following repeated IVF treatment is ‘more’ special. Women who have undergone several IVFs do have unique pregnancies where complex emotions surround the experience and the developing woman-baby dyad. Ellie’s story of tenacity in the prologue reveals the depth of emotional and physical challenges experienced in order to become a mother. It is now enhanced in this chapter by the voices of the other women who participated in this research.

Fertility awareness

Knowledge of menstrual cycles, availability of contraception and more latterly, the possibilities offered by IVF have all influenced women’s awareness of their fertility. Perhaps in earlier eras, pregnancy simply happened (or did not). For the participants of this research there was a time when they realised they were not getting pregnant as they expected.

An un-ready-to-hand situation arose (Heidegger, 1962/2008). Something was not working. Thus, trying to become pregnant became a present-to-hand activity; often in their thoughts. In actively seeking a pregnancy their sense of fertility became heightened and they monitored very closely their personal signs of the optimal time to try to achieve conception.

Olive (39 years), who is a health professional, talks about her sense of awareness regarding her own fertility:

Having intercourse at the right time was re-learning everything; you know how your cycle works, when you actually ovulate, making sure everything was happening at the right time especially since I was taking medication. The medication really knocked me around emotionally. I was up and down and feeling irritable; it was just really hard. Especially when you have to work fulltime and dealing with my patients, it was hard. They're young and they're pregnant and they want a termination...it was very, very hard. It's very frustrating. I'm not getting any younger...everyone is talking about this ticking clock...In the treatment room where I work, the clock is very loud, tick tick tick, and sometimes when I'm standing there drawing up my own medications I think this clock is mocking me and I talk to it to be quiet (laughter).

Olive was struggling to keep in perspective her infertility as young women who were fertile surrounded her every day. She was paying attention to every detail of her fertility potential including ensuring choreographed sexual intercourse, whilst having to organise terminations of pregnancies for women who were fertile but did not want to be pregnant. Every day she was faced with the fact that women much younger than herself were conceiving without paying any attention to their fertility. The terminations she organised for her patients reinforced that conception is intrinsically easy for women. These women were simply living their life without viewing their possibilities as mothers, whereas Olive was actively making physical and emotional decisions in order to attempt to become a mother. She was sensing that fertility was for the young and that she had left it too late.

Olive further elaborates:

I don't want to mess around, I just want to get pregnant. We just wanted to hurry up and get to IVF. But at the same time the lifestyle changes were really important to do. Then the specialist said 'we better go for some IVF now' and I was like oh hallelujah, thank you for getting to that stage.

Olive was desperate for a panacea so she could become pregnant and battled with the startling reality that she had to make some lifestyle changes. Access to IVF would then be 'allowed' by the specialist who in her mind was the "God" of her fertility. The women she provided health care for on a daily basis had the power over their fertility but Olive did not, and to some degree she had accepted this in her desperate need to hand over to the specialist.

Women undergoing ART battle throughout their treatment with the transfer of power from their 'biological right' to conceive to the power that the ART specialist/technologies have in assisting in the production of a 'biological' pregnancy. Cussins (1996) produced a motivating paper in which she describes 'ontological choreography' the process through which women pass many varying stages of objectification during IVF treatment. Women, rather than being powerless throughout their fertility treatment process, shift the power and control to the doctor. Cussins suggests that through objectification the woman manages to alienate herself from the treatment and the impending danger or threat to selfhood. Olive is a knowledgeable woman, her fertility was present-to-hand. She was constantly doing what she could, viewing IVF as the nostrum, in order to maximise her possibility of conceiving.

Many of us live our everyday life without consciously making decisions about this or that with no thought for our potential possibilities, rather living out of habit (Large, 2008). Heidegger believes that humans have the opportunity to think of their individual existence in terms of possibilities either actively, termed authentic, or avoiding owning up to the task of Being, therefore in inauthentic existence (Polt, 1999). "What makes my life my own is ultimately the sheer fact that it is mine to live, mine to make

something of” (Polt, p. 87). Either way, the individual existence of Being is mine (mineness) and is deeply personal. For Olive who identifies her authentic existence in the future as a mother that means modifying her current lifestyle behaviours (mineness) in order to access the possibility of treatment.

Procreation

At the very core of our primordial existence is the need to produce an offspring, connected to our own identification of mortality. Five out of seven of the women in this research made conscious decisions to become mothers later in life. There is a common misnomer in our contemporary society that if a woman looks after her body she is able to impede the ageing process and will be able to have a baby later (Cowan, 2003). Lurking in the future is their menopause, a reminder that women are mammals, constantly degenerating towards the finality of life (Pawson, 2003). Tess, who experienced four IVF treatments including miscarriages and a medical termination of pregnancy for a recessive disorder in the fetus following IVF, describes her sense of having a biological clock:

When I was 37, quite late in life, my partner and I tried to conceive...I was fairly ignorant about my biological clock, which is a bit stupid really; I should have known better. I was 40 by the time we did our first IVF cycle and ineligible for public funding, firstly because my diagnosis was unexplained infertility and secondly because of my age... Each IVF cycle that we did, produced fewer eggs as I was getting older...vintage eggs.

Tess did not appreciate that her professional career meant little to her in the stark reality that she could not become a mother. She lived most of her fertile life in a state of ready-to-hand, not thinking about her fertility. Now she realises that whilst she feels young in herself her eggs are “vintage” and unable to perform as well as she would like. Tess desires to be a mother to the extent that she pushes herself back time and again in the search for motherhood. She was exposed to a taste of motherhood with a pregnancy to 20 weeks and needs to continue repeated IVF in order to gain that full life experience of womanhood, which is motherhood.

Womanhood equating to motherhood was a concept shared by the other women who participated in this study. Tess does not verbalise her core desire to be a mother but her expression of having “vintage eggs” together with the tenacity she demonstrates to return for repeated treatment is driven by the glare of her own sense of time running out.

It wasn't until the women in this research faced the reality of their reduced fecundity that they questioned their existence and meaning of Being as Jane shared:

It took over my life really, thinking what's going to happen if it doesn't work and are we ever going to be able to have a baby? It was hard to stay positive sometimes but we were keen to get on with the third cycle even though my mindset was that it probably wasn't going to work...When you find that maybe you won't be able to well it's one of the most difficult things I've ever had to think about 'what's life going to be if we don't have kids'. 'What's the use?' and all those sorts of thoughts.

Jane seems to be saying that although she previously felt fulfilled and valued by being a professional woman if she had to face life without motherhood then she could not understand her existence. She was unable to identify another manner of Being that meant she was valued in society. Her quest for motherhood had transported her so far from her hold of professional career woman. In facing the thought of not being able to become a mother she identified as being isolated and lost. After the interview recording with Jane was stopped she questioned my outcomes of IVF and I shared that I had not achieved a pregnancy with a viable outcome. Jane said up until meeting with me that day she did not believe that there was a valuable place in society where she could exist if she did not become a mother. Her vision of herself was only ever going to be complete with a baby in her arms. The vision of existing in the manner that I do was never something she could visualise. Jane dreaded how she would cope or continue to exist if her IVF treatment had never been successful.

As discussed in Chapter Two, New Zealand women from a very early age are aware that their biological make-up relates to their potential inevitability of reproduction (Batty, 2002); it is biological destiny for women to reproduce. In New Zealand society there is a subtle but popular lexicon that motherhood equals womanhood. Unless a woman has become a mother she is less than a 'true' woman. Our human motivation to procreate is superficially to be like everyone else. Society and families pressurise women to conceive. "Western discourses of motherhood as an inevitable outcome of a woman's biology, as living up to social expectations and as a pinnacle of an intimate relationship obscure the personal, social and economic experiences of having and not having children" (Ulrich & Weatherall, 2000, p. 333). In contrast to the biological predetermined instinct, some women defined their reason for having children as a reproductive decision-making process; that they demonstrated choice and active decision-making believing the assumption that choice would mean success in conceiving (Papaligoura et al., 2012; Ulrich & Weatherall).

Pawson (2003) takes this motivation to a deeper level founded on Erik Erickson's epigenetic theory, the eight stages of development. Generativity has at the heart of its concern the establishment and guidance of the next generation (Erickson, 1995). Generativity is usually achieved through the production of an offspring and the adults need to be needed and valued by someone, usually their progeny. In some instances generativity may be achieved through creativity (Black & Scull, 2005), due to misfortune (such as infertility) or because of genuine creative gift (Erickson). For women who discontinue IVF treatment they experience a need to redefine their existential void of incompleteness by redefining how to create a legacy not based on having children (McCarthy, 2008). It seems to be that generativity and the need to be needed drives these women to perpetually return to IVF treatment. Jane suggests this in her response to acknowledging the need to be valued. One cares sufficiently about society that one's Being in society is valued by the creation of something or someone.

Belonging

Jane knew that she now wanted to be a mother rather than a professional career woman but she was very cautious about sharing her IVF experience until one day she broke down in tears at a social gathering:

I didn't even tell my really close girlfriends...I was usually good about hiding my feelings...I can't really explain why I didn't tell them earlier; your girlfriends are often the most supportive people. Even though most of them don't have children, I think I felt that I'd rather just say that we decided not to have kids than to tell them we couldn't. I think it's hard for people who don't have children, or who have never wanted to have children, to understand that feeling of when you decide that you want to have kids, you just want them...I remember the response from one of my girlfriends who has never really wanted children. Her first reaction was 'it's not the end of the world'. I never said anything but it really does feel like it is the end of the world!

Jane belonged to a group of close girlfriends, many of whom had made the decision not to be mothers. Some of the other women may well have silent conversations like Jane, wishing/trying to become mothers but not sharing the information, rather wearing a mask of 'normality'.

Identifying where she belongs is important; as soon as Jane told her close girlfriends (to explain her out of character behaviour) of her IVF treatment she suddenly no longer belonged with this group of professional women. Jane now found herself in a situation of unfamiliarity – if she managed to get pregnant and become a mother then she would have to develop new friendships and a new source of belonging to another group. If she didn't get pregnant then she didn't belong with these close girlfriends because she had identified herself as wishing to be different from them. Throsby (2004) acknowledges that in a world where normal femininity is bound closely with motherhood, seeking resolution to the problem of living without children is about finding a sense of belonging.

Heidegger (1962/2008) describes 'thrownness', a mode of being in the world. He suggests that we are constantly being 'delivered over' (p.174) to the world; finding ourselves in a world that we did not choose and a life that we did not ask for (Kisiel, 2010). Thrownness is a central feature of Dasein's existence, revealed in moods and out of Dasein's own control (Inwood, 1999). "Dasein gets dragged along in thrownness; that is to say, as something which has been thrown in to the world, it loses itself in the 'world' in its factual submission to that with which it is to concern itself" (Heidegger, 1962/2008, p. 400).

Jane was thrown from a world of professionalism into a world of infertility, from a world where she had control to a world of not having control. She was thrust from the comfort of relating to close girlfriends to wanting to belong in the world of motherhood, but found herself in the world of infertility. She had endeavoured to keep her options open. By not disclosing to her girlfriends her IVF treatment and her ache for a baby, they would never have known her quest. She would have identified herself as voluntarily motherless like many of her girlfriends; she would have protected herself by retaining a presence but also by not exposing her failing. Now, by revealing her ache for motherhood and with her repeated failure to conceive, or retain an IVF pregnancy, came with it the decision about ceasing or continuing treatment. Jane found herself in an ambiguous space "...neither unambiguously voluntarily nor involuntarily childless" (Throsby, 2004, p. 163).

Failure

Whilst failure to conceive is experienced by many women when they make the decision to become pregnant, for the women in this research failure was repeated and expensive. Some of the participants chose to share their IVF journey with friends and colleagues whilst for others it was taboo; I sense their pain was too personal to share.

Jean questions her own decision-making about whether she should have shared her journey and sought support:

It's kind of difficult to know whether it would have been easier or harder with having your family and friends know, about the IVF. I guess we could just take it in our own time and not have to worry about people asking questions. Friends are all having babies and they seem to be going just fine so it's kind of a bit difficult to talk to somebody. I guess people who conceive naturally, it's quite a personal experience, and they don't go round sharing with everybody. Just because you have to go and see doctors and get poked and prodded and take all these hormones, why should everybody around you know that that's what you're going through?

Both Jean and Jane chose not to share their journey and were surprised during their interview to find themselves weeping as they relayed their experience. Jean wept with uncontrolled abandon, the tears falling whilst she expressed her agony of repeated failure and miscarriage. Her pent up grief suddenly finding solace in the interview that to some degree was a cathartic experience and, I sense, may have been why she chose to participate. The interview was a safe respite by which to reveal her true pain with someone whom she identified could relate to the experience yet was unknown to her. Jean knew that due to her husband having cystic fibrosis she would require IVF treatment and was comfortable on entering her marriage agreement that this was the case. Becoming a mother was so important to Jean that pre-marriage genetic screening had occurred to ensure that they could indeed produce offspring without cystic fibrosis. Jean appears to not have accepted that she herself had infertility issues and that the IVF was not straightforward. Both Jean and Jane chose to maintain a countenance of silence throughout most of their treatment. Silence is a contingency by which to maintain a social acceptance not dissimilar to wearing a mask pretending to be 'normal' (as described by Ellie below). "Silence can provide a social shield or wall that enables invisibility and forecloses painful conversations and unwelcome advice, criticism or questions" (Allison, 2011, p. 17).

For the participants who did choose to share their IVF journey the deeper the experience of failure the more they withdrew into their relationships with their partners/husbands. Stella describes her experience of repeated failing:

We did four rounds of IUI, we kind of did it month after month but that didn't work. We thought IUI would be fine but we got to the end and then realised we were going to have to go on to IVF treatment. We didn't ever suspect that we would need to get to IVF. It was very hard going back especially after the miscarriage and then the second one not working and then, the third one...it takes an emotional toll and a physical toll on your body. And...yeah I thought that we were going to have to stop. I didn't think I could continue afterwards at all actually...If we did it again we would keep it much much quieter, you know, we finally learnt we didn't need to tell everybody about it.

We live in a society where failing is generally viewed with disdain. "Society rejects or marginalises those that it perceives as failures (Pawson, 2003, p. 67). The women all had careers where they held responsibility. Stella who is a health professional objectively accepted that her husband was azoospermic and they would require sperm donation. Her physical inability to become pregnant with four IUI treatments and poor egg production during IVF treatment, including a miscarriage, was devastating. Stella speaks very objectively about these events which I suggest is her way of coping with her body failing. Stella did not want to face the fact that after significant treatments they were not succeeding. She knew she could not put herself emotionally through any further treatments yet makes the comment that if they did it again they would keep it quiet. It seems that Stella needed to take time out from treatment, that she would return to treatment in the future but it would not be shared. She had come to the end of sharing her failings outside of her relationship.

Ellie, who experienced a stillbirth at 38 weeks as a result of her third IVF, describes her need to escape the world:

I just wanted to cocoon myself...through everything, through all the IVF. It's that whole stop the world, I want

to get off. It's like any kind of crisis I guess, you just want everything to stop...you're just feeling so fragile. I don't cry a lot but I do...I still feel it. You put on your brave face for everybody else and your smiley face, your philosophical face and your logical face and all that sort of stuff. The cocooning is very much that you just want to get on with it by yourself and kind of climb down a hole and not go out, and not have to deal with people.

Ellie seems to recognise that the world would accept her if she behaved in what is viewed as a 'normal' manner. She wears a mask in order to cope and to hide her feelings of failing in society where motherhood is the norm. She knows that society expects happy, smiling faces and in order to conform she has to wear a mask. Ellie would much rather take time away from society to return when she knows what her future is. However, Ellie has to live in the present to face the everydayness, that is, Ellie being Ellie the teacher.

The women who participated in my research appear to have had a deep emotional investment in the treatment. Each cycle or frozen embryo replacement renewed the potential for success as well as the sense of failure and despair (Gonzalez, 2000; McGrath, Zukowsky, & Baker, 2010). For six out of seven of the women failure was exacerbated by miscarriage or intrauterine death. In these instances the women also had to face not only the failing of their fecundity but also that their body was incapable of retaining and growing a baby, which they perceive other women to do with apparent ease. Repeated failure resulted in women training their minds to anticipate failure with future treatment cycles (Harris & Daniluk, 2010; Sandelowski et al., 1990) evidenced by Jane's story above. "Paradoxically, the anticipation of failure coexisted with the hopeful maybe-pregnant state" (Sandelowski et al., p. 278). Harris and Daniluk identified that pregnancy loss was the culmination of many losses that the women endured as they embraced their infertility treatment.

Whilst living with the present, and visioning the future the women also had to face their past. Having to own past decisions that have influenced their future possibilities may well be associated with guilt (Throsby, 2004). The decision to delay having a baby until being older or past infections that

resulted in blocked fallopian tubes would be two examples. Ellie, as included in the prologue, describes her experience over 18 years of finding out she would be unable to have her own biological child:

I had an emergency appendix removal and they said to me afterwards that I had PID. Then I had my tubes removed and for me emotionally that was huge. I cried a lot of tears over that one. It was a real grieving process because I realised that there's absolutely no way that I can get pregnant naturally. That was really tough. It wasn't something that played on my mind a lot, but it was something I was aware of. There had always been this fear I guess, or this slight shadow that we might have problems. We finally got our first IVF in 2008. None of the eggs fertilised, so that was it. Basically they said we can't use your eggs...I thought for God's sake, this is ridiculous...how on earth...I'm never going to have my own biological child. Finally, a year later, I put an advert together for a donor and did nothing with it. A couple of weeks later a friend rang to tell me she had found me an egg donor.

Ellie believed that she would be a mother, that this was her purpose in life. Yet time and time again she faced different aspects of her body failing to fulfil what she viewed as her purpose in life. Ellie does say she grieved over these events yet it seems she failed to absorb the reality of her infertility. She took 12 months to write an advertisement for an egg donor and yet couldn't bring herself to complete this process. I would suggest that Ellie did not want to accept that she was unable to become a biological mother. She had to face her past whilst endeavouring to visualise her future. It was only through a friend finding her the potential egg donor that Ellie identified the truth that she could not maintain her ideal of having her own biological child.

I sense that the women were often in a game of Russian roulette with each treatment cycle, struggling to visualise their futures and each failure thrusting them back into the presence coloured by the past. According to Van Manen (2007a) the past changes itself as we live towards a future that we see taking shape, which Heidegger would term temporality. We all live in the present whilst carrying both the future and the past, for we are

our past, our present and indeed our future (Paddy, 2010; Polt, 2010). “The present and past are awakened as such by Dasein’s need to pursue some possible way of existing” (Polt, 2010, p. 73). Heidegger refers to the past, present and future as the three ecstases of temporality “it’s essence is a process of temporalizing in the unity of the ecstases” (Heidegger, 1962/2008, p. 377) Dasein self-projection is grounded in the future. By resolutely choosing our future potentiality-for-being then our lives in the world at large become clearer (Heidegger, 1962/2008).

