

The experience of combining fertility treatment and paid employment:
women's narratives.

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Attestation of authorship

I hereby declare that this submission is my own 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 or a university or other institution of higher learning.

Signed _____

Dated _____

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Abstract

The use of fertility treatments, including in-vitro fertilisation (IVF) has increased significantly in the past three decades (Wang, Chambers, Dieng, & Sullivan, 2009) as has the proportion of women in the workforce (Statistics New Zealand, 2006). Psychological implications have been associated with fertility treatments, including psychological distress, depression, and identity issues (Ulrich & Weatherall, 2000). Research has alluded to the challenge for women combining fertility treatment and paid employment. However, no targeted research has focused specifically on this. Using a narrative approach informed by a social constructionist and third-wave feminist lens, this study sought to explore how combining fertility treatment and paid employment was experienced by women. Employing a narrative perspective defined as holistic-content (Lieblich, Tuval-Mashiach, & Zilber, 1998), individual narratives were analysed for unique themes and motivations. Final analysis was undertaken with a thematic narrative analytical approach (Riessman, 2008). Themes such as private versus public narratives, failing as a woman and related identity challenges were observed. It is hoped that the findings discussed could assist mental health practitioners in supporting this cohort and may offer insights into appropriate work-place policy development.

Introduction

This research was designed to explore the experiences of women who have combined IVF treatment with paid employment. As a first consideration, it is contended that there is a biological assumption or question of reproduction that is part of every woman's journey through life. Whether that assumption is self-driven or whether it comes from the social constructs of the societies we live in is arguable (Daniluk, 2001a). However, it seems to be an inevitable question that every woman is presented with at some point in her life. In addition, the concept or consideration of motherhood has broadened within the past few decades. From the rise in women with careers that began as a result of second-wave feminism, to the development and advancement of assisted reproductive technologies (ART), motherhood has possibly become a less simple or straightforward notion than that of our grandmothers or great-grandmothers.

The second wave of feminism emerged in the late 1960s to 1980s as a response to the ongoing subjugation of women that had been active since the suffrage movement of the early 20th century (Tong, 2007) and which had culminated in what was best described as the "happy housewife" paradigm in the 1950s (Friedan, 1963). There were three distinct ideologies within the second-wave of feminism, liberal, radical, and Marxist-socialist all of which shared a strong desire for women's liberation albeit through different foci (Tong, 2007). Of particular interest to this study are the liberal and radical feminist viewpoints as they have both played an important role in the changing concept of motherhood.

The focus of second-wave liberal feminists was to liberate women by opening the public, economic world to them, specifically through the world of work (Tong, 2007). An important component of this ambition in mid-20th century liberal feminism was that one did not preclude the other and that women could 'have it all', a career and a family, although it should also be noted that this remained conceptualised within the dominant patriarchal paradigm (Tong, 1998). Irrespective, the primary tenet was still the opening up of the world of work (and careers) to women, thereby engendering that motherhood potentially might be considered within a wider context, that of one's career

and how and when to fit motherhood within or alongside a woman's career identity.

For radical feminists, in addition to the right to a career, another key focus was the right of women to have sexual and reproductive freedom (Tong, 2007).

Simultaneously, alongside this feminist ideology, rapid medical advances in ART were taking place. From the development of fertility drugs in the 1950s, the late 1970s witnessed phenomenal advancement of ART, particularly with regard to IVF. This groundbreaking technology became a reality in 1978, when the first baby resulting from IVF treatment was born (Throsby, 2002).

From a radical feminist perspective, the successful advent of technological reproduction appears to have elicited two distinct and opposing responses.

The view of the Feminist International Network for Resistance to Reproductive and Genetic Engineering (FINRRAGE) was that ARTs fostered the continued subjugation of women within a pronatalist paradigm (Harwood, 2007).

However, the alternative, as most famously posited by Shulamith Firestone in the 1970s (cited in Harwood, 2007), was that ART was a powerful opportunity for women to achieve equality through self-determination of their own reproductive activities (Harwood, 2007; Tong, 1998).

Considering the impact of both the role of feminism and the advent of ARTs to lives of women from the 1970s onwards, it would seem that important changes for women have occurred. There have been dramatic changes to the gender composition of the labour force in Western societies over the past fifty years with increasing numbers of women participating in the world of work (Barnett, 2004; Statistics New Zealand, 2005). It is estimated that in New Zealand, 47% of the workforce is now comprised of women (Statistics New Zealand, 2006) in comparison with the early 1970s which saw women at approximately one third of the workforce (Statistics New Zealand, 2005). Perhaps, in relation to the rise in volume of working women, the age of women becoming mothers for the first time has also increased, with the median age of first time births for New Zealand women now 30 years old (Statistics New Zealand, 2005).

Nevertheless, as noted by Arendell (2000) motherhood is still "presumed to be a primary identity for most adult women" (p.1192). This presumption is part of a strong and recognised pronatalist ideology that prevails within all of

humanity (Greil, McQuillan, & Slauson Blevins, 2011). Pronatalism has been defined as the belief that a woman's social worth and even her sense of identity is invariably linked to her ability to produce children (Parry, 2005; Ulrich & Weatherall, 2000). Considered from a psychological perspective Erikson's (1980) theory of psychosocial development through the lifespan would also seem to embrace pronatalism. He proposes that to achieve generativity over stagnation in adulthood, the primary goal is "establishing and guiding the next generation" (Erikson, 1980, p.103).

As such, infertility poses great concern when considered within a pronatalist ideology as it implies a failing on a woman's part to attain a primary social goal (Parry, 2005). From a lifespan perspective, infertility has been viewed as a 'developmental life crisis' in that it is a potential roadblock to achieving generativity (McWhinnie, 1992; Van den Broeck, D'Hooghe, Enzlin, & Demyttenaere, 2010). Indeed, it is argued that the sociocultural context, in this instance a pronatalist ideology, plays a significant role in the experience of infertility (Greil, et al., 2011).

To define infertility there are two avenues to consider. Firstly, the influence of pronatalism on infertility gives credence to the concept of the social construction of infertility (Greil, et al., 2011; Greil, Slauson Blevins, & McQuillan, 2010). Greil et al. (2011) cogently argue "infertility is best understood as a socially constructed process whereby individuals come to regard their inability to have children as a problem, to define the nature of that problem, and to construct an appropriate course of action" (p.737).

Furthermore, they state that it is an inability to achieve a desired goal that creates an awareness of infertility rather than the presence of any medical problems (Greil, et al., 2011).

In contrast, from a biomedical stance, infertility is commonly defined as the inability to conceive after 12 months of unprotected intercourse at the appropriate phase of the menstrual cycle (Gnoth, et al., 2005). Medical professionals also recommend that if the woman is aged over 35, she potentially seek fertility advice earlier, perhaps after six months (Fertility Associates, 2011b; Greil & McQuillan, 2010). Worldwide estimates of the prevalence of infertility set it at around 9% (Boivin, Bunting, Collins, & Nygren, 2007). Within New Zealand it is estimated that one in five New Zealand

women will have some experience of difficulty in trying to conceive (Fertility Associates, 2011a). This research acknowledges the relevance of both the medical and socially constructed definitions of infertility offered above.