For women with chronic IVF failure/loss the future that they envisage becomes more distant and their mental health for even the most resilient woman is challenged (McGrath et al., 2010). Women such as Jane and Jean who had difficulty envisioning a future without children, believing motherhood to be a major part of life, probably experience more emotional distress during treatment and are particularly vulnerable (Moura-Ramos et al., 2012). This vulnerability remained with them throughout their pregnancy and in to early motherhood.

Waiting for the outcome of embryo transfer is one of the most stressful aspects to IVF treatment, experienced by both men and women (Eugster & Vingerhoets, 1999). Whilst waiting many of the women performed pregnancy tests at home even though it was against the fertility clinic advice as Tess shared:

I did home pregnancy tests all the way along, against the advice of Fertility Associates. The first IVF cycle I went through I said I wouldn’t do it and I snuck off into the bathroom and did it and it was positive. Then it just became kind of routine....I thought if I do home pregnancy tests, even though I know they’re not 100% accurate, at least I’ve got some idea of what is coming my way.

Cola, who experienced nine miscarriages all related to IVF treatment, also described performing pregnancy tests:

I took a pharmacy pregnancy test before the proper blood test on the day, because I couldn’t wait, and it

came up as pregnant. I was showing my partner, I'm so excited, tomorrow we have the blood test and it's going to confirm it. I put the pregnancy test in my pocket, probably about four hours later I pulled it out and it had faded. It was unclear whether it was a definite or not and I was really, really upset because I said I've lost it in the space of a few hours!

For some of the women performing a pregnancy test was something they did privately, without their partner/husband knowing. It was their sense of needing to perform something that 'normal' women did, as described by Ellie:

I'd done a pee test from the supermarket because I couldn't help myself. Even though I knew the feelings, I was like oh, these are the drugs that are making me feel like this because of the other time when I thought I was pregnant, because I had such sore boobs but in hindsight that was drugs. It would be really nice to be 'normal' and have a pee on a stick. So this time my husband was away and I just went out and bought a pee test and I did that probably two or three days leading up to the blood test, didn't tell anyone, but it just made me feel better. I also knew that I was potentially setting myself up for a real heartbreak as well.

The stories above seem to reveal that although the women knew they were opening themselves up to potential distress, being able to confirm if they were pregnant or not was worth the risk. Ellie had experienced previous positive pregnancy tests related to the effects of the treatment rather than the actual onset of pregnancy. This had been identified as a risk of self pregnancy testing, probably why they are discouraged to self-test, but a risk women were prepared to take (Sandelowski et al., 1990). For the women the opportunity to have time to recover in advance of being informed officially that they were or were not pregnant was worth it. The risk of opening themselves up to further emotional pain was minimal compared to having to cope when receiving the information via the phone. The women also wanted to be 'normal' and being 'normal' constituted confirming their pregnancy test themselves.

The women identified pregnancy home test kits with 'normal' fertile women. I sense what they were really wanting to say was that women who do not require ART have control over confirming whether they are pregnant or not. These women did not necessarily want to be 'normal', they already knew they were not, but rather they wanted to take control. Needing to have a sense of control is an important part of human response reflecting self-determination or what Heidegger would refer to as authentic freedom (Inwood, 1999).

For these women their self-projection, or the vision of themselves in the future, was obtaining/retaining a pregnancy to the extent that it overwhelmed the present causing a sense of being out-of-control. When our sense of Being feels out-of-control we become uncomfortable and vulnerable. Making difficult choices is part of the responsibility of living an authentic existence rather than an inauthentic existence where one supposes life is laid out and planned for us in advance (Polt, 1999).

Success

Success is an important part of this chapter; it is a vital component of the next chapter, and the work of this thesis. However writing this portion was difficult for me as I came to recognise for me personally there was no success in finally having 'my baby'; only failure upon failure. I had to process that for me this renewed a sad moment in time, but also provided the opportunity to appreciate that these moments whilst rare are also real and necessary.

Olive, who had never achieved a pregnancy with her past two IVF's, viewed success differently to the other women:

People, who get pregnant all the time, don't realise when your husband comes home and you say 'I'm pregnant', they treat that like [common]...but to us it's like a huge thing and it's a rite of passage and that when it's taken away from you suddenly it becomes this BIG thing. I thought no, I want the chance to say to my husband

when he comes home, I'M PREGNANT! I want that opportunity; I don't want that taken away. When they called me I was like...my heart was beating so hard I couldn't actually hear her...your whole world just stops and everything depends on this one thing. She said 'Well done you're pregnant'. I said 'Oh!' I couldn't stop crying, just couldn't stop crying...then I just threw myself on the ground and just cried and cried and let everything out. When my husband came home I nearly ripped his arms off (laughter) 'we're going to have a baby honey!'

Pregnancies had previously been elusive to Olive; she had never experienced any moment in time that she could identify as having been pregnant.

Success brought with it hope that the women would be mothers, akin to other women, but it also reminded them that they are not like other fertile women. Thus a dichotomy of play occurred between being 'normal' whilst not being 'normal'. The women (other than Olive) had a lived experience of things going wrong; they now lived with the possibility that it would go wrong again. "In some women adjustment to pregnancy after ART is "problematic" because of the persistence of an "infertile [sense of] self, leading to tentative acceptance of the pregnancy" (Fisher et al., 2008, p. 1105). As a result they lived with the emotional tension of being really excited yet at the same time being really scared as Jean shares:

I got them to ring my husband with the results because I didn't want to know, I couldn't cope with getting the phone call. So then when we met after work he told me that it was positive. I guess I sort of had at the back of my mind that I didn't want to know at work if it's a bad result. I really wanted to know, but on the other hand did I really want to know? So then it was all very exciting but I guess after having had a miscarriage it was kind of like oh well, we'll just wait and see. Like, it's great that we're pregnant but not really sure what's going to happen.

Stella also requested her husband be called and for him to tell her at the end of her shift:

He took it all literally. He managed to hold off until he saw me that night. We were very, very happy, but it was also you know, the sort of immediate anxiety as well because of the first miscarriage. So I didn't want to get too excited about it. You want to sort of temper your emotions I guess a little bit.

Neither Stella nor Jean chose to receive the phone call of confirmation or failure from the fertility clinic. Previous experience meant that any news from the clinic could render them unable to cope at work; they shared apprehension toward the news.

For most women who have their pregnancy confirmed there is elation, the thought of becoming a mother is exciting thus provoking a joyous response. Understandably for any woman who has experienced a miscarriage in the past her response will be curtailed by her previous experience. Women with chronic infertility and pregnancy loss are cautious choosing to not fully invest in the excitement of a positive pregnancy test until they have a baby in their arms (Harris & Daniluk, 2010). The women in this study battled to become pregnant, to even have the opportunity to be told they were pregnant. "From the moment of conception their pregnancy experience is emotionally intense, with feelings of elation at achieving a pregnancy juxtaposed with deep concerns about the survival and wellbeing of the unborn baby" (McMahon et al., 2013, p. 998). Whilst anyone reading their stories would be excited for them the women had to temper their response. They had to prepare themselves. Indeed for Tess her almost immediate reaction to confirmation was concern:

When they called and gave me the HCG level it was just great news, just lovely. Then of course I started to get anxious about the next HCG test to see that it had risen enough.

The women's concern at believing that they were pregnant is not uncommon for women who have laboured to conceive through ART. "Infertile couples had difficulty *conceiving* of themselves as *having conceived*, of reconciling the idea of conception with its

physicality...infertile couples typical standpoint of waiting-to-fail made success harder to accept” (Sandelowski et al., 1990, p. 278). The repetitive exposure to failure for these women has ignited the mood of dread. An effect of this mood is fear and will be discussed in more detail in the following chapter. The development of fear continues to flourish throughout the pregnancy and for some women further into their adaptation to motherhood.

Following these women into the next part of their pregnancy will demonstrate that for all of them the transition from getting pregnant through to believing they were pregnant occurred at various different points in time.

Conclusion

Women who under go repeated IVF treatment, often with recurrent failures of pregnancies, have had to develop a deep understanding of what it means for them to live in-their-world. The women in this research were unable to identify a world outside of the dreamed for mother-world, this was critical at that particular time to provoke the courage to continue. They have found the tenacity, despite adversity, essential to enduring the emotional and physical challenges of further IVF treatment.

The generativity that a pregnancy brings with it in all instances renders it as special. The pregnancy after repeated IVF treatment and failures I suggest contains an element of being ‘extra’ special. There is excitement at the success of a positive pregnancy but the lived experience of things going wrong means they now live with the possibility that it could go wrong again. Whilst the women appreciate their pregnancies as being special, the shroud of fear and the mood of dread, which permeates the pregnancy, compromise the celebration.

Chapter Eight

Living with dread

“Our past is not external to our present, but belongs intimately to it. We live the past through the present, and the present through the past”

(Large, 2008, p. 12)

In the previous chapter I revealed my belief that for the women in this research the intensity of their emotional response to their pregnancy is exaggerated more than for women who become pregnant spontaneously. This chapter develops the notion of the non-specific mood of dread with the specific affect of fear (Polt, 1999) and the hope of success. I suggest that hope never extinguishes the dread nor does dread extinguish the hope, but that rather the women walk an emotional tight rope trying to balance hope with fear. Whilst it could be argued that all pregnant women, to some degree walk this tight rope, I believe this is intensified for women pregnant after repeated IVF attempts: they have further to fall.

In this chapter I argue that these women experience their pregnancy under the shroud of fear that influences their attachment to their unborn baby and influences when and how they share their pregnancy news. Fear impacts on their choice of LMC and the care received compared to their underlying emotional needs. The experience of infertility and pregnancy is life changing with a sense of a ‘greater force’ prevailing over their destiny. All of these emotional needs are carefully concealed under the ongoing mask of their perception of ‘normal’.

Moods

Heidegger (1962/2008) understands moods to be always present before we become cognitively aware or disclose the mood; they are a fundamental existential. Dasein always has a mood. When we become cognisant of ‘being in a certain mood’, especially a deteriorative mood, it is

a moment in time when Being has become burdensome (Heidegger, 1962/2008). Likewise this burden of Being can be alleviated by a mood of elation; although Heidegger states that for a mood of elation to exist it further discloses the burdensome characteristic of Dasein. Moods are always changing or deteriorating which simply confirms that Dasein is always in some form of mood. "A mood makes manifest how one is, and how one is faring" (Heidegger, 1962/2008, p. 173). Moods can be powerful and can settle in to become perpetual states of Being without any disclosure occurring, as if there were no moods there at all (Dreyfus, 1991). I may take clear action against the mood, dismissing the mood or conversely I may not specifically recognise it as a mood at all (Polt, 1999). What we do know is that Dasein is always affected and coloured by moods that permeate our existence whether we are cognisant of the mood or not. If I am in a frightened mood then I am constantly fearsome (Dreyfus). Moods give Dasein its primordial access to being (Smith, 1981). Whilst the women in this study revealed many moods, 'dread' showed itself as one of the most prevalent.

Dread

All of the women in this research had experienced the mood of dread. Heideggerian philosophers often refer to dread as angst or anxiety. I have purposely chosen the word dread, as I believe it has a depth that embodies the emotional pain of the mood. "Angst is something like a haunted spirit that seems to whisper, as though to itself, better take care...where are you headed...who are you?" (Scott, 2010, p. 65). The novelist Sarah Quigley (2011) eloquently describes this obdurate mood "the dread followed him day and night like a stubborn stray dog" (p. 13).

Olive describes the mood of dread in the first trimester:

At the beginning I kept expecting to notice bleeding every time I went to the toilet and when there isn't each time you think oh good, there's still none there. Even though I was feeling positive and great it was still a relief

not to see any...as soon as you feel any twinge you thought something's happening, something's going on. I think I'll go and lay down, I should put my legs in the air, what do I do? I think the most nervous I was, was at the first scan...I just thought we're going to get in there and she's going to say 'I'm sorry but the baby's gone'. So laying on the bed and doing the scan I was at the point of vomiting. I am expecting what she is going to say and I'm going to go to pieces on the floor needing my husband to carry me to the car, it will be all over. As soon as they saw the little peanut thing and said 'There's the baby'...I thought it's not over yet, there's no heartbeat, and then...'There's the little heartbeat'. 'Oh!' (I cried out). Relief just flooded out of me and I could not stop crying, I just couldn't stop crying. That's when it sunk in for me, that was the scariest time just those words and hearing that heartbeat.

Olive knew that she was pregnant from ongoing blood tests. In her heart she believed that identifying herself in the pregnant world was too costly emotionally and to cope she kept preparing for loss. Olive had never ever been pregnant before this third IVF cycle. Her dread of not succeeding was rendering a physiological response; Olive felt nauseous and imagined collapse. She wanted to be positive and enjoy being pregnant but the threat of loss clung to her Being.

Even though the women's pregnancies progressed with minimal complications the deep sense of dread never resolved, as reflected by Tess when interviewed postnatally:

I definitely didn't relax at any stage or take anything for granted. I had anxiety with each scan just thinking that at any time something could go wrong. So I was always anxious.

Tess recognises that she spent her pregnancy in a heightened state of anxiety. The idiom she uses "take anything for granted" refers to her previous failures and that just because she has made it (being pregnant) does not mean that everything would be okay. Tess was never able to assume that all would be fine even though her continued pregnancy was axiomatic progress. For Tess, and the other women in this research, to not fear the demise of the pregnancy would be to change the value of the

pregnancy itself and to potentially jinx the outcome. Tess remained anxious throughout her pregnancy, unable to find relaxation other than a transient moment in time, when via a scan she could visualise her baby without physical signs of the previous congenital disorder her son had.

Every human being has at some time experienced the mood of dread but for most this mood is not fully faced. Rather we turn away or purposely engage in the business of life to disengage from the mood. Dasein develops the ability to master its moods by using a counter-mood but we are never ever free of moods (Heidegger, 1962/2008). "Dread is the basic mood which lies at the ground of man's being, although it rarely rises to the surface and few of us might recognize it as fully and explicitly experienced by us" (King, 1964, p. 128). The threat of dread comes from within us individually. It is not external to us nor is it from other beings but rather is one's own individual challenge of finite existence in the world. The mood of dread can leave one totally impotent and helpless, with a sense of not being "at home in the world" (Inwood, 1999, p. 17).

The mood of dread challenges the women's established view of how they identify themselves within the world, their own being-in-the-world-itself (King, 1964). It is a particular way of being that leaves them feeling alienated and isolated from others (Polt, 1999). Whilst they have already determined their own identity by choosing to be who they are to date they have a deep fervent desire to be like 'every other woman, to be a mother. I propose that the sense of dread comes from having to face that they may be different from other women: They may never have their longed for baby. "Angst [dread] is calm and collected, while fear makes us lose our heads" (Inwood, 1999, p. 17).

Fear

Fear is akin to dread, however fear reveals a definite threat to Dasein approaching in a way that man is able to turn away from or to address the

threat (Smith, 1981). “No matter how fearsome a thing is, we may not be totally helpless before it; we can at least try to run away or try to do something, as we say, to help” (King, 1964, p. 130). It is only through the mode of fear that Dasein can uncover what is to-hand in the environment as threatening, and therefore is able to address the threat (Smith).

Jane in her antenatal interview, which she consolidated in her reflection during her postnatal interview, demonstrates facing threats to her pregnancy and the fear of loss:

I stopped going to the gym when we started the third cycle of IVF and then kept delaying my return thinking I'd better not go back this week because what if something happens. Unfortunately I haven't returned and I do regret that now...I probably don't need to worry but I worry that I could do something personally that could cause something to go wrong. It's something in the back of my mind thinking oh what if I over-exert myself and cause something to happen, to go wrong. Also, the safe eating thing, I've got the Ministry of Health list stuck to my fridge and I pretty much follow that religiously and yet I'm sure it's a bit overboard with all the things that it says 'Do not eat this. Do not eat that'. I'm very much on the conservative side with everything. Always thinking just in case...(Postnatal reflection) I kept thinking to myself it's only nine months and what if I did just eat something that I maybe shouldn't of and there was a bad outcome, I would never forgive myself. Looking back I was probably a bit over the top with it.

Jane faces the daily threat of something going wrong by addressing the threats through modifying her lifestyle. Jane pulls out all stops with this her third IVF. I suggest her need to respond in such a manner could be related to previous remorse/regret over her miscarriage when perhaps she didn't change her lifestyle. Whilst she identifies being 'over the top' there is no freedom from these threats until she has her baby in her arms. For Heidegger what is essential in language is not the words that are spoken but what is being spoken about. In speaking to others what is important is what we are talking about that reveals something about our individual worlds (Heidegger, 1962/2008). Jane does not disclose her fear using specific language rather she describes her everyday experience of living

with fear. When Jane reviewed her narrative she inserted the word 'always' which I believe demonstrated how deep and perpetual the mood of fear was.

Heidegger (1962/2008) in *Being and Time* describes a tripartite structure of viewing the mood of fear, that all belong together and which I shall apply to Jane's story:

Firstly there is the 'before-what' of fear. This is a sense of being that 'matters' in a particular way. Before Jane's fear of this pregnancy not succeeding is the before-what of her 'mattering' in life. For Jane once she made the decision that she wanted to be a mother rather than a professional woman, her 'mattering' in life is solely that of being a mother and the threat is identified.

Secondly, there is the fear itself. "Fear is a slumbering possibility of finding-oneself in one's Being-in-the-world (we call this possible way of finding-oneself 'fearfulness'), has already disclosed the world in such a way that something like the fearsome can come close" (Sein und Zeit as cited in Smith, 1981, p. 222). Fear is not spontaneous rather it occurs due to past experiences that have created the fearsome. It is something which we encounter within-the-world that threatens and may either be ready-to-hand or present-to-hand. Jane has been exposed to repeated IVF cycles followed by pregnancy failure therefore the world of failure has been disclosed so often that she now is fearsome of recurrence. It is therefore a priori disclosure of the before-what of failure. Thus the threat that Jane fears is failure. "Fearing, as a slumbering possibility of Being-in-the-world in a state-of-mind (fearfulness)" (Heidegger, 1962/2008, p. 180).

Thirdly, is the about-what of fear, "what" fear is fearful "about". Jane is fearful of the potential disclosure that she may have to identify that she has failed to carry a pregnancy and failed to become a mother.

By actively monitoring what she eats, and reducing her exercise she identifies managing the threats to the failure of her pregnancy. Jane does

not want to live with the guilt that perhaps she may have brought failure on herself, so her actions are “conservative and over the top” in order to subdue the fear. Jane’s reaction is not uncommon to IVF pregnant women as described by Fisher, Hammarberg and Baker (2008):

Women conceiving with ART have prolonged uncertainty about whether their pregnancy is real, have high anticipation of failure, and have had to tolerate intrusions into intimate experiences and disproportionate exposure to reproductive loss that are likely to influence pregnancy psychologic functioning. (p. 1105)

Jean, who had developed cholestasis in her pregnancy, describes her antenatal appointment when induction of labour was advised (postnatal interview):

So, then they came in and the consultant was very brisk and didn't have the time to explain anything, just said 'We're going to induce you next week...at 36 weeks'...he didn't really leave me an option to make a decision and when I started questioning it, it was like, the risk of sudden fetal demise is...and it was like Whoa! When you've been through all this to get pregnant in the first place, you think there is no way I'm going to risk this now. Then he said 'If you don't feel 10 movements every two hours contact your midwife and she'll know what to do'. That was on Friday and it was we'll do it Monday.