It is also acknowledged that fertility issues are more prevalent once a woman is 35 and even more so once she has turned 40 (Bewley, Davies, & Braude, 2005). Indeed, at a prominent fertility clinic in New Zealand the average age of women seeking fertility advice is 36 (South, 2008). This may support a suggestion that the successful introduction of ARTs, such as IVF, have potentially enabled women to consider pregnancy later in life, opening up opportunities for them to attempt to have both a successful career and a family (Beck-Gernsheim, 2011).

Whilst the initial focus of this study was IVF treatment, it was discovered in the course of interviewing participants that the process of working and combining any kind of fertility treatment was a more fitting concept. It was therefore decided that the study would be broadened to encapsulate the whole fertility treatment experience. There are a wide range of different technologies and procedures that can impact on a woman's working life, including hysterosalpingograms, Clomiphene, and intrauterine insemination (IUI), for which definitions are provided in the glossary (Appendix A). However, a definition of IVF treatment seems salient as it was the initial focus of this work and was one of the primary recruitment criteria for this research. IVF is a multi-stage process for a woman: ovarian stimulation by way of drug treatments such as daily injections; oocyte retrieval, a procedure to remove the eggs; fertilisation of the eggs; embryo transfer, where embryos between three and five days old are replaced into the woman's uterus via her cervix; and finally the luteal phase, which is in effect a waiting period to determine if the embryo transfer has been successful (Brod, Verhaak, Wiebinga, Gerris, & Hoomans, 2009).

Over the past few years a sharp increase in the use of IVF treatments has been observed in New Zealand and Australia. In 2007 there was an increase of 53.7% in the number of ART treatment cycles, such as IVF, compared with those conducted in 2003 (Wang, Chambers, Dieng, & Sullivan, 2009). In New Zealand it is estimated that one in 20 couples undergo fertility treatment resulting in approximately 450 live births per annum (Ministry of Women's

Affairs, 2008). However, it should also be noted that success rates for IVF treatment are typically not high with estimates of the chances of IVF treatment producing a baby at approximately 17-20% (Boden, 2007; Wang, et al., 2009).

Literature review

Psychological effects

The psychological implications of infertility and the fertility treatments associated with it have been well researched (Greil, 1997; Greil, et al., 2010; Klock & Greenfeld, 2000; Verhaak, et al., 2007). As previously noted, the advent of assisted reproduction is not new, however, the more technological ARTs, such as IVF, emerged in the 1970s (Harwood, 2007). These technologies have precipitated a burgeoning interest in them from a psychological perspective, possibly in part due to the emerging debate regarding the ethics of such treatments. Harwood (2007) notes that questions of the ethics of ARTs have arisen in many scholarly fields: philosophy, religious, feminist, and biomedical with compelling arguments for and against the use of such fertility treatments. Furthermore, as ARTs have become more readily available, it may be that an increase in the availability of potential participants for research has occurred as more and more couples have sought medical assistance for their infertility. Thus, it could be concluded that perhaps as a result of the ready availability of participants for research as well as the ongoing philosophical struggle to determine the morality or otherwise of ARTs, researchers have sought to offer insight into the personal and psychological experiences of people undergoing fertility treatment.

Indeed, Greil (1997) commented on the sheer multitude of studies since 1986, when he conducted a comprehensive review of the literature on the subject of infertility and psychological distress. Greil's review encompassed research from 1980-1995, reviewing both quantitative and qualitative studies and dividing the literature into articles that explored a psychogenic hypothesis (the psychological causes of infertility) and those that were interested in the effects of infertility on psychological well-being. Of particular salience to this research was the latter section of this review.

Greil (1997) identified a range of dominant themes in the literature from this period. Most notably, themes emerged that focussed on identity and its relationship to infertility, feelings of loss of control, feelings of failing as a woman and feelings of stress related to the treatment process. Going on to review the literature as it related to gender differences it was also noted that

women were at greater risk in the areas of psychological distress, self-esteem, depression, and anxiety.

Greil (1997) did however also note that the work up to 1995 had not provided equivocal results citing a number of methodological issues such as over-sampling of women, small sample sizes, and failing to study those women who had not sought treatment. Greil also observed a weakness in the theoretical framework for such research. Specifically, he noted that the tendency to medicalise the issue of infertility rather than consider it in a more holistic social context. He therefore recommended that future research should be undertaken within a wider theoretical basis, allowing the experience of infertility and associated treatments to be examined from a more socially constructed perspective. Many subsequent research efforts would appear to have heeded that advice as a more comprehensive approach to research in the past few years has been observed (Greil, et al., 2010).

Research has broadly examined psychological implications of infertility and fertility treatment from comparisons with fertile women (Fassino, Piero, Boggio, Piccioni, & Garzaro, 2002; K. A. Morrow, Thoreson, & Penney, 1995; Seok Kee, Jung, & Lee, 2000) to gender comparisons between infertile couples (Anderson, Sharpe, Rattray, & Irvine, 2003; Beaurepaire, Jones, Thiering, Saunders, & Tennant, 1994; Laffont & Edelmann, 1994; Slade, Emery, & Lieberman, 1997). In addition, research undertaken from a qualitative perspective has sought to understand women's psychological experiences whilst undertaking fertility treatment (Hämmerli, Znoj, & Berger, 2010; Peddie, van Teijlingen, & Bhattacharya, 2005; Redshaw, Hockley, & Davidson, 2007).

The stressful nature of infertility and subsequent fertility treatments would appear to have been universally acknowledged in the research literature (Brod, et al., 2009; Cousineau & Domar, 2007; Greil, 1997; Hammarberg, Astbury, & Baker, 2001; Hämmerli, et al., 2010; Laffont & Edelmann, 1994; Lemmens, et al., 2004; Verhaak, et al., 2007). Greil, et al. (2010) posit that the primary motivating factor for stress in this situation is the "inability to achieve a desired social role" (p.141). It is also noted that anticipating and experiencing ARTs, because of their invasive medical nature (self-injections, oocyte removal, and embryo transplant) as well as the physical pain involved

(Hammarberg, et al., 2001), can also be highly stressful (Brod, et al., 2009; Klonoff-Cohen, Chu, Natarajan, & Sieber, 2001; Laffont & Edelman, 1994; Mahlstedt, Macduff, & Bernstein, 1987; Yong, Martin, & Thong, 2000).

Furthermore, it has also been suggested that the experience of stress can in part be attributed to the hormonal treatment a woman undergoes as part of her fertility treatment (Brod, et al., 2009; Peterson, Gold, & Feingold, 2007). It is also noted that different stages of treatment are likely to yield differing levels of stress (Brod, et al., 2009; Yong, et al., 2000). Ultimately, however, it may be that potentially some or all of these causal factors mentioned could be involved at varying stages throughout the infertility and fertility treatment journey.