What is missing from Jean’s narrative is recorded in my field journal “Jean was very tearful when she was told baby might die in utero. Jean spoke after the interview of a weekend of concern (streaming tears falling uncontrolled)”. She was overwhelmed with fear that her longed for baby might die over the weekend. Her fear of fetal demise was wrapped in the unresolved grief of her miscarriage. For the entire weekend whilst awaiting her induction of labour Jean monitored her baby movements constantly for any sign that baby was not well; this was the only action she could take against the threat and her fear that her baby might succumb. Hammarberg, Fisher and Wynter (2001) in their systematic review of 28 studies and 46 papers reveal consistent evidence that mothers who conceived through IVF reported higher anxiety regarding the survival and wellbeing of their fetus than did women spontaneously pregnant.

Something greater

There was an impression from some women that there had to be something greater having command over their outcomes. The fear the women experienced became a sense of their lack of control. Stella conveyed this in her sense of monitoring statistics:

It was all about the percentages because this whole treatment process has been about percentages; my husband has a condition that affects 1% of the population and for me premature ovulation is like 0.5% of the population and...the chances of success for IVF was 46%...the whole way through it's been percentages. (antenatal)

After the 30 weeks my husband and I had talked about it quite a bit and thought that was the magic mark, and that even if she came early she was going to be okay. I had an app on my phone that we'd follow every week that would say that babies born at 'this' week, they have a 'this much percentage of being ok' and 'this much percentage of having serious medical issues' and that would get less and less every week and that would be like a 'goal' for us. (postnatal reflection and interview)

There was so much that Stella had no control over. She sensed a relationship with the wrong side of the statistics that prevented her believing in her pregnancy until she was at 30 weeks gestation. Identifying the percentage of failure, and repeatedly being a part of that percentage, I suggest assisted in removing some of Stella's self-blame. In turn this assisted Stella to continue with treatment but it also meant that she became obsessed with monitoring her pregnancy progression through the statistics. With the comfort of the 30 week statistic, Stella was now on the right side; if baby was born after this time all would be okay.

Ellie also described the tension of the play of hope and fear:

I used to say, and I still do, when it comes to things in life that you really, really want, or you really think you want, or you really think that you should have, when you are not getting it, it's like God, the universe, whatever...you get a little 'tap' on the shoulder and you kind of ignore it because you really want it and then you might get it

much harder, or you might get a kick in the shin. And then the time after that, you might get a punch that knocks you out and the time after that you might get knocked off your feet. It's like 'what is the universe trying to tell us?'.

Ellie believed in powers much stronger than anything she could control. The harder Ellie tried to achieve something the more she felt thwarted. She was having an internal battle in her head perhaps akin to a spiritual battle. The harder she was knocked, the stronger she became. It was as though she was actually psychologically fighting against this force to prove that she was the stronger. Perhaps such battles provided Ellie with the sheer determination to continue against the adversity of her third IVF baby being stillborn.

I suggest that at times it is easier for some of the women to believe in a greater power, because there is a sense of someone or something else looking after them. Much of society has at some stage in their lives, been subjected to doctrine of one belief or another that there is a spiritual power in control of their destiny. At times of trial human nature returns to those doctrines due to the innate need to seek help beyond one's own strength. Toscano and Montgomery (2009) suggest that when women have faith in either a higher power or in magical thinking they were less likely to reflect hopelessness. Being tested by God or by a form of universal power regarding their 'warrant' to have a child was identified in two phenomenological studies (Benasutti, 2008; Harris & Daniluk, 2010). A recent hermeneutic study performed by accessing women's experiences of infertility through the internet in Russia also identified being tested and/or blessed by God (Isupova, 2013). Therefore having a personal faith, as Ellie seems to suggest, brought her a trust beyond her own abilities to control things and is a real belief shared by many other infertile women.

Hope

Struggle embodies hope and these women expressed hope in many guises. “Hope springs eternal” is an often quoted saying (Pope, n.d.); it seems that it is human nature to look or hope even in the most hopeless of situations (Benzein & Saveman, 1998). The women in this study envisioned futures as mothers. At some point they started to believe that it could be true, they really were pregnant. In doing so they allowed the metamorphosis from womanhood to motherhood to begin, albeit, I suggest, later than for women spontaneously pregnant.

The women’s hope is orientated towards the safe birth of their baby. Permitting hope to develop is the result of their persistent efforts to achieve a viable pregnancy following/having experienced repeated dashed hopes. The hoping process only continues because the women have sufficient value placed upon the end goal of motherhood to continue their pursuit. “The successful pursuit of desired goals, especially when circumventing stressful impediments, results in positive emotions and continued goal pursuit efforts” (Snyder, Lopez, & Pedrotti, 2011, p. 187). A feedback loop of positive emotions (for example, visualising the baby on scan) provides the continued hope process. This feedback loop is a critical part of Snyder’s theory of hope (Snyder et al.).

Heidegger (1962/2008) addresses the phenomenon of hope stating that hope is wholly related to the future, potentiality-for-Being, and that the analysis of hope should be in the same vein as analysing fear. Heidegger is not particularly interested in the future characteristics that hope displays but rather in the existential of hoping itself. “Even here its character as a mood lies primarily in hoping as hoping for something for oneself. He who hopes takes himself with him into his hope, as it were, and brings himself up against what he hopes for” (Heidegger, 1962/2008, p. 396). My understanding of what Heidegger is describing is that the process of actually hoping requires the women to expose themselves to what they were hoping for. That is to say, the women could only hope when they

allowed themselves to recognise that their pregnancy progressing meant that they would ultimately become mothers. Hope as a state-of-mind does relieve us of despondent moods and therefore is related closely to our burdens (for example, fear or dread) and the mode of Being-as-having been (Heidegger, 1962/2008).

Silence

The first expression of hope came with revealing to others that they were pregnant, which in many instances was not enunciated with a tautology of words but rather a silence. Ellie describes the manner in which they told her parents she was finally pregnant:

We hopped in the car one day after work and had a copy of the scan photo for their fridge and put it in an envelope. Over a cup of tea we said to them 'we've got something for you'. They were like 'what's this' and I'm like 'open it and find out' and they cried! They knew exactly what it was as soon as they looked at the picture, and they knew exactly what it meant. We pretty much told my siblings in the same way...

In describing how she 'told' her family that she was pregnant it is noteworthy that Ellie never used words. She chose to 'show' her family she was pregnant through the use of a scan photo in a sealed envelope. The silence that was present when the envelope was opened, and the cries of joy that escaped were more powerful than the use of language. Linguistic articulation was ineffable for Ellie but the silence and the photograph expressed it all. In *Being and Time* Heidegger refers to silence as an important component of discourse⁶ and that "discourse is the articulation of intelligibility....hearing and keeping silent are possibilities belonging to discursive speech" (Heidegger, 1962/2008, p. 204). Heidegger suggests that keeping silent strengthens what one has to say

⁶ "Discourse is the articulation of the world into recognizable, communicable patterns of meaning...discourse makes language possible." (Polt, 1999, p. 65)

“in talking with one another, the person who keeps silent can ‘make one understand’ ” (Heidegger, 1962/2008, p. 208).

Ellie goes on to describe telling her colleagues:

I was about 16 ½ weeks...because my plan had been that I wouldn't tell staff, because a lot of them asked if we were going to do it again. I'd just fob them off, they were asking my friend and that was getting awkward for her. What I thought would happen was that people would start to see that I was looking a bit round in the tummy and they would ask me.

Allison (2011) suggests silence provides a shield that enables invisibility and

forecloses painful conversations and unwelcome advice, criticism, or questions. At the same time, the regular employment of such strategies is indicative of the reach of relations of power in reproduction and sexuality wherein a failure to conceive constitutes a deviation from social norms. (Allison, p. 17)

Silence, as demonstrated by Allison in her study, is a strategy that women who experienced infertility became competent at using and continued to use into the early stages of their pregnancies. The use of silence is an explicit protection strategy from unwanted conversations and pity (Throsby, 2004). Silences may be broken through the use of internet chat rooms, where those sharing experiences can relate to each other without unwelcomed advice (Hinton et al., 2010). The sharing of silences in this manner may be beneficial but I suggest should not be at the detriment of real world support through health care providers

The gravid body was another expression of hope and an axiomatic mien of being pregnant requiring no articulation with language. Cola describes:

I must have been 23 weeks pregnant and I was shopping and a lady that I kind of vaguely know came up and said, ‘Oh, are you pregnant?’ I thought...oh yes, I have to say yes because I thought I can't say no. And then, I started to feel a bit nervous because I knew that she would tell her partner who would tell other people

and it would all start to come out. And then I started to feel, well...at that point, gosh...if it does go wrong I can't hide this forever...otherwise...I would have liked to really not tell anyone and just walk in the mall with a baby! That would be my ultimate to be honest.

The gravid body is physically obvious evidence of pregnancy that requires no explanation; it is easily understood, as it is difficult to conceal. A dichotomy occurs here for Cola and Ella as on one hand their gravid body excites them as it declares to the world that they are pregnant; an experience they can now share with other women. Yet, on the other hand, it reveals. As a consequence an expectation is set for there to be a baby, their fear of again losing a baby shadows the celebration.

As both Ellie and Cola begin to hope they enjoy that others are noting their pregnancy. Silent hope is a powerful expectation of a personal tomorrow (Benzein & Saveman, 1998). For these women tomorrow was motherhood. According to Benzein and Saveman, hope is a human phenomenon that is closely intertwined with other phenomena, such as desire, rendering it difficult to identify clear boundaries. What is clear though is that hope brings with it restitution for past loss.

Safety and preparing for baby

When interviewed at the end of their second trimester (28 weeks gestation) the women were all beginning to feel safe. They knew that if the baby was born it had a very good chance of surviving and this enabled them to let their hope develop. The women started to prepare for their babies as described by Stella:

I waited until 20 weeks and then I bought one outfit (laughter). Probably only in the last week or two (28-29 weeks) we started getting a bit more stuff and I've been pulling out stuff...I feel a lot more comfortable with things now, but it took a while. I used to think that I'd be out there straight away shopping and things but you are a lot more hesitant actually and then before you know it you've got no time left. I've been planning my baby shower for a couple of years now so we have definitely

started preparing. It's quite exciting to be able to finally put together our nursery and to look at things we want to buy and I don't know, get all the preparation under way. It's very exciting for me.

Preparing for a baby is tangible evidence that a baby is expected. Growing hope brings the women to a point where they can risk viewing this tangible evidence and start getting excited. Preparing for a baby is part of the anticipation that a baby is coming. My experience as a midwife is that most women (those who have spontaneous pregnancies) start preparing for the baby soon after they enter the second trimester when they feel their pregnancy is safe. It seemed the women in this research did not feel safe until they were nearing the end of their second trimester. They could not take safety for granted and tempered their innate desire to prepare for their baby.

Human beings have future orientated ideas, always making plans and anticipating; assuming and expecting (MacLeod, 2013). It is the ability to think about and be future-orientated that according to MacLeod provides us with a sense of positive well-being. I propose that the women's stories above demonstrate that nurturing the seeds of hope was as important for their sense of well-being as for the in-utero well-being of the fetus. No matter how challenging their fear these women always held hope in their hearts; it was their hope that drove their tenacity to continue IVF treatments, to embrace their pregnancies and to start preparing.

Beginning to believe

The women diminished their fear that something would go wrong, developing cautious connections to their baby in utero. There was nothing romantic, rather they chose a prosaic relationship to guard their emotions. Cola regarding connection to her baby in utero:

It's still hard for me to think of her being an actual baby at the end, because I do still feel like 'well hold on, we're not there'. We've got a lot further along and every week...every day they say now is a good thing. Because she's just that bit much stronger and so forth but we're

still not there. I still feel like there's a long way to go. So definitely not blind excitement, more aware. I probably focus on the things that could go wrong than thinking about holding my lovely baby at the end.

Jane:

It still seems hard to believe that we are going to be having a baby, like I keep saying that to my partner that it seems funny because, it's hard to actually get your brain into that belief that we are going to have a baby. So, I suppose that's starting to feel a bit more real the closer we get.

The women, whilst experiencing baby movements and acknowledging that this did indeed mean a baby was present, still chose to be cautiously optimistic. It was difficult for the women to believe they were pregnant despite obvious baby movement to me as the interviewer. Jane had to keep reminding herself of her baby by announcing to her partner on repeated occasions that they were going to have a baby. For her to hear herself voicing this was a cognitive way to try and believe that the baby was real. By speaking of her baby out loud Jane began to cement the belief that her baby was real. Juxtaposition occurred; audible confirmation of a baby within the safety of the future parental relationship whilst at times maintaining the safety and retention of silence in wider relationships. All of the women, as demonstrated by Jane and Cola, were waiting patiently but in a state of partial disconnection with reality. Permitting hope to grow enabled a sense of waiting to ensue.

The women in this study were waiting for their pregnancy to be viable, waiting to hold their baby in their arms. Heidegger believes that there are two different forms of the human activity of waiting (Heidegger, 1966). One is the waiting 'for' something that pertains to goals and desires. The other is an unknown waiting; a sense of waiting without consciously knowing what one is waiting for. In the latter the waiting is deeper, it is a waiting 'upon' something not expressed in human terms. The women were waiting 'for' the baby whilst waiting 'for' something to go wrong. Within the experience of waiting 'for' they were waiting 'upon' the transformation from

the vacuity of infertility to the transcendence of what they perceived as complete womanhood through motherhood.

Pretending to be 'normal'

All of the women had a desire, at varying stages in their pregnancy, to be 'normal'. But what is 'normal'? For some this was an important part of choosing their LMC. Olive, Jean and Stella all chose to have a LMC who was a midwife as they stated that they viewed their pregnancies as being 'normal'.

Jean: I think the midwife was always going to be the option for me... I think I kind of wanted to be as 'normal' as possible after having gone through all that. I guess you just want to put all the intervention that you've gone through behind you and just focus on having a healthy baby. Well, not exactly 'normal', because you can't forget what you've been through but you just want to... I don't know, have a nice experience and not just be worried about what might happen.

Having a midwife as their LMC is what 'normal' healthy women do and Jean was adamant that this was where she belonged. Jean wants to forget the experiences that she has been through to get to this point and wants the autonomy of being 'normal'. Here Jean wishes to be in control of her pregnancy. She takes back the power she had handed to the infertility specialist and chooses to develop a partnership with a midwife, to be viewed as 'normal'. Remember that Jean had not disclosed her infertility treatment to her friends. If she had chosen an obstetrician LMC then there would likely be questions about why she chose medical care. Rather, choosing a midwife LMC not only cemented in Jean's mind that she was 'normal', but confirmed in her social encounters that she was 'normal', having a midwife just like her friends.

Stella similarly decided that she did not need reassurances by an obstetrician and that a partnership with a midwife was essential to her pregnancy care:

I never felt that the pregnancy was unusual or high-risk, even though there's always a risk of miscarriage, so it never crossed my mind to be under the care of anyone besides a midwife...It was important to me when I did choose a midwife that they had experience with people who had had IVF. I guess, not that we had a huge big discussion about it to be honest, but she is aware of it. I emailed her initially, and a few other midwives as well, and that was one of my questions "do you have experience with other women with IVF?" I guess because the journey we've had to go through to get to the point where we are at it takes a big toll.

Stella on reflection in her postnatal interview talks about the growth scans prescribed after an obstetric consultation:

I felt very secure having the extra scans and felt like even though things were still okay they were still doing them to keep an eye...I felt like I was well taken care of because of that. If anything was an issue then it would have come up. There was always just that little bit of anxiety just before the scan...what if there was something...but because the scans were always ok, it was fine. Just made me feel well taken care of to be honest...I felt quite fortunate to have those extra scans. Even though I can feel her and I'm quite reassured, being able to see her is quite a different experience.

No matter that Stella thought her pregnancy was 'normal'; one of the most important things for her in her pregnancy was the reassurances from obstetric follow up and the regular growth scans. There is no doubt that she was confident in her midwife's ability to care for her. But she needed to visualise her baby on the scan to have a moment in time when she believed her baby to be well. On reflection, Stella realises her wanting to be 'normal' was not as strong as her need to have visual reassurances of a 'normal' healthy baby.

There is no disputing the partnerships that these women developed with their midwives were a very important component of their satisfaction with their pregnancy care. However, they also needed the medical reassurances; they could pretend they were 'normal' but in reality they were not.

Jane and Cola conversely chose to have obstetric LMC care:

We really trust our Obstetrician, I trust him to make the right decision. My preference is not to have any drugs involved but we've talked about it and both agree that we'll definitely take his (the Obstetrician's) advice if he is saying 'you need this...' then my view at this stage is that I'll do whatever he says I should do to make sure the baby gets out safely. (Jane)

We don't regret having an Obstetrician, as there were no complications during the pregnancy we didn't particularly need his expertise at all. But, in saying that, it was a comfort for us...I liked every time we went and saw him he would do a scan and that was just reassuring being able to actually see that everything's alright, which I guess wouldn't have been done if we were not with an Obstetrician. (Jane reflection at postnatal interview)

I haven't had any input in, who, what, how. It's just really they say whatever and I just follow along. I mean I trust that they must know what they're doing, it should all be fine. (Cola)

Both were comfortable with the obstetricians making the decisions as demonstrated in their stories. They had transferred the control of their bodies completely to the infertility specialists and in so doing continued with this transfer of power throughout their pregnancy. As in Chapter Three, Cussins (1996) describes 'ontological choreography', the process through which women pass many varying stages of objectification during IVF treatment. Women, rather than being powerless throughout their fertility treatment process, shift the power and control to the doctor. Cussins suggests that through objectification the woman manages to alienate herself from the treatment and the impending danger. Cola and Jane preferred to be led by their obstetrician than by making decisions for themselves. By relinquishing this responsibility to make decisions they were also reducing the opportunity for self-blame and therefore potential threat to selfhood.

For pregnant women in New Zealand there is a strong emphasis on informed choice, on making decisions after receiving all the information. Most pregnant women are well versed in this model of care that is endorsed through the preparation for pregnancy classes, the media and books such as *'The New Zealand Pregnancy Book'* (Pullon & Benn, 2008). I believe it is unusual to have women this disinterested in the decision-making regarding their pregnancies. I consider this to be driven from the women becoming accustomed to the change in power relationships through their repeated infertility treatments.

Ellie after her interview commented that when she goes to the obstetric clinic they reassure her that "everything is 'normal'" but said she really just wants to scream at them and say "I'm nowhere near 'normal'".