Turning specifically to the experiences of psychological distress that have been explored, one of the more researched topics would seem to have been that of depression and anxiety (Eugster & Vingerhoets, 1999). Contrasting findings have emerged although this may be as a result of differing methodologies and theoretical frameworks (Greil, et al., 2010).

In gender comparison studies regarding the psychological aspects of IVF treatment, it has been found that women experience higher levels of anxiety and symptomatology associated with depression (sleeplessness, weight change, guilt, sadness, discouragement and isolation) than their male partners (Anderson, et al., 2003; Beaurepaire, et al., 1994; Laffont & Edelman, 1994; Oddens, Den Tonkelaar, & Nieuwenhuys, 1999). This is perhaps unsurprising as it is women who physically experience this particular treatment and as such are therefore likely to have invested more psychologically as well (Laffont & Edelman, 1994; Shaw, Johnston, & Shaw, 1988). In addition, as mentioned above, the hormonal treatments a woman must undergo may also be a related causal factor (Peterson, et al., 2007). However, it has also been noted that whilst between couples women appear to experience higher levels of anxiety and depression, it has not always been determined whether the levels of depression demonstrated could be classified as clinical depression (Ismail, Menezes, Martin, & Thong, 2004).

Quantitative research has attempted to quantify the presence of anxiety and depression in infertile women in comparison with fertile populations. Several studies have found significant increases in anxiety and depressive symptoms

for those women undertaking IVF treatment compared with their fertile counterparts (Domar, et al., 2000; K. A. Morrow, et al., 1995; Oddens, et al., 1999; Seok Kee, et al., 2000; Slade, et al., 1997; Wischmann, Stammer, Scherg, Gerhard, & Verres, 2001). However, research has also pointed to variables affecting the data. For example, the point at which measurement of any possible pathology is taken in the woman's infertility journey would appear to have an effect on the degree of depressive or anxious symptomatology (Brod, et al., 2009; Klonoff-Cohen, et al., 2001; Yong, et al., 2000). In addition, the success or otherwise of any fertility treatment would also appear to have an effect on levels of distress (Hammarberg, et al., 2001). Furthermore, in a study designed to overcome many of the identified methodological issues with research in this field (Greil, 1997), McQuillan, Greil, White, and Jacob (2003) found that infertility was associated with long-term consequences such as psychological distress, but only for those women who had remained childless.

Whilst less specifically or clinically observed, qualitative research has also suggested similar experiences for infertile women. One of the primary reasons given for choosing to end IVF treatment has been emotional distress (Cousineau & Domar, 2007; Domar, Smith, Conboy, Iannone, & Alper, 2010). Notably also choosing to end IVF treatment has been observed as a release from the emotional distress of IVF treatment (Peddie, et al., 2005). In a longitudinal study that explored infertile couples' transition to childlessness, it was noted that many of the themes at the beginning of that decision making process were also related to psychological distress, such as hopelessness, emotional depletion, feelings of emptiness, and a sense of failure and despair (Daniluk, 2001b). Furthermore, even for women who had successfully become pregnant and given birth, themes of emotional pain, emotional stress, and the emotionally unbearable experience of the treatment process were reported (Redshaw, et al., 2007).

However, there have also been studies that have suggested less significant differences between infertile and non-infertile populations with respect to symptoms of depression or anxiety (Edelmann & Connolly, 1998; Verhaak, Smeenk, Van Minnen, Kremer, & Kraaimaat, 2005). Other studies have found that those who did score higher in areas of distress during the course of

treatment also tended to have higher scores in those areas on psychometric tests administered initially (Edelmann & Connolly, 1998; Van den Broeck, et al., 2010) perhaps indicating that levels of distress could be related to individual personality characteristics. Furthermore, in a study of first round IVF treatments, it was found that couples were generally well adjusted and able to cope with the strain of treatment and that it was a successful pregnancy that was the determining factor of emotional adjustment to treatment (Holter, Anderheim, Bergh, & Möller, 2006).

Nevertheless, the implications for those working with this cohort in a mental health capacity are unequivocal. With potentially higher risks of depression and anxiety for women experiencing fertility treatment (Verhaak, Lintsen, Evers, & Braat, 2010), mindful therapeutic strategies are important (Peterson, et al., 2007) given the burden of such mental health issues on those experiencing them as well as the wider societal costs. In addition, as Edelmann and Connolly (1998) observed, identifying characteristics of people likely to experience difficulty coping with fertility treatment is important as it would enable counselling and support services to be better focussed.

Closely related to feelings of depressed mood is grief. The experience of grief for women (and couples) experiencing infertility has been frequently noted (Exley & Letherby, 2001; Johansson & Berg, 2005; Kirkman & Rosenthal, 1999; Lukse & Vacc, 1999; McWhinnie, 1992; Oddens, et al., 1999; Peddie, et al., 2005; Ulrich & Weatherall, 2000). In addition, grief in the face of fertility treatment has also been observed (Lukse & Vacc, 1999; Peddie, et al., 2005). For many of the women experiencing grief, it is described as a deeply rooted sense of grief (Kirkman & Rosenthal, 1999) suggesting that its relationship to depressive symptomatology may be rather intricate. Moreover, a feeling of necessity to keep the grief hidden has also been referred to (Exley & Letherby, 2001; McWhinnie, 1992) perhaps compounding feelings of isolation and depressed mood. It would also seem that because the grief associated with infertility is often towards an intangible concept there is also a lack of understanding and social support compared with the way that grief related to bereavement might be responded to (Peterson, et al., 2007). Nevertheless, the grief a woman experiences in her journey through infertility and potentially fertility treatment is very real and as Braverman (1996) noted for any couple

experiencing infertility theirs is a “journey through the grief and into an uncertain future” (p.95).

Identity

Also of interest to researchers has been the effect of infertility and fertility treatments on identity. Defining identity has been the focal point for a considerable body of research stemming from the seminal work of Erikson (1980). Whilst Erikson’s focus on identity and its achievement related to early adulthood, specifically as a life stage, more latterly attention has turned to identity as it spans an adult’s life (Kroger, 2002; Marcia, 2002). Marcia (2002) proposes that identity is repeatedly reconstructed throughout adulthood as a person deals with subsequent life stages, such as generativity versus stagnation (Erikson, 1959), operationalising it through his ‘identity status’ paradigm of moratorium, diffusion, foreclosure and achievement (Marcia, 1966). Thus, with a growing recognition that identity does indeed form the basis for ongoing interactions and challenges for a person as she or he continues through life, interest in the effects of life events has peaked (Letherby, 2002; Marcia, 2002; Raskin, 2002, 2006; Riessman, 2002; Todorova & Kotzeva, 2006). However, it is McAdams’ (1995) definition that resonates most closely to the focus of this research: “identity in adulthood is an inner story of the self that integrates the reconstructed past, perceived present, and anticipated future to provide a life with unity, purpose, and meaning” (p.365).