Ellie at 28 weeks:

I push it down most of the time but when I actually stop and think about it I'm petrified. But, I mean, who wouldn't be. You can't live in that state of mind because you'd go insane. You've got to just go 'right o, you're going in that box over there and I'm just going to keep acting as if I'm having a baby and I'm going to get a baby at the end of it'. And that's what you do.

Ellie reflecting on her antenatal period:

Occasionally I'd lose it and I'd have a wee meltdown. Generally, it was only ever my husband that saw that and sometimes even he didn't see that. It's funny I don't know if it's our society, or whether it's a woman thing, but you know, it's very important to be seen to be coping isn't it...I don't feel as though I'm playacting whereas I probably was in my pregnancy.

As demonstrated in these stories I suggest that all the women in this study became experts at pretending to be what they perceived as 'normal'. In the infertility period they were 'normal' career women, as demonstrated in the previous chapter. In this chapter they are 'normal' pregnant women. In many ways this was unsurprising; there was an expectation on entering this research that women would have coping and protective strategies. It

has therefore confirmed that strategies developed in the infertility period carry on throughout the pregnancy, and in some cases through their roles as new mothers.

Conclusion

Heidegger believes that moods are fundamental to our existence, and as such there are times when we may become cognisant of a particular mood. The mood of dread is an obdurate mood that I suggest all of the women in this research experienced, whether cognisant of it as such or not. No matter that the women ached to become mothers, the fear that underpinned their pregnancy that there would yet be another loss made it difficult for them to embrace the hope that their progressing pregnancy was trustworthy. The shroud of fear/dread permeated their pregnancy, influencing decision-making and the development of the mother/baby relationship. In pretending to be viewed as 'normal' pregnant women they applied their already apt coping strategy, gained from years of infertility; in most instances managing to conceal their fear. For some the relinquishing of control instigated as a coping strategy during infertility treatments continued with the transfer of this control to the LMC obstetrician.

These women were proud, yet concerned that their gravid bodies revealed their potential baby to society and thus physically exposed the risk of failure. In order to cope they reserved the development of the relationship with their baby and cautiously prepared, not wanting to believe until they have their baby in their arms.

Chapter Nine

Lingering dread

To gaze into her eyes, knowing that she was the baby we had wanted for so long for was so special (Tess)

“The past changes under the pressures and influences of the present”
(van Manen, 2007b, p. 104).

In this chapter we will see the flame of hope come to fruition with the birth of the baby. We have the privilege of hearing from the women how the experience of birth changes the past. I suggest in this chapter that for the women in this study the transformation from womanhood to motherhood is more dramatic than the birth process itself. Their perception of time, which isn't linear, changes with the birth of the baby and the transition into motherhood. The specialness of the pregnancy continues as the women express gratitude for the baby. This influences their view of motherhood as not being ordinary or taken for granted.

There is a sense of finiteness as the women endeavour to embrace the physical and emotional reality of motherhood. The shroud of fear that they carried through their pregnancies now changes. For some women, this shroud of fear wraps around them and the newborn. A heightened sense of vigilance is required in order to ensure all is well as the mood of dread continues to lurk. For one woman however, the mood of dread and the shroud of fear were shed soon after the birth.

The dream becomes reality

Birth of the baby, birth of motherhood

Up until the birth of their baby the women had been thwarted from achieving their dream of having a baby and becoming a mother. This

continued throughout their pregnancy because of the fear, so that when the baby became a reality it was a surreal moment and almost caught the women⁷ by surprise, as described by Stella:

I look back on the video and see her and having her there is such a sense of wonderment and amazement and of just...blown away massive feelings of love and happiness. In the video she's wrapped up next to me in the bed and I just can't stop touching her and looking at her...Just complete wonder and I'm like I just can't believe that she's here.

Tess in her journal entry:

I can recall my first words were 'she's our baby. We finally did it!' To have this little being put on my chest for skin-to-skin contact was amazing. Our baby was alert with eyes wide open. To gaze into her eyes, knowing that she was the baby we had wanted for so long for was so special.

All of the women have spent numerous years dreaming of maintaining a pregnancy. They battled the fear during their pregnancy to physically begin preparing their home for their baby. But still the reality is surreal. They had to put this part of their lives on hold, not willing to dream what it would be like to hold a baby in their arms. To physically hold the baby, to touch it and gaze into its eyes is an overwhelming, emotional experience. The waiting 'for' had concluded, they had their baby; they had become mothers.

As we saw in the previous chapter Cola was very cautious of developing any relationship with her baby in utero due to her fear of something happening. For Cola, on the morning of her caesarean she suddenly realised that perhaps she was not ready, that the dream of a pregnancy was now in reality a baby.

I was probably in denial really during the pregnancy, just cruising along, you can't deny that your stomach's getting bigger and bigger! But I think I was probably not

⁷ Olive is not included in this chapter refer to methods chapter for explanation

really thinking much further than day to day. Witness the fact that when I went in for the C-Section I was in tears and didn't want her to come out because I wasn't really prepared for her to come out! I hadn't really thought about what was going to happen and how it was all going to happen and how we were going to do things. I hadn't really sorted all that out.

I think I would have not been surprised if someone had come in and said 'oh sorry, you haven't actually had a baby' and taken her away. That wouldn't have surprised me. Because I was trying to get my head around...oh my goodness, she's actually here and she's ok (crying)...I was trying to get my head around all that and it was definitely surreal.

Perhaps for Cola, who had experienced so many miscarriages and years of IVF, the reality of a baby was completely lost in fighting the fear of another loss. It was perilous for Cola to even dream of having a baby at the end of her pregnancy. Rather she was disassociated from her baby in utero. Cola had frozen the possibility of motherhood to cope with recurrent failures; the thawing was a very slow and arduous process. She took time to believe that the baby belonged to her. I noted in my journal that when her postnatal interview came to a conclusion she talked about not allowing herself to attach to her baby in utero; how she now wished that she had spoken to her baby. Cola would like to imagine that this would be different if she was to be pregnant again, although doubts that she would actually change.

Expressing this dissociated behaviour toward her unborn baby is not unusual for IVF mothers according to some of the literature (Hjelmstedt et al., 2003; McMahon et al., 1999). However, there are other studies that suggest prenatal attachment is no different for IVF mothers than for spontaneously conceiving mothers. There is suggestion that some women have few conversations with their unborn babies (McMahon et al., 1999) as demonstrated by Cola.

The disbelief in the reality of becoming a mother also became apparent in the thoughts that it was almost expected that someone would come and

take the baby away, that someone had made a mistake and that there was really no baby at all. "It seems that IVF women do not start to worry about the baby until they feel secure that the pregnancy will proceed" (Hjelmstedt et al., 2003, p. 160). In the context of Cola, she could not start to worry, or develop a relationship, until the baby was, and remained, physically present.

Birth synonymous with healing

The years of their lives being played in a minor key had now changed to a much sweeter melody. Jean, as we saw in Chapter Seven, strived to be a 'normal' pregnant woman and become a mother. She is the only woman who had a vaginal delivery of her baby or who paid much attention to the birth process. Jean as a mother suddenly became confident in herself, she took control of situations as they arose:

So you sort of think how am I going to cope with this because we'd been expressing and giving her extra top ups and things like that, it was like how are we going to manage with that? We had the breast pump and in the packet with the breast pump there was a bottle with a teat on it and I was like right, I'm going to give her a bottle, she's still getting the good stuff even if it's not the ideal method of delivery.

When we first came home the midwife came quite regularly. The first week was a bit stressful because they were worried about her weight. She got weighed seven times within a week, on about seven different scales with differing weights. In the end I thought, she seems to be fine...let's just not worry about what the scales say.

It seems that for Jean the birth of baby was synonymous with healing. Jean not only gave birth to her baby daughter I suggest she also gave birth to Jean. The Jean that evolved from this moment was no longer burdened by the struggles to conceive and retain a pregnancy. Jean experienced being thrust into a world where she had long ago identified she belonged; her thrownness into the infertile world was over. She instantly became confident and seems to have thrown off the shroud of fear embracing the world of motherhood for all that it offered. However, I

suggest even though Jean appears to have been released of the fear there are possibly moments when it returns.

Jean experienced a dramatic change in her mood, an *augenblick*⁸ (Heidegger, 1962/2008). In a 'moment' she moved from dread and fear to suddenly believing in her baby's wellbeing. She identified that whilst she could continue to obsessively have her daughter weighed, the other option was to simply observe her daughter's wellbeing. It appears that Jean experienced her own personal epiphany when she realised the instinctiveness of being a mother and believed in herself. The overpowering need to worry was somehow gone in the moment of our interview. Yet, it is possible it still lingered in the unspoken and would be reawakened at the first sign of a problem.

Jean could be viewed as different from the other women. Because of her husband's infertility she knew from the outset she must undergo IVF. Perhaps she saw infertility as 'his' problem, not her own physiological inadequacy. However Jean did bring a burden of sorrow due to her failed first IVF and miscarriage from the second treatment, grief she had chosen to repress rather than process. At no time did Jean question her own fecundity in response to these failed treatments and I suggest this expedited her matrescence. Jean's matrescence could be similar to other women who access repeated IVF treatment when the cause of the fecundity is unrelated to the women.

In many ways the birth of the baby was a healing process as described by Tess and Ellie in their journals:

The journey of conception that my partner and I have had now pales in comparison to the birth of our little girl. It seems hard to believe that we spent over six years trying to conceive. The roller-coaster ride now seems like a pleasant jaunt in the countryside. The heartache of failed IVF cycles, miscarriages and a terminated

⁸ Translated to mean a moment of vision

pregnancy has faded and a new stage of life has begun – that of being a parent. For so long, I thought I would never be a mum and struggled to understand how the miracle of life could come so easily to some but be so incredibly difficult to others. I still pinch myself everyday when I look at my daughter and realise that my dream has finally come true. (Tess)

We will continue to embrace all of the 'blissful' emotions that we are experiencing in these early days for as long as they last...we have endured seven and a half years of frustration, fear, heartbreak and many other rollercoaster highs and lows. Savouring the birth and initial weeks and months of our daughter's life is truly a gift! (Ellie)

Stella described at her interview the healing as a result of the birth of her daughter:

It feels like it's been very quick but it hasn't. Obviously its been a very long process but it feels like the pregnancy, and having her growing eight weeks now has gone incredibly fast and I just can't believe that she's actually here and she's ours and she's healthy and well and that it's actually happened.

Whilst in objective calendar time it took years for these women to battle their infertility to become mothers; the calendar time was condensed by the birth of the baby. In the past, when the women were undergoing their IVF treatment they were unable to visualise their future and as a consequence lived time was subjectively slow. Now, with the birth of their baby they suddenly see their futures taking shape, they now have direction and a new chapter in their lives. The long months and years of waiting have been transformed in to the busy days of motherhood. Even though their days are busy they are full of the future, which is what the baby represents. During their years of infertility and treatment they had been unable to visualise their futures, now they could and busy motherhood was a part of that. Heidegger states that “everything begins with the future” (Heidegger, 2001, p. 159).

We encountered the women referring to time in Chapter Six, when their biological clock was ticking. The women referred to the concept of time

throughout their experience because time mattered to them. Time was moving too slow in becoming pregnant but too fast in the sense of their biological clock ticking.

Now in the present they were busy with the inauthentic everydayness of life, with the past and future mattering only in relation to the present (Polt, 1999). "Being-in-time...cannot be studied except within the context of its having-been-ness and being expectant, its past and future, by which it is constituted (Leonard, 1994, p. 54). The women's having-been-ness was about needing to maintain their pregnancies; their being-expectant is about accepting the reality of their baby.

Matrescence

Nearly all the women, with Jean being the exception, had a quixotic view of motherhood. This view stemmed from their focus being upon succeeding in their pregnancies and perhaps losing sight of what the reality of motherhood entailed. This experience is not unusual for women post IVF; "adjustment to pregnancy and parenthood may take a different course for IVF women and that 'models' of adjustment to pregnancy and motherhood derived from studies of naturally conceiving women do not necessarily apply to this group" (McMahon et al., 1999, p. 355).

Emotional revelation

The emotional relationship the women experienced was an element of becoming mothers that emerges almost by surprise. Ellie describes this:

It's not how I imagined it would be and I don't know how I imagined it to be, the actual emotion and the physical love, 'I would walk over hot coals for you' is indescribable until you have experienced it.

Ellie was surprised at how emotionally attached she became to her daughter. In my experience as a midwife it is not unusual to hear women commenting on their love for their baby. For some who have not felt

particularly maternal this often comes as a surprise. Therefore perhaps the surprise that Ellie experienced was not related to not feeling maternal, but rather due to the withholding of the in utero relationship. Once the baby was born then she was able to believe her baby existed, astounded at the amount of love she experienced.

Cola at ten weeks was still coming to terms with the concept of being referred to as a mother:

It's funny when you say it like that, like 'I'm her mother' I suppose it feels a bit funny. But I do feel like I am, it's just it still hasn't really 100% dawned on me. But I guess again that would be quite normal for a lot of people anyway with their first child wouldn't it? But there's a really deep-seated denial of it coming to this point and then apprehensive about the next few years!

Cola provided the physical and emotional needs to her daughter but had not truly identified with the label of mother. Her relationship with her baby was perhaps compromised to some degree by an ICU admission post caesarean section. The delayed relationship with the baby has been evidenced suggesting “negative effect[s] of infertility on self-esteem and feelings of self-efficacy may persist after giving birth and hinder the development of a confident maternal identity” (Hammarberg et al., 2008, p. 1572). By ten weeks it seems her relationship with her baby and the apprehension about the years ahead suggest that the transition to motherhood is still one of disbelief. Having a baby may not yet be the complete panacea for Cola.

Tess who held a romantic view of what motherhood would be like was shocked at the reality:

I can clearly remember in the first two weeks sitting, trying to breastfeed and she wasn't latching on, I was in tears and she was in tears and just thinking what have I done? What a crazy thought after all that we'd been through, to actually sit there and think what have I done? The reality that it's permanent. The whole sleep deprivation...it's not just one or two nights. It's going to be a long time before you can have a decent sleep. I

think once I'd sort of thought that through in my head I got over it. It was like, ok, that's how it is, move on. And I did. I was quite surprised to have those feelings. So, it was she's here to stay and that's a really great thing because we've been waiting for her to come along for a long long time.

The almost abrupt reality of the life-changing event of having a baby after such struggle, especially for the older woman, is emotionally challenging. Tess had to grieve the past world that she knew of, the freedom to do whatever whenever she liked. There was the adjustment from a previous mindset of only considering their individual needs to always considering the demands and needs of another. Tess was torn between the grief of letting go of the old whilst wracked with the guilt of feeling emotionally responsive to the harshness of the mother world. Guilt is a response that was not uncommon in this adjustment to motherhood and becomes entangled in the fear of the 'what if' and the struggles to leave their baby cared for by someone other than themselves. The dream, nurtured for so long, perhaps has within it some unanticipated elements of a 'nightmare'.

Fear of the 'what if'

Now that the women had entered the world of motherhood for some of them their previous mood of dread continued. Dread was now lurking in the shadows of motherhood. It seems that dread of their baby being taken from them was ever present. For some this fear of the 'what if' occurred almost immediately after the birth as Tess describes:

I almost felt that if I closed my eyes and opened them she'd be gone. She would either have just disappeared or stopped breathing or, something would go wrong so I kept my eyes open the whole time. And it wasn't until about the third night that I was in hospital that I actually forced myself to turn away from the cot and go to sleep because I couldn't even turn my back to the cot for those first nights or something would happen.

Tess welcomed her long awaited daughter but with this arrival was the need to watch her every breath. She was so concerned that if she were to

turn her back her daughter might not exist. I suggest Tess had prepared herself over the many years of failure by never allowing herself to imagine being a mother. Suddenly becoming a mother she imagines she is in a dream, somehow out of touch with reality. In order to protect the dream she decides to watch her baby with no respite; this is relentless observation. After about 72 hours she realises that this continual watching of her daughter is not sustainable. Tess 'forces' herself to turn away with a sense of acceptance that she has to learn to trust her baby will stay safe.

Fear of being thrust back into the motherless world was so incredibly strong that it even resulted in nightmare dreams for Jane:

I never feed her in bed because I'm so paranoid that I might fall asleep so I always hop out of bed and go and feed her in the lounge. It must be in my subconscious because, particularly in the first few weeks, I would wake up a few times in the night and sit up in bed. I'd be like feeling round the duvet and thinking oh no, I've got her in the bed somewhere and panicking, like my heart would be beating like anything and then my partner would say it's alright, she's in her bed and I'd be like right...and lie back down again. It does still happen.

If dread was the baby being taken then the effect of fear was the baby being harmed, or potentially harmed resulting in mortality. As we have already seen in Chapter Seven, fear is about addressing the threat. The women would fear harm occurring to their baby in a variety of guises. For Jane it was suffocating her baby in her bed, even though she never brought her to the adult bed. Stella would constantly check on her baby when sleeping, returning to her obsession with statistics:

I was really scared of SUDS⁹. I really felt petrified if we leave her alone in the room or whatever I need to go keep checking that she's breathing, that for some unknown reason she is going to stop breathing and even now...if it's been a few hours, I go in...I still want to check on her and check that she's ok, that she hasn't passed away that she's still with us....I guess it has been so hard for us to get to this point and to have her and I

⁹ Sudden unexplained death syndrome

do feel that the percentages have always been against us, and you get really obsessed with percentages. I know it's such a low percentage for SUDS but then I kind of feel like I've had low percentage about lots of different things and if there's a low percentage then there's a good chance it is going to happen to us.

The mood of dread, fearing the loss of the baby, permeate the pregnancy. For Stella this mood and the subsequent fear has changed to the next statistical fear, that of SUDS. The relentless mood of dread continues, the cause of the fear has altered but continues to focus around the potential loss of the baby. Stella remains still fearful, still watching, waiting for something adverse to happen to her baby, and as a consequence to the mother-world she has worked so hard to gain access to.

Cola describes her strategies to reduce the risk of harm:

I've recorded every dirty nappy she's had, every wet nappy and how much she drinks on every feed and she's now 10 weeks old. I've kept it all just in case...there's no real basis for that because she's been incredibly healthy and she's had so many checks and everyone says she's fine and everything's great.

We spent about \$4000 worth of safety glass in doors and windows and she can't even walk yet! (laughter). Then to reduce the heat for her we are now getting these windows with a film that reflects out the light.

I was very, very scared to take her out in the car but even now I'll drive and my partner will sit in the back with her or he drives and I sit in the back with her. But I'm not comfortable with the two of us in the front and her in the back on her own, I feel like there should be someone in the back with her. Obviously when I take her on her own with me I'm just always listening...I don't have the radio on, I put the air conditioning on low, all so that I can hear her and respond if there's any problem...