There are two areas of interest with respect to identity in this research: that of a woman’s identity as a woman and potential mother and that of her vocational identity (or career or working identity). It is possible that both of these identities could be altered, disrupted or challenged as a result of infertility and treatment.

Focussing on a woman’s identity as a woman, Parry (2005) asserts that pronatalism, defined as the attachment of social worth to the attainment of motherhood, remains a dominant ideology in Western society. This assertion has been supported frequently in the literature (Greil, et al., 2011; Harwood, 2007; Kainz, 2001; McQuillan, Greil, Shreffler, & Tichenor, 2008; McQuillan, et al., 2003; Peterson, et al., 2007; Riessman, 2002; Rothrauff & Cooney, 2008; Ulrich & Weatherall, 2000). Therefore, infertility and its attendant issues could

be viewed by society as an unwanted disturbance in a woman's identity development (Ulrich & Weatherall, 2000). Indeed, as noted by Peterson et al. (2007) the experience of infertility will often result in questions of identity, challenging an individual's or couple's understanding of who he or she is or they are.

Research in this area has explored how a woman's identity might be affected when she is faced with infertility. Todorova and Kotzeva (2006) identified a number of interesting themes in their study of Bulgarian women. The themes included a sense that one's identity was incomplete because of infertility as well as a sense of 'separateness' from others in conceptualising one's identity. This separateness was manifested in the women identifying themselves as 'other' or 'defective' because they had been unable to have children (Todorova & Kotzeva, 2006).

Other work in the area of identity and infertility has also explored this sense of 'other' or 'outsider' in relation to the individual's previous identity as well as in relation to others (Daniluk, 1997; Exley & Letherby, 2001; Letherby, 2002). The complexities of this 'otherness' were noted in one study, with participants wanting their 'otherness' to be acknowledged yet at the same time anxious to ensure it did not become their primary identity (Exley & Letherby, 2001). Furthermore, Daniluk (2001) reported themes of 'identity confusion' for couples facing the prospect of biological childlessness.

Identity for women faced with infertility has also been described as a 'spoiled identity' (Greil, 1991, cited in Parry, 2005), the implication being that the failure of one's body to reproduce leads to feeling of failure that encompasses a woman's wider sense of identity (Parry, 2005). The concept of 'failing as a woman' has been an important theme in much of the research undertaken (Boden, 2007; Cousineau & Domar, 2007; Haelyon, 2006; Kainz, 2001; McCarthy, 2008; Parry, 2005; Shaw, et al., 1988; Ulrich & Weatherall, 2000). Such a strong use of wording would seem to indicate that for the women concerned this failure may be all-encompassing. Indeed, for women who are unable to achieve motherhood it would seem that infertility poses a significant challenge to their long-term central identity (McQuillan, et al., 2003).

Another important consideration with respect to identity is the contribution that a woman's work or career can make to her interpretation of who she is

(Raskin, 2002). Where fifty years ago a woman's identity was firmly linked to that of her reproductive ability (Friedan, 1963), it is now acknowledged that women also develop working or career identities (Plunkett, 2001).

Furthermore, it is believed that women's career identities are often different from those of men as women enter their career roles potentially mindful of their future reproductive activities (Plunkett, 2001). Plunkett also observes the coexisting roles of serendipity and agency with respect to women's career identities, defining agency as the agentic choices women make with respect to advancing their careers and serendipity as the events which women view as 'accidental yet lucky' when building their career identity.

With this recognition has also come awareness that Marcia's (1966) 'identity status' paradigm may not fully encompass the experience of women who will often vacillate between moratorium and achievement in their identity as they negotiate the combination of motherhood and career (Raskin, 2002, 2006). Raskin (2006) proposed a fifth identity status of 'conflicted achievement' that acknowledges the multiple roles women will often contend with.

Certainly, identity issues have been found to arise for women transitioning from career to motherhood (Buzzanell, et al., 2005; McQuillan, et al., 2008; Millward, 2006; Raskin, 2006; Shapiro, Ingols, & Blake-Beard, 2008), many of which are consistent with Raskin's (2006) theory of 'conflicted achievement'. Thus when faced with the challenges posed by infertility and its relationship to identity, it would seem likely that the challenges and disruptions experienced by women regarding their career or working identity could be compounded.

Some research has considered women's experiences of their career identities in the face of infertility. Todorova and Kotzeva (2006) suggested that infertility had led some of the women in their study to feel differently about their career identities, questioning their abilities as well as the meaningfulness of their work. In contrast, Throsby (2002) and Parry (2005) found that for some women working was a means for them to maintain a sense of self-worth in the face of infertility. The influence of infertility on careers has also been examined (Olshansky, 1987, cited in Olshansky, 1996), finding three patterns of influence: that infertility becomes central to some women's identities overshadowing any career identity they may have had; that for some women, they are able to successfully balance the two identities of themselves; and

that some women will actually make infertility part of their career identity by changing focus in their careers. Furthermore, Kirkman (2001) observed that many of the women she had interviewed in her research had seemed to seek to keep their infertility separate from their working life perhaps as a means of maintaining their career identity.

However, any potential disruption to a woman's working identity through the duration of fertility treatment does not appear to have been specifically investigated. It may be that in the face of infertility and subsequent fertility treatment a form of 'conflicted achievement' (Raskin, 2006) becomes even more oppressive as a woman attempts to negotiate meeting the demands of her identity as a woman and that as a career person.

Infertility and illness

Also of interest to the focus of this research is the conceptualisation of infertility and related fertility treatments as illness, as they might relate to the world of work. If an individual has a chronic illness, there may be workplace policies that offer guidance as to how work can be adjusted to suit the individual's needs (Munir, Jones, Leka, & Griffiths, 2005). Furthermore, in New Zealand, the Human Rights Act 1983 states that physical and psychiatric illness are prohibited grounds for discrimination, an Act to which all employers in New Zealand must abide. But the question arises as to whether such adjustments have been or are extended to infertility or fertility treatment.

The concept of infertility as an illness has had a varied and often politicised reception (Becker & Nachtigall, 1992; Todorova & Kotzeva, 2006). Whilst from a biomedical perspective it has a definition that would suggest illness (Greil, et al., 2010), often the etiology of infertility is less distinct (Todorova & Kotzeva, 2006). In addition there is the issue of attribution, as infertility is often defined as occurring between a couple (Greil, et al., 2011) with statistics suggesting up to one third of fertility problems reside within both partners simultaneously (Cousineau & Domar, 2007; Peterson, et al., 2007). A contrasting opinion of infertility is that it is a socially constructed phenomenon (Becker & Nachtigall, 1992; Greil, et al., 2011) and therefore not one that should be pathologised (Todorova & Kotzeva, 2006) as to do so heightens the risk of stigmatisation and disempowerment, particularly for women.

Nevertheless, its classification as an illness may be useful in assisting people

through their experience of infertility. Indeed in the United States, the national organisation set up to support people experiencing infertility, RESOLVE asserts that “infertility should be considered as an illness or disease and therefore treated the same as any other illnesses” (Harwood, 2007, p.42). The primary reason for this argument is the organisation’s agenda to achieve insurance cover for fertility treatment. Furthermore, as noted by Harwood (2007) two other valuable outcomes would occur as a result of defining infertility as an illness: the experience of infertility would be legitimised as real and it might in some way remove the religious stigma associated with infertility (the will of God). Todorova and Kotzeva (2006) also note that defining infertility as an illness would enable acknowledgement of the suffering people experience as a result of infertility.

Indeed, comparison studies between chronic illness and infertile women have revealed similarities including similar levels of anxiety and depressive symptomatology (Domar, Zuttermeister, & Friedman, 1993), expressions of grief (Exley & Letherby, 2001), and negative impacts upon a person’s sense of identity (Exley & Letherby, 2001). Kirkman and Rosenthal (1999) also draw parallels in narratives of chronic illness and infertility, observing that both often take the form of a quest narrative: stories which “meet suffering head on; they accept illness and seek to use it” (Frank, 1995, p.115).

With regard to fertility treatments, for example IVF treatment, there appear to be some similarities with the experiences of a chronic illness, particularly within a work environment. Research has indicated that chronic illness can require adjustments to working conditions (Munir, Jones, et al., 2005), lead to higher rates of workplace absences (Munir, Leka, & Griffiths, 2005), and that there may be considerations around privacy and disclosure depending on the perceived level of employer support (Munir, Leka, et al., 2005). These issues have also been mentioned in research focusing on fertility treatment (Brod, et al., 2009; Finamore, Seifer, Ananth, & Leiblum, 2007; Laffont & Edelmann, 1994; Redshaw, et al., 2007).

It has also been observed that disclosure of chronic illness at work may be mediated by other potential stigmas in the work environment, such as being a woman (Burström, Holland, Diderichsen, & Whitehead, 2003) or caring for children (Lewis & Cooper, 1999). Given that it is the woman who invariably

experiences fertility treatment that might involve disruption to her working life, it would seem that she may be at further risk of stigmatisation within an organisation should she disclose her treatment. This may indicate that an exploration of how women negotiate their treatment in the work context could offer some valuable insights.

Sociocultural contexts

As previously discussed, Greil et al. (2011) advocate for a mindfulness of the social construction of infertility believing that it is best understood from within this context. Within this framework a number of studies have been undertaken in the past decade. As noted by Greil et al. (2010) this developing body of literature is beginning to offer an understanding of the 'lived experience' of infertility.

Investigating infertility from a pronatalist perspective, Parry (2005) observed the role of society in the experiences of infertility as described by some women. The participants in her study had observed that delays in child bearing were met with questions of 'when' and unsolicited advice with a view to 'fixing' their problem, thereby implying that there was an implicit belief women would want to and should be able to conceive. Parry also noted that many women spoke of feeling as if they were 'lesser women' when unable to meet society's expectations of them to conceive.

Attention has also turned to the concepts of social stigma and isolation as a result of infertility and fertility treatment (Cousineau & Domar, 2007).

Matthews and Matthews (1986) offered the following conceptualisation of stigmatisation: "stigmatized (sic) persons come to accept themselves as stigmatized (sic) as a result of negative reactions from others" (p.646) thus acknowledging the social construction of stigma. Furthermore, in societies where pronatalism prevails, infertility creates a feeling of deviance from the norm, which may lead to a fear of being considered abnormal or experiencing 'felt stigma' (Todorova & Kotzeva, 2006). Thus, whether the stigma of infertility is felt or experienced, it remains a very real fear for infertile people in a sociocultural context perhaps leading them to isolate themselves in order to maintain a sense of security. Indeed, reference to the negative experience of social stigma and resultant isolation has regularly been made (Exley &

Letherby, 2001; Matthews & Matthews, 1986; McQuillan, et al., 2003; McWhinnie, 1992; Ulrich & Weatherall, 2000).

Exley and Letherby (2001) also investigate the role of 'emotion work' in infertility, finding a number of women have used it as a means of attempting to control social stigma. 'Emotion work' is defined as two distinct activities: "the work people do on their own emotions in order to conform to dominant expectations" (p.115) and work people do in order to moderate the feelings of others (Exley & Letherby, 2001). The women in that study were active in both domains as a means of reducing tension to ensure normal interaction. In addition, the authors also noted that these women would also ensure their own feelings were not publicly displayed but rather hidden, so as to protect those around them.

Indeed, one of the more pressing social concerns for women undertaking fertility treatment is the question of disclosure: whether to disclose at all and if so to what degree (Finamore, et al., 2007). There are a range of sociocultural factors involved in this decision-making process including fears of stigmatisation and isolation but also anxiety that arises around an anticipated workplace response that may include limiting career options or advancement (Finamore, et al., 2007).

Kirkman (2001) also explores this challenge, defining it as a question of 'public versus private narratives' and noting that an uncomfortable tension between the two is often created. In her narrative focussed work with infertile women, she identified that there were a range of possibilities for women regarding the public or private nature of their infertility story: one or the other or a combination of both. However, she also noted that infertility was still largely a private experience. Kirkman sees the experience of creating a narrative regarding infertility as situated in paradox: a woman must not only make sense of her infertility from within a pronatalist ideology but also there is a sense of needing to explain oneself to a wider public domain that is in itself the pronatalist society.

The current study

Whilst there have been some studies that have alluded to the impact of fertility treatment on work from a psychological perspective as well as a practical perspective, it has invariably been as an aside to the main tenets of the

research. Considerations from a psychological perspective have included: concerns and anxieties about work performance as a result of treatment (Brod, et al., 2009; Peddie, et al., 2005); the added stress of maintaining secrecy in the workplace in order to have appointments (Hammarberg, et al., 2001); and a sense of continual conflict between work and treatment (Redshaw, et al., 2007). From a practical perspective, concerns have centred around the disruptive nature of fertility treatment to daily life, including work (Balfour, 2010; Brod, et al., 2009; Eugster & Vingerhoets, 1999; Laffont & Edelman, 1994; Payne, Goedeke, Balfour, & Gudex, 2011) as well as juggling appointments outside of work hours (Redshaw, et al., 2007) and perhaps, more disconcertingly, concerns regarding job security and career advancement (Finamore, et al., 2007).

However, given the increasing rates of fertility treatment as well as the increases in numbers of working women over the past few decades (Barnett, 2004; Statistics New Zealand, 2005), the opportunity for targeted research into the experience of combining fertility treatment and working has become apparent. From a practitioner's perspective, highlighting the potential relationship of the two factors may assist those mental health practitioners working with women during this time in further developing their understanding of how best to offer support to women at this critical phase in their lives. As noted by Kainz (2001) and Boden (2007), psychologists or other mental health practitioners have an important role in helping couples through all stages of their infertility journey, as increased understanding and empathy on behalf of such mental health practitioners may lead to better psychological outcomes for clients experiencing fertility treatment. The purpose of this research therefore, is to consider the gap in the literature that has been identified as understanding the experiences of women who have combined both working and fertility treatment. It is also anticipated that offering an understanding of women's experiences could also assist with work-place policy development in the future.