For Cola and her partner after nine miscarriages they now have their longed for baby in their arms and they will do everything in their power to keep their baby safe. Cola's list of mitigating strategies against harm to her baby provides her with some inner peace and reassurances. Whilst Cola acknowledges that her baby is healthy and to some degree this should

reassure her, she is only able to accept the wellbeing of the baby when she knows she has strategies in place. She knows in her head that the list of the baby's input/output is over the top but she continues to ensure her partner and her nanny keep the list up to date. The list is a way of analysing any deviation from what is normal for her baby in order to act quickly and responsively. It is Cola's mitigation strategy because she knows she cannot place her in a bubble that will completely protect her. Whilst these mitigating strategies are to protect her baby they are also for Cola. She must know that she is/has addressed everything to protect her baby and therefore in turn protect her own emotional relationship with her baby.

The women's fear becomes paranoia about keeping the baby safe and protected. Cola implementing the multiple physical changes in her home or Stella constantly going to check on the baby breathing are both examples. There are many other stories that the women shared and they all emphasise that for these mothers their hyper-vigilance toward baby safety is different to that of most mothers.

The other very common strategy was to reduce the risk by not leaving the baby with anyone, other than the baby's father, for short periods of time. They see themselves as the governors of the baby's safety and that they should at all times remain their caregiver. Stella first left her baby at three weeks of age for 30 minutes returning when she heard the baby crying when she phoned to check. Stella defines the experience:

It was liberating but I was wracked with anxiety actually but I've done it now a few times without her but I'm no longer than an hour generally. I just race around and get a few things done as quick as I can and it's fine.

Ellie attended her neighbourhood hairdressing salon a few meters down the road. She understood that she was not physically far from home where she had left her baby in the care of her partner:

I'd been there about 20 minutes, texted and he didn't respond. I didn't worry too much but was getting a bit

ancy. So, 20 minutes later, I text him again. Still no response. Trying to hold it together in front of the hairdresser, I left as soon as I could. Rushed home and took one look at her and just burst into tears, it freaked me out not knowing what was going on and that I needed to be reassured. I wouldn't recommend that to anyone! It was just the dumbest thing I ever did. I've done it a few times now; I'd rather not.

Ellie needed to check in and reassure herself that her baby was okay at home with her partner. With no response to her first text she tried to reassure herself that the silence didn't mean anything untoward. However, the silence to the second text gave her an overwhelming sense that something was wrong at home. Ellie who is apt at pretending to be 'normal', a mask well developed, endures the completion of the hair appointment then rushes home fearing the worst.

As previously discussed, silence according to Heidegger (1962/2008) is just as important in discourse as the use of language. Considering silence strengthens what one has to say (Heidegger, 1962/2008), then for Ellie the silence coming from home is screaming that something is wrong. Ellie was experienced in the use of silence during her journey to motherhood. Implementing silence at times in order to cope with the emotional stress, or retracting from others who were not silent. Now she herself is the recipient of unexpected silence. It is not surprising that she immediately interprets the silence as an announcement for something being wrong. Ellie leaps into fearing the worst. Her mood of enjoying the opportunity to have some care and attention on herself moved instantly to the mood of dread. Ellie did not realise until this moment the stress of silence in the motherhood world where she constantly needed reassurance her baby was well.

Jane first left her baby when she was seven weeks old. Jane went five minutes down the road for about an hour and returned as soon as her partner texted her. But, she describes the thought of leaving her baby to go out with her partner when he suggests a movie:

I said 'I don't know how that's going to be possible with her at this age and for me to go. You might have to go with a friend?' But he said, 'oh...we might be able to leave her with someone'. But I just...I don't feel like I could do that at the moment...leave her with anyone [else].

The women found it extremely difficult to abdicate responsibility as the sole care giver. If the 'what if' occurred during someone else's 'watch', even their partners, it would be an unthinkable event.

They could not allow themselves to be away for long, nor geographically far; the guilt of leaving their longed for baby was too great. "We ordinarily associate guilt with causing something that we should not have caused, or with not causing something that we should have caused" (Polt, 1999, p. 89). Humans have a sense of guilt because they have a past upon which that guilt is based and a future projection of negativity. "Being-guilty as 'having debts' is a way of Being with others in the field of concern, as in providing something" (Heidegger, 1962/2008, p. 327). The women's foundation is the experience of infertility, and their future is an indebtedness and responsibility to provide care to that baby. For these women they have a heightened (authentic) sense of consciousness (indebtedness), struggling to relinquish the care of their baby. Leaving the baby under someone else's watch, plays on the women's conscience and they feel guilty.

Jane attempts to 'normalise' her adaptation to motherhood by deliberately thinking other women all face the same transition:

A lot of it's a huge big learning curve really (laughter). I was going to say, especially when you leave having a baby until later but I suppose it's probably not different regardless of what age you are in terms of learning, adjusting to what you're meant to be doing. She's pretty cruisey when you hear what a lot of people go through with their babies I think were pretty lucky really. She's pretty chilled out most of the time (laughter). (Jane)

Jane identifies her baby as being an undemanding one, and once again 'normalises' this by comparing her daughter to what she hears about other

baby temperaments. It requires effort for Jane to identify that it has been a huge adjustment for her and she modifies this exposure of the truth with her laughter.

Ellie also discusses the temperament of her baby:

She's just so cruisey and we're just so besotted with her that all the bad stuff is not really bad. Not that there really is bad stuff. She's not a baby that cries for hours on end. She just is incredibly laid back and just goes with the flow and we are just so blessed that we not only have a baby, but we have a baby that is easy and hopefully it will stay that way. I think I've been incredibly blessed. (Ellie)

Jane and Ellie both describe their daughters as being 'cruisey' and easy to provide care for. They anticipated with the long wait to have a baby that their reward would be a baby that was difficult to settle and a challenge to parent.

There could be the suggestion that there is an Idealisation of motherhood and denial that they have any problems. Letherby (1999) and Fisher et al. (2008) both state that women pregnant after ART disclose an obligation to be perfect mothers. "It is possible that a woman who has conceived under the much more difficult circumstances of ART feels a low sense of entitlement to complain or to express any doubts, uncertainty, or mixed feelings about the realities of motherhood" (Fisher et al., 2008, p. 1111). I would like to suggest that these new mothers demonstrate their depth of character, character chiselled over their years of treatment. They, and their partners, have developed a tenacious ability to fight the battles; the demands of a baby perhaps pale into paltriness.

Equivocal empirical findings in the determination to prove the hypothesis that gestational stress, especially following IVF treatment, have a correlation with various phenotypes, such as temperament at birth (Fisher et al., 2008; McMahon et al., 2011, 2013; Talge, Neal, & Glover, 2007). Whilst the studies provide interesting insights they are predominantly from the quantitative paradigm. Hammarberg, Fisher and Wynter (2001) from

their systematic review of studies and papers suggest that from the emergent literature it is possible parenthood after ART may be idealised, which may hamper the development and adjustment of a confident parental identity. The women, as demonstrated in these chapters, only reveal their experience when they are given the opportunity to tell their stories. Answering the surveys/questionnaires and the use of Likert scales does not elicit their true depth of experience; there is an element of silence to the experience. The manner in which the women in this research have play-acted at being what they perceive to be 'normal' brings to question the validity of the quantitative empirical studies, in which their full experience cannot be revealed.

I suggest that women in the quantitative studies provide anticipated positive responses to the forms of questions/methods used, responses related to their perception of infant behaviours, as opposed to observed actual behaviours and to their transition to motherhood. Cola is an example. In my journal I have written after Cola's interview a comment she made where she describes how she pretends to be 'normal' and everyone believes her. "Everyone that comes, including the midwives, all tell her that she is a really relaxed mother. In reality she said she appears relaxed but underneath the surface her mind is on constant alert looking for impending risks. Cola stated she is good at pretending to appear relaxed". There may be a sense that these women are expressing their gratitude for actually having a baby at last rather than the raw truth.

Comportment of motherhood

The women in this study have an epistemological understanding of how it is to be a mother. They have developed this understanding through their ontological development, through exposure to literature and conversations but also through the relationships with other women who are mothers. The women have observed other mothers' ways-of-being in the world and seek to exist in the same manner.

Heidegger's concept of Dasein and how individual human beings exist in the world is how the women in this study are attempting to identify being mothers (Dreyfus, 1991). Dasein has a way-of-being that takes into account the stand, for the individual, on what it is to be. Our "way-of-being embodies an understanding of what it is to be" (Dreyfus, 1991, p. 15). As humans our manner of being-in-the-world is "as comportment" and our mode-of-being relates to how we are in the world (Giles, 2008; Heidegger, 2001). As humans we are constantly comporting to something (Heidegger, 1962/2008). Comportment demonstrates to others how we are being-in-the-world in relation to what is important to us. Comportment then is "Being absorbed in what concerns me just now. It is a letting oneself be engaged with what concerns me" (Heidegger, 2001, p. 161).

Comportment is an unconscious manner in which every human being publically displays his or her individual Being in-the-world, or Dasein. (Giles, 2008). Whilst this view of comportment is public and viewed by others, the individual cannot visualise their own comportment (Dreyfus, 1991). Comportment is sensed and felt by others, it directs to Dasein's stand without the use of language. "In this way our comportment shows the *how* of Dasein" (Giles, 2008, p. 121). Therefore, the women in this study know from observing other mothers *how* it is to be a mother.

The women have yearned to have a baby to care for because to care is to be concerned for someone or something. To care is a basic existential phenomenon of Dasein (Heidegger, 1962/2008). "To care is important to Dasein as it makes sense of our being-in-world in relation to the world around us" (Miles et al., 2013, p. 3). To care is the manner in which we are occupied and involved in the world, taking our being-in-the world seriously (Harman, 2007). The women are endeavouring to comprehend their being-in the mother-world, where caring is extended beyond care of their own being-in-the-world (*sorge*) which is demonstrated in the women's mood of dread (*angst*) and fear, to providing constant care and attention to their baby (*sorgen*) (Inwood, 1999).

Each woman in this study is making her own adjustment in attempting to settle into a new way of being, “in their being [they] comport themselves towards their Being” (Heidegger, 1962/2008, p. 67). I posit that on entering motherhood they have an unbalanced sense of the way-of-being in this new world. They have concepts of how it is to be a mother but the emotional experiences they have lived through over multiple years of repeated fertility failure make it difficult for them to find comportment. They cannot identify if their individual being-in-the-world equates to how they sense comportment of motherhood to be.

I probably romanticised motherhood...I have these lovely thoughts of how it's going to be and not reality...not actually thinking about reality. I often think it won't be too bad. (Tess)

In their desire to establish the comportment of motherhood the women endeavour to develop an equilibrium, balancing their fear with the ability to believe in their skills to mother and care for their babies. Jean developed this equilibrium early as we saw when she had an epiphany to trust in her baby and her ability to mother. Other women in this study at ten weeks postnatal were still endeavouring to develop a balance. Mothers have to balance the knowledge that for the rest of their lives there is always the chance that something might happen to their child. For the women in this study the relentless behaviours of guarding their baby in case of the ‘what if’ was difficult to sustain. Cola was able to transfer this to her nanny, a woman that she trusted to care for her baby as well as she could herself. Others, such as Jane, were still trying to balance how to care for their baby in a sustainable manner that facilitated some equilibrium between the needs of themselves and the baby.

Family support

Whist we have already discussed that the women were virtually unable to leave their baby, the social supports they received were seen to be vital to their adaptation to motherhood. The mother-baby dyad required support,

not only from the partner but also from the nuclear family (parents, siblings) and friends as Stella describes:

I found that our friends and family who know about our journey, which is pretty much all of them, have been really supportive and loving. I think people have felt that she is extra special, we felt that she is extra special...all babies are special but we've had quite a journey to get here and I think the support and love that we've had from people has been quite amazing actually.

Stella is taken aback by the support that she received in the postnatal period. She identifies that others view her daughter as special but perhaps does not really understand that her family/friends have also been grieving and waiting for a baby to arrive.

The women demonstrate that having postnatal support, especially from the nuclear family is important. Indeed, there was a clear shift from being dependent on the health professionals, long established practice through the IVF journey, to that of the woman's partner/family. This was somewhat surprising given the partnership model of care in New Zealand. However it could be related to the women receiving what appeared to be 'routine' postnatal care and not extra visits, this women therefore had to depend on their partners and families more. The women who had shared their infertility experience with the extended family appeared to have the greatest support. There is no question that individual family members' have unique relationships with the new baby, however that relationship is more profound when the family are aware of the journey the parents have travelled. This demonstrates that it was indeed not only the infertile couple on a journey but also their nuclear and extended family members. Infertility therefore, whilst distressing for the couple, affects the wider family and the birth of the baby is healing for everyone.

Seeing everyone else so excited, friends and family, just so thrilled for us. Many a person came through the door and they'd cry. (Ellie)

Parents, whether they conceived through IVF or spontaneously, perceived that the care they provided and their adjustment to parenthood was

influenced by family support (Gameiro, Moura-Ramos, Canavarro, & Soares, 2011). Certainly the women in this research evidenced this, albeit at times visitation was taxing, the support was worthwhile. Only a few months prior to Cola giving birth she had to grieve her mother's death and at eight weeks sought support through a nanny:

I felt quite comfortable at nine weeks with the nanny, that she knew what she was doing and how she was doing things and that she could call me and that sort of thing, I really trusted her. Yeah, it is quite a big trust really when you think about it, isn't it?

Cola chose a mature woman as her nanny. When I commented to Cola about the age of her nanny she said that identifying a nanny she could trust had been difficult but that she also saw this older woman as a mentor. The older woman was also a confidant and guide. Cola's isolation from a new mother peer support network was mostly driven by her earlier disassociation with the pregnancy and her identifying as being significantly older than the other women. Cola returned to work at nine weeks postnatal due to her need to maintain her business, to maintain the previous life to some degree. She was prepared to leave her baby with a woman she trusted despite her fear of something going wrong. For Cola leaving her baby with a nanny is perhaps part of the playacting of what she views as 'normal' mothering. She continues to be cautiously optimistic that her and baby have a life long relationship but deep down the mood of dread persists.

Heidegger's notion of concern is the essence of Being-in-the-world and fits well with matrescence. In *Being and time* Heidegger indicates the multiplicity of ways of Being-in-the-world, which can be applied to the way the women described caring for their baby. In the way Heidegger identifies '*having to do with something*' the women are ensuring the safety of the baby, such as Stella checking on her baby regularly due to the risk of SUDS. The women '*attending to something and looking after it*' show the need for them as mothers to be the main care provider. In constantly being on alert for the 'what if' to occur, struggling to allow others to care for

the baby they are *“giving something up”*. “Because Being-in-the-world belongs essentially to Dasein, its Being toward the world is essentially concern” (Heidegger, 1962/2008, p. 84). All mothers share the kind of Being characterising concern, but it is, I suggest, heightened for the women in this study.

Conclusion

The previously vulnerable flame of hope came to fruition in this chapter, as the women welcomed the birth of the baby and matrescence. Emancipation from the infertility journey had occurred; time that previously moved slowly now moved quickly and the past had changed with the welcome of the present and the possibilities for the future. Awareness occurred of the reality and permanence of motherhood, of the unexpected emotional adjustment and the previously quixotic view of motherhood.

With the exception of one woman, all the women in this study appeared to demonstrate that finding a sense of balance in mothering had been challenging. Motherhood for them has been influenced by the shroud of fear and the obdurate mood of dread.

As each woman endeavoured to settle into motherhood a variety of ways-of-being in the mother-world characterise the Heideggerian notion of concern. The women were cognisant of the comportment of motherhood from an ontological and epistemological perspective and they were at times tested by being-in the mother-world. The women in this study strove to identify a sense of balance along with the anticipation of the ‘what if’. For two women especially the mood of dread had become such an everyday mood that most of the time they rarely noticed their mask of pretending ‘normality’.

Chapter Ten

Articulating meaning

“You cannot heal a single human being...if you do not first restore his relationship to Being” (Heidegger as cited in Wilberg, 2004)

This study was about how women who have had repeated IVF treatments experienced their pregnancy and early mothering. The years of infertility, layered with repeated treatment and pregnancy loss influenced the manner in which the women traversed the pregnancy and their matrescence. The findings suggest that the frustration of infertility and the strived for pregnancy became so intense that it became a constant part of their everyday being-in-the-world. Added to this everydayness were the prolonged years of infertility, which affected their natural dispositions¹⁰ and impacted on their childbirth experience.

The meaning of the experience

To come to write this chapter is a sense of coming near the end, to find a clearing. It is where the original verve to commence this research is revisited and the meaning is drawn from the women’s experience. A clearing is “a space of intelligibility wherein knowledge of beings first becomes possible” (B. Davis, 2010, p. 9). It provides the opportunity to think, to turn and be oriented so that a fullness of the phenomenon is revealed (Figal, 2010).

I have sought a clearing - space where I endeavoured to explore and extrapolate how these women’s experiences have been extraordinary in order to review the perhaps commonplace phenomenon of pregnancy

¹⁰ “In Heideggerian language dispositions are emblematic of beings who have an involvement with the world as part of their own existential structure” (Hinchliffe, 2006, p. 102).

(Sandywell, 2010). Finding the clearing brought its own challenge, in recognising that portions of the women's stories have been interpreted but that there is so much more to their experience. The clearing is important for it is that I "...look beyond what is close at hand – not in order to look away from it but to see it better, within a larger whole and in truer proportion" (Gadamer, 2003, p.305).

As all human beings traverse the often-uneven journey of life a milieu of moods and emotions are experienced. Gadamer (1996) refers to an ongoing dynamic process that aims to maintain/achieve the individual's being-in-the-world as the state of equilibrium. It "concerns the totality of a person's whole relation to the world" (p. 45) determining the individual's very state-of-being. This equilibrium is a taken-for-granted neutral state in that everything is almost invisible/unconscious most of the time. "Equilibrium is a condition of experienced weightlessness in which different forces balance each other out. The disturbance of equilibrium can only be redressed by the introduction of a counterforce" (Gadamer, p. 113).

Gadamer (1996) uses a striking metaphor to describe equilibrium by reminding us about learning to ride a bicycle. In the early stages one learns quickly that leaning too much on one particular handlebar renders the balance unsafe, and we counterbalance by leaning into the opposing handlebar. Finally we learn to balance with equal pressure on either side. Every time we ride a bike we do not even pay attention to the act of balance until we inadvertently lean too far one way, quickly and spontaneously correcting ourselves. When one experiences a disturbance, such as the challenges associated with infertility, the equilibrium is interrupted and the individual seeks re-orientation to re-balance their equilibrium. Gadamer identifies that both disturbance and the overcoming of the disturbance are married. Gadamer's metaphor of learning to ride the bike is similar to the earlier analogy I applied of the women balanced on the tight rope of dread, where they were continually balancing the fear and hope as they progressed through their pregnancy. It is this ongoing

disturbance to equilibrium, endeavouring to balance on the tightrope, driving their pursuant dream of motherhood that was most noticeable in the women, both in their stories and their physical demeanour, in this study.

The ongoing struggle for equilibrium for the women in this study had become an everydayness of unsettledness. Heidegger (1962/2008) describes the change in the state-of-mind that occurs when the everydayness is interrupted, when Dasein's everyday familiarity collapses, as *unheimlich* or not-at-home-in-the-world. Being-at-home-in-the-world is a primary condition that impels us to seek a home. Dasein feels at home in the 'they' dominated everydayness, which is, 'they' say that women should get pregnant and have babies. Women who have lived through the experience of having a baby following repeated IVF treatments arrive in the postnatal period seeking to be like everyone else, to be at-home-in-the-world. I found that the women's desire to become mothers had provoked deep individual challenges to their potentiality-for-Being. The consequential effect had been a sense of not-being-at-home with themselves for many years. Their not-being-at-home became the taken-for-grantedness, or the ordinariness of their everydayness.

In returning to Gadamer's metaphor, in order to balance on the infertile-bike of life, the women had readjusted their state of balance. This became the everyday way until they became mothers, which then challenged their balance because their infertile balance (with its practised lean to the side of dread) had become so taken-for-granted. It was as though they were always riding against a strong side wind. They had forgotten how to balance on the natural life-bike when the winds seemingly had settled. This demonstrates the "sliding scale of effort and relaxation is a quite natural part of human life" (Gadamer, 1996, p. 161), albeit for these women the effort was prolonged. Learning to ride the natural life-bike came quicker for some than others.

All of the women experienced years of infertility and a perceived challenge to their womanhood as a consequence. It has been documented in the literature that women who have faced long years of infertility experience chronic grief (Johansson & Bergh, 2005; Kirkman, 2003). Layered upon their experiences of repeated IVF cycles, for all but one woman, were the recurring miscarriages and the grief associated with the chronic pregnancy losses. "Chronic sorrow accompanying the multiple losses and failures associated with infertility may leave women particularly vulnerable to extreme grief when a pregnancy is lost" (Harris & Daniluk, 2010, p. 718). The women's inability to control their fertility and associated repeated suffering rendered their equilibrium unbalanced. Dwelling in their existential everydayness changed due to their fixation on needing to become a mother.

The women experienced a variety of moods throughout their infertility, pregnancy and matrescence. The mood of dread seemed to dominate, essentially dreading the real possibility that they would always fail in their quest to become a mother. The dread meant the celebration of the small on-the-way successes, such as elevated pregnancy hormone levels, were often short-lived. The dread was a powerful mood because in order to turn away from their deep angst the women had to choose to continue treatment, and strive to believe their tentative pregnancy would succeed (Fisher et al., 2008). If they did not they would eventually have to face that they would always live in an infertile world.

The mood of dread did not leave these women when their pregnancy was progressing. Rather it impacted on their confidence in their pregnancy evidenced by their delay in sharing the news or preparation for the baby. When the birth came it seemed to be something of an emotional surprise. Yet even at the safe arrival of their baby, the dread did not leave. The fear of not becoming a mother changed to a fear of the 'what if?' For most a heightened sense of cautiousness prevailed with an unrelenting vigilance and unease about the safety of their newborn baby, despite the joy at the longed for arrival of their baby. They had experienced the thrownness of

being-in the infertile world and their mood of not belonging-in-the-world. Somehow they now needed to claim their sense of who they had become, their thrownness of now being a mother of a healthy baby.

The years of not-being-at-home appeared to require energy to sustain and there were times of emotional exhaustion when all they wanted was to hide away until they could re-appear with a baby. It seemed that the women could not sustain not-being-at-home in an authentic manner. Rather they put on a mask of coping in order to continue to find the emotional and physical energy to continue. For some, the sharing of the journey with family and friends appeared to provide emotional sustenance although sharing also meant retaining some silences. An example of a silence is in the story shared by Ellie (prologue). For others keeping the journey secret resulted in unshared grief and exaggerated silence.

I suggest when a woman is not feeling at-home with herself she is less likely to express her feelings because of the vulnerability that accompanies those feelings. Throughout this study there is suggestion that the longer the women were exposed to failing, the more common the silences became. Indeed, many suggested that had they continued to access further treatment (if the current pregnancy had failed) the less they would share what was occurring in their lives. The woman's use of silence requires those present to listen to the silence in order to 'hear' what is not being said. By not choosing to verbalise anything the emotion is acknowledged as something beyond words. When the silence is allowed and respected then the women are given the choice to express verbally, or not. Respect is provided in supporting either of these responses by simply allowing the silence to occur and honouring the sense of shared presence. The attitude of silence may strengthen or weaken that which is not linguistically spoken, or what may be ineffable. Silence always demands an interpretive stance from other, with the risk that they may not interpret in an attuned manner. Silence also requires those in attendance to be comfortable with letting the silence hang, without intrusion and to be comfortable with their own inner silence.

The countenance of silence is one that has been documented as a coping strategy used by infertile women (Allison, 2011; Throsby, 2004). It inhibits the questioning of what is a deeply personal and life challenging experience that occurs within the everydayness of life for most people. This countenance can continue throughout the pregnancy and into early matrescence unrecognised by on-lookers or care providers. It requires listening and attunement often not made available in the busy everydayness of life. Silences protect and prevent the disclosing of the mood of fear and dread that permeates the pregnancy. For some this mood of fear and dread continued to shroud the mother and her newborn in the postnatal period. For women where silence is a means of protection, the privacy of such needs be respected by not pressing for verbal responses if the woman does not respond to sensitive invitations to break her silence.

As the women settle into motherhood they endeavour to settle into the everydayness of who they are. Women in this study experienced varying degrees of becoming attuned to how it is to be a mother. The women provided care to the newborn within a sense of comportment in flux. On the one hand they endeavoured to display a manner of caring for their baby in a mode of 'whatever will be fine', relaxed and confident, not unduly worried. On the other hand there was the pull to the leap-in mode of the 'what if', with concern to prevent every possibility of harm to their baby. The women in this study were initially caught in caring for their babies in the leap-in mode of the 'what if' and did not find it easy to move towards the sense of comportment of not needing to unduly worry. However an epiphany occurred for one of the women when she suddenly realised early on that she could believe in her ability to be a mother. This comportment to becoming like 'normal' mothers occurred over time for others in the study. However two remained with the 'what if' dominating, unable to embody the 'taken-for-granted mood' of motherhood and they therefore remained not-at-home. I suggest they were unable to readjust their balance to the natural 'taken-for-granted' state of equilibrium and were

endeavouring to sustain the angst of the 'what if' in the busy life of motherhood. It was as though the side wind of loss still had them at an angle as they strove to retain balance on their bikes, pressing on with relentless concern.

The women in this study re-adjusted their personal equilibrium as they sought to redefine their everydayness as part of their matrescence. It is beyond this study to recognise if and when that being-at-home-in-the-world occurred for all of the women, however, most of the women in this study, appeared to have achieved a state of 'taken-for-grantedness' within eight weeks of birth. Where the fear of the 'what if' remained as the dominant mode it revealed itself in 'over-protective' behaviours toward the baby, the everydayness of still not trusting.

Expanding my own horizon

To uncover prejudices and traditional understandings facilitates an appreciation of the 'hermeneutical situation' (Wright St Clair, 2008). By doing so the interpreter is able to develop her own position and thereby to appreciate her horizon of understanding. "The horizon is, rather, something into which we move and that moves with us" (Gadamer, 2003, p. 304). When interpretations and understandings come together, they move backward and forwards, as in the hermeneutic circle, creating a fusion of horizons.

I came to this research wanting to expand my horizon, to grasp an understanding of how women experienced their pregnancy following repeated IVF treatment. Did the years of treatment have an influence on their experience of pregnancy and did it also influence how they embraced motherhood? There were some experiences that I was already anticipating from my personal experience such as the women's ability to hide behind a mask of 'normality'. But I was unprepared for the profound use of silence. Silence is now a phenomenon that I am aware of in my

everyday practice as a midwife. It is no longer the ordinariness of being silent; it is what the silence is potentially not sharing that now intrigues me. The concept of the pregnancy being more special was not a surprise, but this was due to my own personal experience of repeated IVF and my belief that if I had ever carried a pregnancy to term I would have expected it to be identified as special. The mood of dread and the impact of the permeations of that mood throughout the women's experiences, with the anxieties of the past still going ahead of them as they considered the safety of their now-born baby, revealed to me the on-going legacy of the infertility experience. The fusing of the women's experience with my personal ontological and epistemological understandings developed an altered expanded horizon.

Illuminating the findings within the literature

With the findings of this study in the forefront of my mind I returned to the literature to seek out whether the findings of this study will add to research knowledge. I searched for notions akin to the experience of not-at-home-in-the-world that seems to be the on-going mood of infertility through to motherhood.

Infertility and failings

The repeated IVF treatments together with the associated failings or the losses of pregnancies are the genesis for not-being-at-home. The findings from my study support some of the findings that Baker (2004), and Ulrich and Weatherall (2000) identified in their qualitative New Zealand research. They suggested that infertility is an unanticipated life event requiring life to be put on hold whilst undergoing treatment. These findings could be consistent with Gadamer's notion of a need to develop personal 'equilibrium' and Heidegger's not-being-at-home-in-the-world that I have linked to the experience that arises from having been through the infertile world. Other international qualitative studies (Morshed-Behbahani et al., 2012; Papaligoura et al., 2012) have also identified similar experiences

although they have not included following through the pregnancy and postnatal periods.

A hermeneutic phenomenological study was undertaken by McCarthy (2008) to reveal women's lived experience of infertility after unsuccessful medical intervention. I single this study out because McCarthy identifies in women's voices their need to search for meaning in the present that will provide them with meaning in their futures. McCarthy does not specifically identify not-being-at-home-in-the-world, although her discussion leads the reader to this search for meaning and 'equilibrium' through the women's existential crisis. The participants shared deeply the pain they experienced, the challenges to their sense of self and the cost in enduring the experience. McCarthy's participants identified that once they had ceased treatment they had to re-establish how they viewed the world and themselves within-the-world. McCarthy's findings are consistent with the experiences of the women who participated in this study with their sense of not-belonging within-the-world.

Plomp's (2003) thesis applied a phenomenological approach with the participants who had become mothers following infertility. They were interviewed twice, first anywhere from six months to three years postnatal. The participants' experiences also ranged from becoming pregnant following one IVF treatment through to four failed treatments and then a spontaneous pregnancy. Whilst the participants and the time frames were significantly different to my study there were some similarities in the findings such as a sense of gratitude, a sense of life's completion and a sense of parenthood as a healing experience.

The findings of the current study add insight into the understanding of women's experience of pregnancy and motherhood. We are now able to appreciate that a past experience of repeated IVF treatments and pregnancy loss(es) influenced the manner in which these women approached their successful pregnancy and their early matrescence. Developing an understanding of these women's not-being-at-home in the

world may enable maternity and well-child providers to reflect on the nature of care they need to provide. They need to develop a relationship of trust where silences can be respected and moods such as dread, fear and hope maybe disclosed as the woman decides.

Considerations for practice

This study has revealed that for some women to become mothers may require significant tenacity, courage and personal endurance, firstly to continue repetitive IVF treatment/failure and secondly to traverse their pregnancy journey. In this section I will discuss the considerations for LMC practice in light of the findings for women pregnant for the first time after repeated (>3) IVF cycles.

It is a skilled LMC who spends the time and is comfortable to allow silences to occur during episodes of care to better facilitate women to disclose how they are feeling. The LMC partnership model of maternity care in New Zealand is thought to be the ideal model through which a relationship of trust can be developed between the woman and her LMC (Grigg & Tracy, 2013). It also provides the opportunity for flexibility in frequency of antenatal/postnatal visits. Once this relationship has been developed the LMC must ensure she/he allows space for silence to occur and not fill the silent voids with noise. To accomplish this the LMC must be comfortable with silences and appreciate that buried in the silences are often fears and concerns. In lieu of silence the woman may in turn fill voids with verbal 'clutter' or as demonstrated in this study convey how 'normal' everything is. In all these situations the LMC needs to be attuned to how the woman is presenting and to pose appropriate, searching questions in order to promote disclosure.

The LMC must appreciate the central importance of listening in the therapeutic relationship (Wilberg, 2004). During the first registration visit, when the LMC is aware of the woman's infertility history, longer time must

be allocated in order to appreciate the significance of her obstetric history. Such space may let the woman share her stories by questioning in a manner that preserves the orientation of openness (Fiumara, 1996), such as “tell me about your infertility journey to get here today”? The LMC needs to not solely record this in her registration/maternity notes but take the opportunity to empathise with the woman regarding the experiences of repeated IVF treatments and failures. It is important to demonstrate to the woman an appreciation of the grief and journey of courage she has endured in order to become pregnant. This is the genesis for the development of trust in the relationship, which is essential for the mood of dread and fear to be revealed, and to become attuned to the woman not-being-at-home-in-the-world. If the registration visit is the first information sharing of the infertility experienced, then the LMC should ensure time is scheduled in the next visit to allow the woman time to share her story.

The women in this study began to tentatively celebrate their pregnancy once well into the second trimester (particularly between 16-24 weeks gestation). Up until week eight of their pregnancy they have had intensive monitoring from their fertility provider and then once they move from the realm of this care the monitoring almost ceases. In light of this I would recommend the women may require more frequent visits than the ‘routine’ during this period of time, which may need to continue throughout their trimesters. LMCs would do well to see these women regularly, as defined/needed by the woman, in order to provide some reassurance of the presence of a baby in utero. Through all trimesters antenatal visits need to have sufficient time allocated to them to provide the space for the disclosure of the fear the woman may be experiencing. Currently the funding available for LMC services through the Section 88 notice is based on ‘routine’ antenatal visits. I recommend the New Zealand Ministry of Health ‘open’ the notice to review the funding in order to promote increased frequency of visits for women who do not fit the ‘routine’ antenatal requirement.

While there were some reassurances of their baby's wellbeing with movements the women in this study felt most reassured when they had been seen by their LMC. Moreover, when the women received informal¹¹ scans organised, or performed, by their LMC this provided a snap shot of time when the women were able to relax and be reassured about the baby. Women need to be educated clearly about the importance of monitoring what is normal movement for their baby and to call their LMC if the pattern of normal movements changes. The LMC must be receptive to the woman's concerns despite the frequency with which the woman may call for reassurance.

The LMC must be aware that there may be some occasions in the pregnancy when formal scanning for fetal wellbeing is essential in order to reassure the mother when her fear is heightened. Currently LMC midwives are unable to perform informal scans or to request scans for reassurance under the Section 88 funding model. On these occasions the LMC midwife will need to discuss with her local obstetric unit opportunities for informal scanning until such time as the Section 88 ultrasound-funding model is reviewed.

Practitioners should consider the need for customised growth charts (Perinatal and Maternal Mortality Committee, 2013), especially due to the women's biomedical risks of an IVF pregnancy (D'Angelo et al., 2011; Filicori et al., 2005; Mukhopadhaya & Arulkumaran, 2007). Monitoring fetal growth on the chart prompts practitioners to further clinical actions when the growth is of concern. The reality is that no LMC can guarantee the wellbeing of the fetus; the best that can be provided is listening to the woman's concerns and providing clinical referrals/reassurances during times of concern.

¹¹ An informal scan is one performed at the bedside as opposed to a formal scan performed in a scanning department by a sonographer

In preparation for the postnatal period the LMC, during the antenatal appointments, would be wise to ascertain how and with whom the woman has shared her IVF experience. The women in this study who shared their journey with family and friends had large support networks that assisted in the early postnatal period, such as frequent visits of support and assistance with daily living activities. As these women spoke about not being prepared in their minds for the demands that mothering brought, having sufficient support networks available is essential to the physical/mental wellbeing of the mother and her partner (Gameiro et al., 2011). The LMC could have conversations with the woman regarding support networks to start preparing the woman for taking home a baby and for the early period of motherhood. Most of the women in this study did attend antenatal classes but these still did not prepare them for motherhood because of their apprehension to acknowledge motherhood to be real until the baby was present. The LMC has the ability to acknowledge this apprehension and tailor preparation for mothering to the individual woman additional to the generic antenatal classes where socialisation is important.

Midwives who are employed in DHB maternity services within the hospitals need to be cognisant of the needs of women just as for the LMC described above. The women in this study who accessed obstetric care did identify that they missed out on the relationship with a midwife. The New Zealand Maternity Standards (Ministry of Health, 2011c) 9.4 states: "The proportion of women with additional health and social needs who receive continuity of midwifery care is measured and increases over time" (p.5). DHBs must answer to the Maternity Standards in their annual report to the Ministry of Health. As a consequence reviews and strategic planning are required to ensure that women, such as those in this study, are able to identify a midwife who provides them with continuity of care. Many DHBs, I suggest, will have some significant reconfiguration of the manner in which women access services but this is an excellent opportunity to ensure women receiving obstetric care develop a relationship with a midwife they can name.

Considerations for education

As described above in the considerations for practice, the salient practice implication is that of understanding the individual woman's infertility journey by which to provide personalised care. In order to accomplish this we must ask the question regarding the skill of midwives in working with women who experience the mood of dread and the effect of fear throughout their pregnancies. In undergraduate midwifery programmes do we develop sufficiently the 'art' of listening and the skill of counselling? Have midwives been taught the 'art' of being with themselves and their women during pregnant silences thereby keeping open the possibility for the silence to be broken?

The Midwifery Council of New Zealand's undergraduate curriculum standards includes communication and counselling skills in the theoretical content. For example, Standard 5.2.2 states: "integrated verbal and written communication skills including working with grief and managing conflict" (Midwifery Council of New Zealand, 2007). The interpretation and implementation of this standard is left to each midwifery school and it is within the schools that the conversation needs to take place regarding the content of this theoretical education. The schools need to ensure that the undergraduate students are taught the significance of the personal process of deep hearing and the 'art' of listening. This includes being intuitive that the person in front of them may be a proxy persona hiding behind a mask and invisible to the listener (Wilberg, 2004). They need to become aware that engaging in therapeutic conversations with a woman is hearing the unspoken dialogue and the differing inner voices of both the woman and the midwife (Wilberg).

Heidegger suggests that it is through the use of words and language that things come into being and are (Inwood, 1999), therefore these can be heard and understood for what they are. Effective listening, different to empathetic listening where the interpreter must place oneself in the others 'shoes', should be based on four components: openness, linguistics, play

and fusion of horizons (Stewart, 1983). This approach to listening is founded upon the philosophical tradition of hermeneutics, which is to listen through which to gain an understanding (Stewart, 1983). With understanding comes the change in horizon to the midwife appreciating the world from which the woman is disclosing her experience. Developing the 'art' of effective listening, and the confidence in silent communications, will assist in the provision of maternity care to an array of women who come to the maternity services with differing psychosocial experiences.

The curriculum does identify in Standard 5.2.18 theoretical content for the midwife to understand women's health issues including fertility issues. Midwifery Competency to practice number 3.5 has the requirement that midwives demonstrate understandings of women and their families in relation to infertility, loss and grief. In order for midwives to fulfil this requirement it is important that the theoretical content not only contain the bio-medical complications of fertility treatment but that the course content does contain the psychosocio-cultural implications of infertility and the women's lived experience and needs.