Methodological approach

It has been observed that “much of the most insightful work on infertility has been qualitative” (Berg, 1990, cited in Greil, 1997, p.1693). With this insightfulness as a noble aim in mind, it was considered that the experiences of women combining paid employment and fertility treatment were best explored by way of a qualitative approach. Historically, quantitative measures have been most commonly used in psychology thus enabling the discipline to fit with the positivist hegemony of the natural sciences (Wertz, 2011).

However, since the 1990s there has been a growing acceptance and use of qualitative methodologies within the field of psychology (Atkinson, Coffey, & Delamont, 2001; Harré, 2004; Michell, 2004), to the point where it has recently been posited that psychology may finally be joining the ‘qualitative revolution’ (Wertz, 2011).

Qualitative research enables the researcher to go beyond quantitative measures to offer a more complex and richly layered insight into the experience being studied. It is a particularly salient approach when the research topic is internally experienced (Wertz, 2011) and where “meaning plays an important role in behavioural processes” (Michell, 2004, p.307).

Harre (2004) argues that “psychology is the scientific study of meaning making and management” (p.4) and qualitative research is one of the most effective methodologies for reaching to the heart of that meaning-making.

In addition to the richness of data that can be garnered from undertaking qualitative research, there is an ethical consideration: one of empowerment for those people who are suffering or have experienced marginalisation (Wertz, 2011). By engaging a research participant in a more responsive and reactive form of research, one potentially allows for the participant to have greater level of expression and engagement (Wertz, 2011). In the instance of women who have undergone fertility treatment this experience could be perceived as disempowering, in that their journey to motherhood has become a medical procedure over which they have little control (Imeson & McMurray, 1996). In the instance of this study, it may be that the women interviewed find the opportunity to express their experiences not only empowering but possibly even therapeutic.

Furthermore, it has been suggested that qualitative research, in particular a narrative approach, is more appropriate when dealing with issues of trauma and or illness (Crossley, 2000a). Whilst infertility and its associated treatments are not specifically classified as an illness, it bears many similarities to chronic illness (Kirkman & Rosenthal, 1999) such as: time away from work for treatments (Finamore, et al., 2007); the need for individuals to adapt to their changed circumstances (Crossley, 2000a); and oftentimes strong psychological responses (Cousineau & Domar, 2007). From that perspective, qualitative research is far “better designed to respect the integrity of personal narratives than analytical investigations” (M. Gergen, 2001, pp.28-29) such as quantitative studies.

Qualitative research is an all-encompassing term suggesting a homogeneity that is fiercely debated (Madill & Gough, 2008). It is considered important therefore, to narrow one’s focus to a specific qualitative methodology and theoretical paradigm. The purpose of this research is to understand the experiences of women combining fertility treatment and paid employment. The concept of understanding, coupled with the fact that this question considers issues that may be considered traumatic or may incorporate the narratives one develops around one’s career and or identity has led to the selection of a narrative mode of inquiry for this research. In addition, the experience under exploration has a clear beginning: the infertility discovery, middle: the experience of fertility treatment and working and an end: the conclusion of fertility treatment. Having a clear plot line is considered essential to narrative research (Cochran, 1990; Crossley, 2000a; Polkinghorne, 1988) as it enables the participant to construct a meaningful and coherent story.

Arguably there are many definitions of narrative research but as noted by Gergen and Gergen (2001) all approaches share “a concern with stories as vehicles for rendering the self and world intelligible” (p.728). One of the earlier significant contributors to the concept of narrative research within psychology was Gordon Allport who was keenly interested in conducting study that embraced the individuality and uniqueness of people (Polkinghorne, 1988). Allport also believed that “psychological knowledge from multiple perspectives leads to greater truth” (Allport, 1942, cited in Wertz, 2011, p.80). This research also seeks to embrace the individuality of the participants and to represent the

multiplicity of experiences of women at such an important life juncture so as to offer greater understanding of the question being asked.

Polkinghorne (1988) further emphasised the role of narrative in describing human experience and deriving meaning from those experiences. Drawing on the work of Heidegger, he took a hermeneutic view that narrative is a linguistic endeavour and that we, as humans, cannot separate our experiences from the language and narratives we use to bring those experiences to life and therefore meaning (Polkinghorne, 1988). Similarly, Crossley (2000a) states that the “basic principle of narrative psychology is that individuals understand themselves through the medium of language” (p.10). This research also seeks to incorporate the role of language in the narratives that are presented and to this end, is aligned with the narrative approaches of Crossley (2000a) and Polkinghorne (1988).

Discussion or research centring on self and identity is often closely linked to language (Crossley, 2000a). Indeed McAdams (1995) posits “that identity is the storied self” (p.385). When a woman is considering embarking on motherhood, these concepts are also often at the fore (James, 2008; Mäkelä, 2011; Smith, 1999) as women contemplate and assimilate the changes to their lives and or careers that motherhood will bring. Furthermore, prior research has indicated that infertility can lead to a disruption in one’s sense of identity (Todorova & Kotzeva, 2006; Ulrich & Weatherall, 2000). From this perspective, a narrative methodology would appear to be an even more appropriate fit, enabling the participants to narrate their story of infertility and how it may have affected their sense of self or identity.

Given that fertility treatment can be a distressing event, carrying with it high levels of emotional and physical stress (Hammarberg, et al., 2001; Peddie, et al., 2005; Verhaak, et al., 2007) and as previously mentioned, shares some similarities with chronic illnesses, a further argument for a narrative approach is developed. A keen advocate of the illness narrative is Frank (1995) who asserted that narratives of illness are necessary to enable the person to reposition themselves in their lives in light of their illness. He identifies three types of illness narrative: restitution, in which illness is a moment in time with the focus of the story being on health; chaos, an often incoherent story of despair that focuses on the illness and the disaster associated with it; and

quest, telling the story of the experience of illness as a journey, seeking to rise to the challenges ahead (Frank, 1995). Indeed, the notion of a quest narrative in light of fertility treatment has previously been considered (Kirkman & Rosenthal, 1999). Similarly, suggestions of hope (akin to restitution) and resistance (similar to quest) narratives of fertility treatments have also been proposed (Kalbian, 2005). Thus it is hoped that through the process of the narrative interview, a participant may find herself able to rebuild her sense of identity (Crossley, 2000b) as she has been enabled to 'story' her experience, constructing plot and thereby meaning (Polkinghorne, 1995).

Similarly, Cochran (1990) and Bujold (2004) argue that a narrative approach has a natural affinity with career research as most people construct a story of their career. In the instance of women who undergo IVF treatment whilst continuing paid employment, their career story may have unanticipated disruptions or challenges, but nevertheless it is likely to be an integral part of the narratives that they share. Furthermore, identity has been recognised as a core element to career theory (Bujold, 2004) and as noted above, narrative plays an important part in the developing of one's identity (McAdams, 1995).

Finally from a life-span developmental viewpoint, a narrative mode of inquiry also fits with this research as infertility can also be viewed as a phase of life problem (Peterson, et al., 2007) and as humans we construct stories about our lives (Hiles & Čermák, 2008; Polkinghorne, 1995). Taking into account Erikson's theory of life-stage development (Erikson, 1980) and in particular the phase of generativity versus stagnation which is strongly associated with parenthood (Rothrauff & Cooney, 2008), one can see how this transitional phase may require some re-storying of one's identity in the face of infertility.

Theoretical lens

The conventional positivist lens that psychology has long advocated has come under increasing pressure and debate in the past few decades (Denzin & Lincoln, 2000; M. Gergen, 2001; Willig, 2008) as an awareness of the multiplicity and complexity of human experiences and how they are perceived has developed. In addition, awareness has also grown of the need to understand and communicate one's own epistemological stance when conducting research.

In selecting a narrative framework in which to undertake this research, the role of language becomes paramount. It is how the researcher and participant communicate with each other, it is how feelings are conveyed and meanings constructed. An epistemological point of view to which narrative research is strongly aligned is that of social constructionism (Crossley, 2000a; K. J. Gergen, 1994; K. J. Gergen & Gergen, 2010): a theoretical paradigm which proposes that knowledge is constructed through the interactions that occur between people, or in this instance, between researcher and participant (Doucet, Letourneau, & Stoppard, 2010; Flick, 2009). Burr (2003) acknowledges that there are multiple social constructionist views but offers some foundation stones for those adopting a social constructionist position. In addition to the definition for social constructionism provided above, Burr identifies that taking a critical point of view is necessary when examining traditional ways of knowing, that it is important to locate one's understanding within the historical and cultural contexts that we are a part of, and that any knowledge and social action are inextricably intertwined. This research will be filtered through a social constructionist lens as defined by Burr (2003).

Whilst infertility can be an issue experienced by either party in a relationship, the experience of IVF treatment will largely be that of the woman's, both physically and psychologically. In addition, as noted earlier, a woman may find the experience of IVF treatment to be disempowering (Imeson & McMurray, 1996). Therefore, further to the social constructionist view of the world by which this research will be informed, it will also be located within a feminist paradigm (M. Gergen, 2001; Tong, 2007). As there is a long and respected tradition of feminist viewpoints within psychology (Pickren & Rutherford, 2010) and they are notably diverse, it seems appropriate to position oneself within a selected paradigm among the multiplicity of feminist views available. The selected feminist lens for this research is that of third wave feminism (Tong, 2007; Walker, 2001). The third wave of feminism was conceptualised in the mid 1990s as a means of recognising and acknowledging the multiplicity of contemporary views on feminism (Reger, 2005). It is also noted to have arisen in direct response to many of the criticisms levelled at the schools of second wave feminism (Reger, 2005). As a movement it heralds the individuality of women although it has at times been criticised for being too focussed on the individual (Henry, 2005). However, it is for this very reason that this lens has

been selected. As a feminist approach third wave feminism recognises diversity and individual differences as critical to understanding the experiences of women and from that perspective it fits well with the focus on individual narratives contained in this work.

Reflexivity

Qualitative research necessitates that the researcher provide the reader with an understanding of how he or she fits into the research being undertaken (Thorne, 2008). This serves two purposes, one: acknowledging the role of the researcher in the shaping of the research through his or her own beliefs and values (Willig, 2008) and two: enabling the reader to draw his or her own conclusions regarding the outcomes of the research process (M. Gergen, 2001).

Reflexivity may also be particularly salient when considering narrative research, for it is the researcher as narrator who is shaping and presenting the participants' narratives (Elliot, 2005). Therefore, in order for the reader to be convinced by the researcher, as narrator, that what she presents is valid, it is imperative that the reader is given as much clarity as possible as to who the researcher is, her background and her beliefs.

I come to this research as a mother of three children. Having had my first child at the beginning of my adult life, I have not experienced a biological yearning to have a child and to be thwarted from that ambition. In many ways, I approached this research from a position of curiosity and ignorance about the experiences these women had had when they first started to trying to conceive a child. My interest in this area stems from a desire to understand and perhaps offer some insight into the challenges that working women currently encounter in modern society. I have also had a professional career in and amongst my role as a mother. In this capacity I have been privy to many of the challenges that working mothers encounter both personally and professionally, as shared with me by colleagues and peers.

Epistemologically, I would consider that the paradigm that is most reflected in my view of the world is that of constructivism-interpretivism: a belief that reality is constructed in our minds and that every construction or co-construction (between researcher and participant) is equally valid (Ponterotto, 2005). Ontologically, I believe in multiple realities that are co-constructed between

individuals as well as the social environment they live in. Furthermore, I would consider the values I bring to this research to be guided by a third-wave feminist axiology. Thus, I am interested in how current organisational structures and the individuals working within them respond to the unique challenges experienced by women, such as undergoing fertility treatment whilst working. I am also curious, from a feminist perspective, about how any implicit or institutional gender biases may affect a woman's experience and furthermore, how these experiences are interpreted by the women themselves.

In conducting these interviews I felt it was important to share with the women I interviewed that I was a mother of three children. I have not experienced fertility treatment and at times was very mindful of the fact that I could not completely understand the complexities of their experiences of treatment. However, knowing the sense of wholeness that being a mother has given me, I felt that I could empathise with the women's yearning for motherhood. Furthermore, I believe that my genuine curiosity and compassion, as well as the fact that we were all mothers, enabled me to create a safe and supportive atmosphere within which participants could be open and share their often, painful stories. I was equally mindful of how my own experiences of working and mothering may have had some influence on the interaction that occurred and indeed on my role as the primary narrator and presenter of these women's stories.

Rigor

In order to verify the trustworthiness of the data contained herein, this research has been undertaken with a number of standards for quality in mind. This research is most appropriately situated within a constructivist-interpretivist paradigm. Therefore, utilising the authenticity criteria proposed by Guba and Lincoln (1989) and expanded upon by Morrow (2005) as best fitting with constructivism-interpretivism, this research has considered the following: fairness; authenticity; and meaning. In addition, the transcendent criteria of social validity, subjectivity and reflexivity, adequacy of data, and adequacy of interpretation have also been taken into consideration (S. L. Morrow, 2005).

Fairness is the first part of the audit trail and is defined as seeking and honouring different constructions. The demonstration of fairness in this study was undertaken through conscious attempts to balance the relationship

between researcher and participant, the narratives were negotiated and co-constructed with participant feedback regularly sought as will be further explained in the subsequent 'method of analysis' section.