In Standard 6.2.8 of the curriculum where midwifery practice requirements are detailed, is the opportunity for midwives to attend gynaecological assessments. This could be extended to clearly identify the attendance at infertility clinics. With the increasing number of women being pregnant directly related to ART, it would be an appropriate addition to the midwifery curriculum. Only then will undergraduate midwives be able to obtain some insight into the physical components of IVF treatments. Attendance at these clinics could be envisaged to be difficult due to the vulnerability the women/men attending. However, Fertility Associates in Wellington regularly have medical and nursing students in attendance with >90% of women giving consent for their presence (Murray, personal communication, October 14, 2013). The motivation for the women in this study to participate was that they wanted health professionals to understand the experience better than they believe they do currently.

Considerations for research

The application of Heideggerian hermeneutic phenomenology to this study means the interpretive meanings are likely to continue to grow and develop. I do recognise that had the timeframe for doctoral study permitted, interviewing the women again later in the first year of motherhood would have been beneficial. There is potential for the study to be extended by gaining ethics approval to revisit the women at 12 and 24 months postnatal. I believe that this would provide the opportunity to understand more fully their experience of motherhood and continued investigation of the phenomenon of not-being-at-home-in-the-world. There would also be opportunity to further investigate the 'what if' associated with fear, whether this mood prevails and becomes the phenomenon of everyday heightened caution. For the couples in this study follow up would provide opportunity to further explore the relationship with the infant that was conceived through donor egg/sperm. Is there an on going relationship with the donor and how does this 'hybridised fusion' of allegiance affect the family unit? Perhaps there will also be the opportunity to observe the behaviours between the mother and the toddler to expand on some of the literature where the suggestion is that maternal anxiety impacts on the temperament of the toddler (McMahon et al., 2013).

The traditional heterosexual and nuclear family form has been broadened by the availability of ART. Society now has families that are constructed of gay or lesbian couples and single women. There is opportunity for a New Zealand research project to understand how these non-conventional families have been embraced and accepted.

This study has provided an insight into the experience of what I see as courageous women becoming mothers. However there is further opportunity for research into the experience of the health professional that has cared for such women. The New Zealand model of maternity care is based on partnership therefore to explore the experiences of midwives and obstetricians in providing care to women who are not-at-home-in-the-

world following repeated IVF treatment would be useful. This would bring understanding of how the LMC views the women's pregnancies to be, such as 'high risk', and the impact that LMC view has on the management plans for women already with a heightened sense of anxiety.

When I presented the methodology of this study at the New Zealand College of Midwives Research forum (2013) several midwives came to ask me about future research with regard infertility. These midwives have experienced involuntary childlessness and yet continue to practice as their passion for midwifery drives them beyond their personal experience and the oft-heard belief that "the best midwives are the ones who have had babies themselves". These midwives were wishing to be involved in further research so that the midwifery community could develop an understanding of how it is for midwives who are infertile to practice.

Being-at-home-in-the-motherless-world

Topics that are very personal can be difficult to research. Initially out of their concern for my personal wellbeing, my supervisors encouraged me to be cautious about approaching a topic that was so personal. Whilst I heeded their concern, my fervent desire was to reveal the lived experience of repeated infertility treatments and to gain a personal and professional understanding of how/if the subsequent pregnancy were affected as a consequence. My supervisors supported me in the decision that I made and ensured I had appropriate emotional supports in place, including their own, throughout the study. I believed that my personal experience would facilitate more open interviewing. It did. According to the women, my experience enabled a deeper and more evocative story telling as they could relate to me as someone coming from the infertile-world. This in turn I believe has revealed a truer resonance of the lived experience that is evocative and thought provoking, as Toscano and Montgomery (2009) suggested it could.

Throughout this thesis I have ensured that any presuppositions from my own experience in infertility have been transparent. It was essential that for the trustworthiness of the study that I was able to bring the women's stories alongside my own in order to hear their stories over and above my personal experience.

This study has provided a cathartic experience for not only the participants but also for myself as the researcher. Whilst at the beginning I was able to identify that I had come through loss of self-identity to a period of self-acceptance and 'equilibrium', this study has further enhanced that acceptance. When I reflect on my years of infertility and treatment I can relate to not-being-at-home and how this Heideggerian notion appropriately describes my experience.

I initially thought a small portion of completing this thesis was to ensure completeness to the 'full stop' of my infertility experience. I became aware early on in the thesis though that the 'full stop' had already become round and complete. A gift of this study is that I am now able to recognise that I am a valuable contributor to society and that my experience of infertility and enforced motherlessness has developed me into a person who is fuller and richer for the experience. For me there is a full and rewarding life without being a mother. My personal Dasein is very much at-home-in-the-world.

Concluding thoughts

This phenomenological study has shown that women thrown into the infertile world require tenacity and courage to continue their pursuant dream of motherhood. The experience of repeated failed treatments and pregnancy losses impacts on the manner in which they embrace pregnancy and transcend through to early motherhood. The infertility experience is powerful and is not washed clean by a confirmed pregnancy.

The years of infertility demanded a change in these women's natural disposition. In order to ride the journey against the ongoing demand of failure they developed a change in their equilibrium that is benefited by a re-balance in the early period of motherhood. The mood of dread and the effect of fear were so strong that for some the natural equilibrium was unable to be restored. Rather they continued in motherhood unable to trust, unable to truly enjoy the dreamed about and longed for motherhood experience.

The women in this study became adept at implementing coping strategies rendering it difficult for others, even their maternity care providers, to truly understand the women's experience. The use of silence and not choosing to share, or perhaps not given the silent opportunity to share, was a common theme for all of the women. The mask that they developed in order to cope in the everyday-world, whilst experiencing infertility and treatment, was also applied throughout their pregnancy and matrescence. The women received 'routine' antenatal and postnatal care as a consequence of their pseudo 'normal' behaviors. Their deep vulnerabilities were not detected and provision of care was not modified.

With the increasing number of women accessing ART, especially IVF, midwifery undergraduate curriculum needs enhancing to ensure adequate clinical knowledge is imparted regarding infertility. This knowledge base needs to be founded upon the physiology of infertility; including the psychological impact on the women of repeated failures and pregnancy losses. It is appropriate that midwives give recognition to the deep vulnerabilities these women have despite their pseudo appearance that everything is 'normal'. Further expanding the midwifery curriculum to focus on developing the therapeutic relationship with an emphasis on the women's silences would be beneficial for wider midwife/women relationships. Time spent in the clinical situation observing the physical process of IVF technologies such as egg collection will facilitate a deeper contextual understanding of what the women physically endure.

Maternity care providers, especially in New Zealand, have the unique opportunity in the partnership model to listen to the silences women bring to their pregnancy. This thesis offers the call to develop a relationship of trust that allows the silences to be, or potentially be, broken. For the moods affecting the pregnancy and motherhood to be revealed. The reality for these women is that the continual drive for a pregnancy, and the repeated losses, renders them unable to be sufficiently prepared for the early emotional and physical transition to motherhood. The concept for motherhood is one of a 'dreamed of fairy tale'; the fear of losing the pregnancy has not allowed space in their minds to celebrate and prepare for early motherhood. The arrival of the longed for baby brings both joy and fear; what is held as so precious is all the more vulnerable to perceived threat. For these women the at-homeness of trust that 'all will be well' will perhaps always remain somewhat tentative, having lived through the experience of repeated loss of hopes and dreams. Yet, their dream is now a beautiful, loved baby. Their lives move forward into a new chapter full of expectations and challenge.

Closing sanguine quote by Ellie:

I would trade it, but I'm thankful for the growth that it has brought to us as individuals and as husband and wife. I'm thankful that it has been positive...an unexpected positive of what we've been through. Its like anybody that's been through a thing that's been arduous I guess is that it's not the destination, it's the journey and you just work your way through stuff and it changes in ways that you can never anticipate and often they are good ways.

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Appendices

Appendix 1: Clinical Assessment

PAGE 24

GYNAECOLOGY / INFERTILITY

National Specialist Guidelines for Investigation of Infertility. Priority Criteria for Access to Public Funding of Infertility Treatment

In 1997/98 the publication of the National Health Committee's consultation document "Access to infertility services: development of priority criteria" received numerous public and professional submissions, almost all being in favour of the general principles that fair and equitable access to publicly funded could be achieved by these criteria. These criteria have been tested in at least 2 NZ tertiary centres and with minor modifications the original proposal is being presented to the HFA to introduce to the NZ Health system.

This document is not about directing therapy. It is about guiding the evaluation of the infertile couple to achieve a standardised diagnosis and then providing a rationing basis for public access for treatment, especially using the assisted reproductive techniques. It is intended to benefit those who are most in need for therapy, but balanced by a system that will ensure maximum benefit. The actual level of access will be dictated by the proportion of public funds available for treating infertility. Evaluation of the pilot application of these criteria for IVF funding have, however, confirmed the view that infertility services are severely underfunded. We see these criteria as an essential step in establishing the level of funding needed for infertility treatment and request that Health Practitioners, working with them, use the criteria with diligence and honesty. Already the HFA have declared its support by providing significant funding to assist in clearing the waiting lists for Assisted Reproduction.

We emphasize that the application of the criteria and their weighting is just the beginning. These criteria need to be validated by ongoing research and public discussion.

Wayne R Gillett, John Peek, July 1999

GYNAECOLOGY / INFERTILITY

SECTION 1

Investigation and Diagnosis – a Standardised Approach

Investigation in Primary Care

Refer to National Referral Recommendations: Gynaecology; Infertility

Investigation in Secondary Care

As for primary care. In addition:

- A post-coital test may be used in the early investigation of a referred couple, but the results should be interpreted with caution. Performance of this test is not essential to complete the diagnostic categorisation of the couple (see diagnostic categories).
- Screening for antisperm antibodies is not a routine test, but is suggested when there is a history of testicular trauma or vasectomy reversal. Performance of this test is not essential to complete the diagnostic categorisation of the couple.
- Sperm function tests and sperm assessment procedures (e.g. swim-up tests) should not be used in secondary care practice. They may be of value in helping a couple choose an appropriate ART in a tertiary level service.
- A hysterosalpingogram may be used to test tubal patency. Laparoscopy is the gold standard test for tubo-peritoneal disease and is the preferred method, especially when evaluation of the pelvis is required. If there is a severe semen defect (score of 6, see next page) then there is no need for laparoscopy unless indicated for other gynaecological reasons (or following failed DI treatment). Furthermore for ovarian defects, a trial of therapy is indicated before laparoscopy is considered. Otherwise laparoscopy should be booked within 6 months in the following circumstances:
 1. severe cyclical pain or suspected pelvic pathology
 2. infertility of 18 months duration and where there is a female history of any pelvic surgery, STDs or PID
 3. infertility of 18 months duration and a female age ≥ 30 years of age
 4. otherwise unexplained infertility ≥ 3 years duration
 5. failed DI or ovulation induction (3-6 cycles of treatment)

Diagnostic categories – to be completed at the secondary (specialist) level


The diagnostic model given here recognises the importance of the severity of a diagnosis and a combination of infertility factors on the probability of a successful outcome without treatment. To define the prognosis calculate the points for each diagnostic category 1,2,3,4,5 and 6.


GYNAECOLOGY / INFERTILITY

Patient ID: Complete patient details or place patient sticker here


Nat. Hospital No.: _____	Consultant: _____
Name: _____ D.O.B. ____/____/____	Name of Assessor: _____ Date of Assessment: ____/____/____
Address: _____ _____	

Initial Assessment

(1) Ovulation Defects	Categories	
From history, including <ul style="list-style-type: none"> a plasma progesterone timed for 5-9 days before the next expected period. If cycle is long to be repeated at weekly intervals until next period plasma FSH, LH, prolactin, thyroid function if the cycle is prolonged and/or irregular. FSH (day 2-5 cycle) for older women (is measure of biological age of ovary). 	amenorrhoea - any cause	6
	oligomenorrhoea from any cause / luteal defect	3
	anovulation with normal menstrual cycle	2
	intermittent anovular cycles	1
	no ovulation defect	0
	SCORE 1	

(2) Semen Defects	Categories	
Semen sample collected after 2-3 days abstinence. To be repeated in 4-6 weeks if abnormal. The measurement of antisperm antibodies, post coital test or other sperm function tests are not essential for this category, but may be included as indicated	<1 million motile sperm/ml / severe ejaculatory dysfunction / severe sperm antibodies	6
	1 < 5 million motile sperm /ml / moderate antibodies / repeat negative PCT or sperm function abnormality	3
	5-10 million motile sperm/ml	2
	Any other semen defect	1
	No semen defect	0
	SCORE 2	

To be completed following laparoscopy

(3) Endometriosis	Categories	
The American Fertility Society Classification (American Society for Reproductive Medicine 1997). This requires direct visualization by laparoscopy. Surgical treatment at the time of diagnosis will be at the discretion of the gynaecologist conducting the procedure, depending on the common practice of the clinic.	stage IV AFS classification	6
	stage III AFS classification	3
	stage II AFS classification	2
	stage I AFS classification	1
	No endometriosis	0
	SCORE 3	

(4) Other Tubo-peritoneal Disease	Categories	
<p>Although classification can be based on experience of examining specialist, we encourage the use of the American Fertility Society classification of adnexal adhesions (1988). In many cases the pathology may be different on each side. The adnexa with the least pathology should be used (best side).</p> <p>Surgical treatment at the time of diagnosis will be at the discretion of the gynaecologist conducting the procedure, depending on the common practice of the clinic.</p>	Proximal or distal (complete or partial) occlusion on best-side / severe encapsulating tubal or ovarian adhesions on best-side, / missing tubes / or unsuccessful proximal or distal surgery after 12 months	6
	Moderate encapsulating tubal or ovarian adhesions on best-side adnexa / unsuccessful surgery after 6 months	3
	tubal polyps / mild encapsulating adhesions on best-side or / normal tube on best-side with tubal occlusion on the other-side or uterine adhesions	2
	minimal tubal or ovarian adhesions on best-side adnexa	1
	No tubo-peritoneal pathology	0
	SCORE 4	

(5) Other Factors	Categories	
<p>These should be classified at discretion of specialist, e.g.</p> <ul style="list-style-type: none"> psycho-sexual disorders fibroids intrauterine pathology 	severe	6
	moderate	3
	mild	2
	minimal	1
	absent	0
	SCORE 5	

No diagnosis abnormality identified, i.e. unexplained infertility

(6) Unexplained Infertility	Categories	
<p>If no diagnostic abnormality then define the duration of the unexplained infertility</p>	Unexplained infertility ≥ 5 years	6
	Unexplained infertility $\geq 4 < 5$ years	3
	Unexplained infertility ≥ 3 years < 4 years	2
	Unexplained infertility < 3 years	1
	SCORE 6	

Final Score for Diagnosis

Add scores 1,2,3,4,5,6 = Score D

GYNAECOLOGY / INFERTILITY

SECTION 2

Access to Publicly Funded Treatment

A General Principles:

1. Provision of basic support and guidance at the primary level should be subject to normal primary care charging
2. Simple ovulation induction may be managed by the GP in consultation with a specialist service.
3. Simple conditions requiring medical or psychological therapy should be provided within the primary or secondary services without need for access criteria
3. Conditions with organic disease requiring surgery to enhance physical health (e.g. ovarian cysts, endometriosis) should be subject to the same criteria as for Gynaecology access criteria
4. Conditions that can be managed equally as well with ART or surgery (e.g. tubal occlusion) should be subject to access criteria for infertility. These treatments include AIH, IVF, IVF and ICSI, DI, ovulation induction using gonadotrophins (\pm AIH). The treatment available per individual couple should be directed by the specialist in charge of the individual / couples infertility and in consultation with that individual / couple. The cumulative amount of treatment available to people will depend on public funding available.

B Steps in defining access criteria

1. Exclusion factors for access to treatment

The first is absolute - with access refused if there are situations that compromise the safety of the couple or a child. However no factor may be used that is unlawful and that might breach the Human Rights Act or the Bill of Rights Act. Ultimately it will be the doctor, practicing at a primary, secondary or tertiary level, who will decide - and that doctor would need to defend this decision.

2. Modifying factors for access to treatment

These are conditions that can be modified to improve the chance of conception:

- Hydrosalpinges

Complete distal tubal occlusion, or the hydrosalpinx, accumulates tubal fluid that may drain into the uterine cavity giving a detrimental effect on pregnancy rates with IVF. Depending on the severity of the tubal disease, either salpingostomy or salpingectomy should be performed in women planning entry into an IVF programme. The surgery should be performed by specialists trained in microsurgery or laparoscopic surgery. Each main centre in New Zealand has such specialists.

- Body weight

Weight improvement programmes should be instituted before beginning treatment in women who are outside the BMI range of 18-32. There are factors that limit the success of weight improvement, and in this circumstance it is reasonable to proceed with treatment providing the ovarian response is closely monitored. Treatment should only continue if the response is satisfactory.

GYNAECOLOGY / INFERTILITY

3. Calculation of the Priority Score

Each of the following criteria should be recorded following diagnosis and request for therapy, and modified on an annual basis. For example, June 1 of each year may be regarded as the 'annual' date of revision, since new HFA funding rounds follow on July 1. Simple spreadsheet programmes are available that can recalculate a priority score, simply by adding a new date. Copy of programme available from Wayne Gillett, Dept. O&G PO Box 913.

The final score is the product of a group of objective factors (O1 – O4) and a group of social (subjective) factors (S1 – S3). Points for each of the objective factors are directly proportional to the pregnancy rate. Points for the subjective factors were derived from the results of questionnaires returned by health professionals and consumers.

- The age of the female partner

The weighting of the points reflects the probability of conceiving with therapy.

- The prognosis of conceiving without treatment

See section I for calculation of diagnostic scores.

If Score D = 6 then prognosis < 5% probability of conception in 1 year

If score D = 3 < 6 then prognosis 6 - 20 % probability of conception in 1 year

If Score D = 2 < 3 then prognosis 21-50% probability of conception in 1 year

If Score D < 2 then prognosis >50% probability of conception in 1 year

The weighting of these points reflect the inverse relationship of the likelihood of conceiving

- **The basal plasma FSH**

Ovarian reserve is commonly measured by basal FSH levels between days 2-5 of the menstrual cycle. The normal range will depend on the local assay. The weighting of points reflect the chance of conceiving. If donor oocytes are used in an IVF programme, the donor's FSH level should be measured. FSH should be measured within 6 months before the first planned ART cycle, and repeated at least every 6 months. The normal value be ≤ 12 IU; borderline be $>12 \leq 15$; and abnormal be >15 .

- **A history of current smoking in female partner**

The point system reflects the relative risk on pregnancy outcome of smoking.

Although this will become a priority factor we envisage most women, by stopping smoking, will increase their priority points after 6 months and improve their eligibility depending on the threshold for access to treatment. We believe every effort should be made by women seeking any form of fertility treatment to give up smoking. Duration of smoke free to be three months and no cigarettes at all.

- **Duration of infertility**

The points given here relate to how people feel about the burden of the duration of infertility, rather than how it affects the chance of pregnancy. The duration of infertility to cumulative of previous and current relationships. For single women or lesbians it will be on the basis of either biological infertility or in the case of unexplained infertility to be confirmed by 12 cycles of DI of which 6 should be within an accredited RTAC unit.

- **Number of children**

A child may include an adopted child. These are children currently living with the couple or person.

- **Previous sterilisation**

The points given here recognise the burden of some people never having had children, or the burden of having lost a child (children) by death.

GYNAECOLOGY / INFERTILITY

National Clinical Assessment Criteria (CPAC) for Treatment of Infertility

Patient ID: Complete patient details or place patient sticker here

Nat. Hospital No.: _____	Consultant: _____
Name: _____ D.O.B. ____/____/____	Name of Assessor: _____ Date of Assessment: ____/____/____
Address: _____	

Calculation of priority criteria points for publicly-funded infertility treatment

Criteria symbol	Points awarded	Criteria and their categories	Points available
O1	<input type="text"/>	Chance of pregnancy without treatment	≤ 5% 10 6-20% 7 21-50% 4 >50% 2
O2	<input type="text"/>	Woman's age	≤ 39 years 10 40-41 5 42+ 1
O3	<input type="text"/>	Basal FSH, day 2-5 cycle, with respect to reference range	always within 10 sometimes above 8 mostly/always above 2
O4	<input type="text"/>	Woman's smoking	non smoker 10 smoker 6
Multiply O1 x O2 x O3 x O4 = OC (points from objective criteria)			
=	<input type="text" value="OC"/>	Now divide OC by 10000 = Revised OC (ROC)	<input type="text" value="ROC"/>
S1	<input type="text"/>	Duration of infertility	< 1 year 5 1<3 year 20 3<5 years 40 ≥ 5 years 50
S2	<input type="text"/>	Number of children	None 30 1 by current relationship 10 > 1 by current relationship 5 ≥ 1 child by prev relationship 8
S3	<input type="text"/>	Sterilisation reference range	neither partner sterilised 20 death of child 20 one partner sterilised 10
Sum S1 + S2 + S3 = SC (points from social criteria)			
		=	<input type="text" value="SC"/>
Multiply ROC x SC = Priority Score (PS)			
		=	<input type="text" value="PS"/>

Appendix 2: Ethics approval



Central Regional Ethics Committee
c/- Ministry of Health
PO Box 5013
1 the Terrace
Wellington
Phone: (04) 816 2403
Email: central_ethicscommittee@moh.govt.nz

10 February 2012

Ms Leona Dann
248 Oroua Road,
RD5,
Palmerston North 4475

Dear Ms Dunn

Ethics ref: **CEN/12/EXP/005** (please quote in all correspondence)
Study title: Women's Experience of Pregnancy and Early Motherhood Following Repeated In-Vitro Fertilisation, a phenomenological study

This expedited study was given ethical approval by the Chairperson of the Central Regional Ethics Committee on 2 February 2012.

Approved Documents

- Expedited Review of Observational Studies (for the above study)

This approval is valid until 31 August 2016, provided that Annual Progress Reports are submitted (see below).

Matters of comment, information or advice

The Chair also forwards the following comments, information and advice, which do not affect the application's ethical approval status.

- Please ensure participant confidentiality

Annual Progress Reports and Final Reports

The first Annual Progress Report for this study is due on the 2 February 2013. The Annual Report Form is available at www.ethicscommittees.health.govt.nz. Please note that if you do not provide a progress report by this date, ethical approval may be withdrawn.

A Final Report is also required at the conclusion of the study. The Final Report Form is also available at www.ethicscommittees.health.govt.nz.

We wish you all the best with your study.

Please do not hesitate to contact me should you have any queries.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Emma Die'. The signature is fluid and cursive, with a large loop at the end.

Administrator
Central Regional Ethics Committee

Appendix 3: Amendment to ethics approval



Central Regional Ethics Committee

c/- Ministry of Health
PO Box 5013
1 the Terrace
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Phone: (04) 816 2403
Email: central_ethicscommittee@moh.govt.nz

16 May 2012

Ms Leona Dann
248 Oroua Road
RD5
Palmerston North 4475

Dear Ms Dann

Ethics ref: **CEN/12/EXP/005** (please quote in all correspondence)
Study title: Women's Experience of Pregnancy and Early Motherhood Following Repeated In-Vitro Fertilisation, a phenomenological study

Thank you for your email dated the 29 April 2012. This documentation has been reviewed and approved by the Chairperson of the Central Regional Ethics Committee under delegated authority.

Approved Documents

- Email dated 29 April 2012 requesting an amendment to recruitment protocol

Please do not hesitate to contact me should you have any queries.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Emma Phelan'.

Emma Phelan
Administrator
Central Regional Ethics Committee

Participant Information Sheet



Date Information Sheet Produced: December 2011

Project Title: Women's experiences of pregnancy and early motherhood following repeated in-vitro fertilisation, a phenomenological study.

Short Project Title: What it has felt like to become pregnant and a mother after three or more IVF treatments

An Invitation

My name is Leona Dann and I am currently enrolled with Auckland University of Technology studying to achieve my Doctorate in Health Sciences. I have been a midwife for seventeen years, working as a Lead Maternity Care (LMC) provider from 1995 until 2003 when I joined MidCentral Health. I currently work as the Midwifery Director (part time) and Charge Midwife (part time) and over my years of midwifery have provided maternity care for women and their partners following successful IVF. My research is inspired from the perspective of obtaining information by which to improve the maternity care provided for women who finally become mothers for the first time following repeated IVF. However, I have had personal experience of repeated IVF treatment and so I have a personal interest in this area also.

I am inviting you to volunteer to be included in my study to reveal the experience of being pregnant and finally becoming a mother after repeated IVF attempts (you would have needed to have had three or more IVF cycles). If you chose to participate in my study you would be able to withdraw at any time, as participation is completely voluntary.

What is the purpose of this research?

To obtain information that allows maternity care providers to understand what the experience is to be pregnant and become a mother after three or more IVF attempts. Once this information is available then maternity care providers (of which 85% are midwives) will be able to provide women with appropriate interventions and support therefore potentially enriching the maternity care that is provided.

It will be important to share the findings of this research, therefore I propose that the research findings will be published in appropriate journals and presented at the New Zealand College of Midwives Biennial conference and other appropriate international conferences.

How was I identified and why am I being invited to participate in this research?

Fertility Associates (FA) has agreed to assist me with this research especially with regard the recruitment of appropriate participants. To be eligible for this study you will have had your third or more IVF treatment and be pregnant following this treatment with your first on-going pregnancy. You would have not identified on your consent at FA that you are happy to be involved in any research. You will also need to be fluent in written and/or verbal English.

You have been invited to participate in this research because your experience of infertility and IVF treatment thus far would provide valuable information and insight for the purpose of the study.

What will happen in this research?

Once you have read this information sheet and agree to be a participant for the study then **you will contact me** on the contacts provided. However, if I have not heard from you within four weeks of posting you the information sheet then I will contact you to ask if you wish to participate. If you contact me in the first instance then I will return your call/email/text

and discuss with you what will be involved; this provides you with the opportunity to ask me questions prior to agreeing to participate.

Following our initial conversation I will have arranged to meet you when you are approximately 28 weeks pregnant for a face-to-face interview in your home (or alternate venue). I have decided on this time in your pregnancy as you will have completed your screening and you will also have reached a gestation where if your baby¹² were to be born early he/she would have the best opportunity of doing well. At this interview we will start by you signing your consent form and completing demographic details (e.g. age, ethnicity, number of IVF cycles, LMC contact details). We will then record the interview where you will tell me your story regarding this pregnancy thus far. I will also leave you with an opportunity to think about recording, soon after the birth of your baby, the experience of the birth and becoming a mother. You may choose to write/email/phone this reflection.

The second interview will occur once again face-to-face in your home once your baby is six to eight weeks old. I envisage that we will plan at the first interview how I will know to make contact for the second interview when your baby would be approximately six weeks old. I will once again visit your home to interview you for an hour regarding the experience of your birth and becoming a mother, I will also be able to meet your baby in person. This will be the end of the interviewing required for this research.

Your interviews will be transcribed (typed up from the audio recording) and posted/emailed to you for you to read and agree that the content has been recorded accurately. You will be able to feed back to me by return post/email. The stories received from you will only be used for the purpose of this research.

¹² Baby in this information sheet may refer to one or more depending if the pregnancy is a twin pregnancy

What are the discomforts and risks?

For women agreeing to participate in this research there may be discomfort associated with interviewing and describing your experience. Interviewing, whilst being recorded, is a very real discomfort for all concerned which is why the most comfortable environment is probably your home, although we could arrange a different venue if you would prefer. There is the potential that the interview brings to the forefront of your mind some previous experience or concerns which upset you. There is also the risk that you have agreed to participate in the research and when I call you something untoward has occurred in your pregnancy and my contact with you would have been very inappropriate and distressing.

How will these discomforts and risks be alleviated?

When we first make contact with each other (after you received this information sheet and **you contact me**) we will make a plan about how you will contact me if at any stage you wish to/need to withdraw from the study. I trust that by doing this will mean that the chance of me calling you inappropriately will have been reduced. The best way to interview will be in the most relaxed, safest environment for you with the least obtrusive equipment. Having a support person at your interview may assist you to feel safe and relaxed, just as long it is only you that participates in the story telling. Before we start our interview I will ensure that I have your LMC contact details and your consent that I make contact if I am concerned about your wellness, if I do this will be totally transparent with you present. I will also have a list of local counsellors available should you need to make contact with one to discuss any past events that arise during the interview that you need to talk about. As I have personal experience of repeated IVF treatments I trust that this will relieve some of your discomfort with your story telling and help you to share your experience with a likeminded woman.

What are the benefits?

By you participating in this research then you will have the opportunity to share your story with a woman/midwife who is passionate about IVF and

pregnancy. You will also have had the opportunity to improve maternity care for women just like yourself in the future. The benefits to me are that I achieve my goal that I have had for years, to identify the needs of women who become mothers just like yourself and potentially improve the maternity care required, I will also achieve my Doctorate in Health Sciences at the completion of my research.

What compensation is available for injury or negligence?

In the unlikely event of a physical injury as a result of your participation in this study, rehabilitation and compensation for injury by accident may be available from the Accident Compensation Corporation, providing the incident details satisfy the requirements of the law and the Corporation's regulations.

How will my privacy be protected?

You will be given a pseudonym for anonymity rather than any reference to your name being made in the research and associate publications/presentation, you can choose this pseudonym if you would like. Your audible story, once transcribed will be deleted from the recording device. The transcription and consent forms will remain locked in my filing cabinet, within my home, which is alarmed when unattended and shredding after six years as recommended by AUT will destroy them.

What are the costs of participating in this research?

The cost to you will be the interview times and the time you may choose to take to write/record/phone your reflection soon after the birth.

What opportunity do I have to consider this invitation?

From the time you receive this information sheet (approximately 8 weeks pregnant) and make first contact with me through to the first planned interview of approximately 28 weeks.

How do I agree to participate in this research?

We will have this conversation when you call/text/email, a consent form and will be obtained when we first meet around your 28th week of pregnancy.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Debbie Payne, debbie.payne@aut.ac.nz, phone 09 921 9999 ext 7112

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTC, Dr Rosemary Godbold, rosemary.godbold@aut.ac.nz, 921 9999 ext 6902.

Researcher Contact Details: Leona Dann: cell phone 021394584

Email: leona.dann@hotmail.com

Project Supervisor Contact Details: Debbie Payne, contact details as above.

Approved by the Central Ethics Committee Reference number
CEN/12/EXP005

Appendix 5: Participant consent

Consent Form



Project title: Women's experience of pregnancy and early motherhood following repeated IVF treatment, a phenomenological study.

Project Supervisor: Dr Deborah Payne

Researcher: Leona Dann

- ☐ I have read and understood the information provided about this research project in the Information Sheet dated December 2011.
- ☐ I have had an opportunity to ask questions and to have them answered.
- ☐ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ☐ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- ☐ If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- ☐ I agree to take part in this research.
- ☐ I agree to notify my LMC that I am participating in this research.
- ☐ I agree to the researcher notifying my LMC, in my presence, if concerns over my wellbeing arise.
- ☐ I wish to receive a copy of the report from the research (please tick one): Yes ☐ No ☐

Participant's name and signature:

.....

Participant's LMC name and contact phone/pager

.....

Participant's contact details:

.....

.....

Date:

Approved by the Central Ethics Committee Reference number
CEN/12/EXP005.

Appendix 6: Counselling resource



Counsellors available for support re research

Winnie Duggan, Fertility Associates Wellington, ph 04 3848401

Margaret Stanley Hunt, Fertility Associates Wellington, ph 04 384 8401

Nanka Beesley-Hoedemakers, Wellington, ph 027 249 4503

Marion Wade, Wellington, 04 385 0094

Sian Harcourt, Wairarapa, ph 06 308 8884

Eleni Zachary, Hastings, ph 06 876 3658

Ursula Bruin, Napier, 021 751 297

Sue Webb, Palmerston North, 06 357 2469.

Range of costs up to \$120.

The free counselling will be provided by our professional counsellors for a maximum of **three** sessions and must be in relation to issues arising from their participation in your research project.

Please inform your participants:

- They will need to contact our centres at WB219 or AS104 or phone **09 921 9992 City Campus** or **09 921 9998 North Shore campus** to make an appointment

- They will need to let the receptionist know that they are a research participant
- They will need to provide your contact details to confirm this
- They can find out more information about our counsellors and the option of online counselling on our website:
http://www.aut.ac.nz/students/student_services/health_counselling_and_wellbeing

Appendix 7: Transcriber contract

Confidentiality Agreement



Project title: Women's experience of pregnancy and early motherhood following repeated in-vitro fertilisation, a phenomenological study.

Project Supervisor: Dr Deborah Payne

Researcher: Leona Dann

- ☐ I understand that all the material I will be asked to transcribe is confidential.
- ☐ I understand that the contents of the tapes or recordings can only be discussed with the researchers.
- ☐ I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature:

Transcriber's name:

Transcriber's Contact Details:

27 Sorrento Place
Kelvin Grove
Palmerston North 4414
ph: 3593355 cell: 0211097973

Date: 16-5-12

Project Supervisor's Contact Details (if appropriate):

Dr Deborah Payne, Director - Centre for Midwifery & Women's Health Research, 09 921 9999 ext 7112

**Approved by the Central Ethics Committee Reference number
CEN/12/EXP005**

Note: The Transcriber should retain a copy of this form.

Appendix 8: Invitation to participate



Date (to be completed prior to posting)

Participants Address

(to be completed prior to posting)

Dear

Your contact details were forwarded to me by Fertility Associates (Wellington) as they identified that you were interested in being involved in research, and that you may be a potential participant for my Doctor of Health Science research.

Please find attached the information sheet/invitation which outlines for you the purpose of my research and what your involvement would be, including contact details so I can explain in more detail as you require.

I trust that you will find my research interesting and that you would like to be involved by contacting me on the details included in the information sheet. If I do not hear from you then I shall contact you to follow up and seek your decision.

Thank you for taking the time to read the information I have sent and I look forward to talking/emailing with you in the future.

Kind regards

Leona Dann

Midwife and Doctor of Health Science Candidate

Approved by the Central Ethics Committee Reference number
CEN/12/EXP005

Appendix 9: Demographic information

Demographic information from each participant to be completed at the time of the first interview

Name _____

Chosen _____ pseudonym

Year of birth _____

Number of previous IVF treatments _____

Number of previous ART treatments excluding IVF _____

Access to 2 public funded IVF treatment approved Yes No

Address _____

Phone number:

Mobile:

Email:

Ethnicity (ies) _____

Education _____

LMC: Midwife GPO Private Obstetrician Unit care

If LMC not a midwife do they have a midwife as well? Yes No

If No who will do their postnatal care? _____

Appendix 10: Interview prompts

Antenatal interview

- Tell me about when you decided to do IVF
- Tell me about what it was like to do your 1st IVF
- Tell me about what it was like to go back and do IVF repeatedly
- Tell me about the day you found out
- Tell me about the wait till you knew you were “safely” pregnant this time
- Tell me about choosing and meeting your LMC
- Tell me about sharing the news of your pregnancy
- Tell me about some times when you have felt really nervous in your pregnancy. What was it about
- Tell me about when you started to prepare for this baby

Postnatal interview

- Tell me about your antenatal care did it meet your needs/expectations
- Tell me about what would have been better
- Tell me about how it felt to get to term

- Tell me what it was like the next day to wake up to your baby
- Tell me about what it was like going home
- Tell me about your first day at home when your partner went to work
- Tell me about leaving your baby and going out for the first time
- Tell me about your postnatal care
- Tell me about saying goodbye to your midwife

Appendix 11: Example of working with the data

Raw data:

Going back for the second cycle I suppose my concern levels were starting to rise a bit at that point thinking 'oh my God' you know...that maybe this isn't going to work for us. The second cycle we kind of knew that throughout that process it wasn't going particularly well, when you go in for your scans and there weren't a great number of eggs was quite difficult really. I think It took over life really, thinking about....you know, what's going to happen if it doesn't work and are we ever going to be able to have a baby? So, that was pretty hard, we were quite keen, after that one failed, to get on with the next cycle. But, I definitely went into this third cycle thinking that it probably wasn't going to work and I even remember saying to my partner that I think we should cancel and hold off because I don't think that I'm ready to do another cycle yet? I just don't think the time is right and I just felt that it was maybe a bit rushed. So, right throughout that, even up to the day before we were getting our blood tests so see if it had worked I was pretty much convinced it hadn't worked.

Crafted story:

Going back for the second cycle my concern levels were starting to rise a bit at that point thinking maybe this isn't going to work for us. During that cycle we kind of knew the process wasn't going particularly well, when we went for our scans there weren't many follicles and it was quite difficult really. It took over life really, thinking what's going to happen if it doesn't work and are we ever going to be able to have a baby? It was hard to stay positive sometimes but we were keen to get on with the third cycle even though my mind set was that it probably wasn't going to work. I remember saying to my partner that I thought we should cancel and hold off because I didn't think I was ready to do another cycle yet. I just didn't think the time was right and I just felt that it was a bit rushed. Right throughout the, even up to the day we were due to get our blood test result I had convinced myself that it hadn't worked.

Initial interpretation:

Jane's feelings continued into the second IVF and her fear of failure, wanting to stop her progressing with the third cycle.

Jane struggled to process the potential of failure with this their last of the package of three IVF cycles they had paid for.

Jane says she entered the third cycle thinking it wasn't going to work, this wasn't because Jane had accepted the potential failure but because she was self protecting.

Deep down Jane needed this cycle to work because the only other option was being motherless and to Jane this wasn't an option hence her wanting to delay starting the cycle.

What is she saying here? For Jane life is about having children.

If life is about having children then delaying them only increases the risk of not having children at all. Does Jane question her earlier decision to delay children, her happiness at work and in her career was a front for the deeper happiness she wanted out of becoming a mother. Does Jane feel guilty for the delaying trying to conceive?