With respect to authenticity, Guba and Lincoln (1989) define four types of authenticity: ontological, the extent to which participants' narratives are expanded and elaborated; educative, the enhancement of participants' understanding of the experience of others; catalytic, the stimulation of action in relation to the research process; and tactical, the degree of empowerment bestowed upon stakeholders and participants. The criterion of ontological authenticity was sought by encouraging the participants to continually interact with their narratives, seeking their feedback and responses. Educative, authenticity is expected to occur later, once the participants have received the full reports so that they can compare their experiences to those of others and develop understandings of other constructions of the experience. The test of catalytic and tactical authenticity will be in the stimulation of action that results from this research.

In testing for meaning, Morrow (2005) proposes a two pronged approach: seeking a deep understanding of participant meanings and an agreed upon mutual construction of meaning between researcher and participant. The process of co-constructing narratives and ongoing dialogue after the initial interview ensured this measure of quality was met.

To meet the standard of social validity as a form of trustworthiness, this research has been framed within a feminist perspective. Reflexivity has been met in the above section explicating the researcher's personal and epistemological reflexivity. Finally in consideration of adequacy and interpretation of data, from a narrative perspective the invitation to tell one's story encouraged the provision of information-rich data from the participants. This was further enhanced by the use of open-ended questions throughout the interview process. Immersion in the transcripts, reading, re-reading and examining initial impressions was considered an important step in the interpretation process (Crossley, 2000a). Lastly, the careful and mindful balancing of researcher interpretations and participant quotations was applied in order to ensure that the interpretations were adequately supported.

Ethical considerations

As noted by Edwards and Mauthner (2002), to be ethical is to follow a code of morality in conduct. It has been suggested that narrative research can help in many ways to empower the participant and create a more ethical interaction than traditional research methods (Graham, 1984, cited in Elliot, 2005) but nevertheless ethical considerations arise for those conducting narrative research (Elliot, 2005).

Conducting research in New Zealand also demands of a researcher that they consider the framework provided by Te Tiriti o Waitangi for relationships between Maori and Pakeha: the principles of protection, partnership, and participation. Whilst this research did not specifically seek Maori participants, the researcher was aware of this potentiality. In addition, this researcher embraces this framework as a guiding principle for all research, regardless of cultural boundaries. The following ethical considerations were made in this light.

Firstly, it is salient to note that this research could be considered sensitive (Johnson & Clarke, 2003) as the researcher is asking sometimes very personal and potentially emotionally charged questions. From the perspective of protection, the emotional safety and ongoing psychological wellbeing of the participants and the researcher was paramount to this research. A number of steps were taken to ensure that this research had those ambitions constantly in mind. During the course of the interview, the participants were invited to only share that information with which they felt comfortable and were reassured that the interview could be stopped at any time if they were feeling any discomfort. The participants were also offered an opportunity to undertake three free counselling sessions at AUT's Health and Counselling Service (Appendix B). They were sent a follow up email the day after the interview providing them with the appropriate contact details and also thanking them once again. Finally, they were sent the final transcripts and invited to make any amendments or deletions as they wished. As a further point of protection, the participants selected a pseudonym for themselves and all identifying language regarding their place of work or type of work was adapted to be more generic.

For the researcher, the primary concerns were around conducting appropriately focussed narrative interviews. As a check in measure, half of the first transcript

was sent to her supervisor the night after the first interview, in order to get supervisor feedback before continuing with the subsequent interviews.

Having the participants offer final approval on their transcripts also allowed for another ethical consideration to be addressed, that of partnership in the process. When undertaking this research, the researcher sought to balance the relationship between interviewer and interviewee as much as possible to create a sense of partnership. The interview schedule was shared with the interviewee and the final question was always whether there were other areas of interest the participant would like to discuss. By then inviting feedback on the transcripts, the sense of partnership was further maintained. Finally, the draft narratives were sent to the participants to ensure that their stories had been narrated as accurately as possible.

Active participation in the process was encouraged through inviting the participants to select the venue that best suited them. It was important to the researcher that the participants be comfortable and at ease and by having them choose their venue, it was felt that this would also occur. As previously mentioned the participants were also provided with both transcripts and draft narratives for their review, which was another attempt to actively engage the participants.

Lieblich (1996) offers an ethical concern that inviting participants to share their stories may be opening them up to reliving their pain but Elliot (2005) suggests that the opportunity to talk and reflect upon one's experiences may actually be therapeutic. By approaching the interview with an intentional focus on rapport building and offering appropriate verbal and non-verbal encouragers, it was hoped that the latter was more likely to be achieved. In addition, by recruiting women who had a child as a result of their IVF treatment, it was believed that their potential discomfort would be offset by their ultimately successful outcome (Hammarberg, et al., 2001).

As a final note on ethics, ethical approval for this research was granted on 3 June 2011, by AUT's Ethics Committee (AUTEK): Reference 11/105.

Method

Recruitment

The participants were recruited through The Parent's Centre, an organisation that has been developed to offer support and education to parents in New Zealand. The Parent's Centre offer a monthly electronic newsletter as part of subscription membership and it was in this newsletter that the recruitment advertisement (Appendix C) was included. The recruitment advertisement provided a link to the website www.parentscentre.org.nz, where interested women could download the Participant Information Sheet (Appendix D). The Parent's Centre monthly newsletter has a circulation of over 6,000 people nation-wide. The invitation to participate was issued directly to recipients of the newsletters, but they were also invited to extend the invitation to any women they thought may be interested.

Participants

The research invitation sought women who had completed (but were no longer engaged in) IVF treatment within the past five years. Selecting women who were no longer engaged in IVF was a deliberate strategy, in order to protect potential participants from a perceived risk of vulnerability if they were currently experiencing IVF. Furthermore, by seeking participants through The Parent's Centre, it was more likely that they had a child (hence their engagement with The Parent's Centre). It was therefore expected that the participants would have more positive memories of their IVF treatment (Hammarberg, et al., 2001) thereby further decreasing their vulnerability when discussing their experiences.

For practical reasons, the five participants were Auckland based in order that interviews could be conducted face-to-face, and it was also a requirement that they be fluent English speakers.

There were 33 responses to the email invitation. The first five women who responded that fit the criteria were contacted and interviews were arranged. The experience of IVF treatment for all five women had concluded within the past five years. However for two of the women, their experience had commenced more than five years before. All of the participants had one child and two were expecting their second child. The women ranged in age from their mid 30s to mid 40s. Four of the women identified as of European

descent and one woman identified as being of New Zealand born Chinese descent.

Data collection

Semi-structured topic-focused (Hiles & Čermák, 2008) interviews were conducted with five women who had experienced IVF treatment in combination with paid employment. An interview schedule (Appendix E) was developed with a list of areas of interest. This schedule was based on existing research in infertility and IVF treatment (Balfour, 2010).

Madill and Gough (2008) posit that interviews “seem designed to tap lived experience” (p.256) and in this way they have a natural affinity with a narrative methodology. In order to focus the interview in a narrative way, the women were invited in the opening question to tell their stories about their experiences of working and undergoing IVF treatment. For most of the women the commencement of this story began with their infertility discovery. This was deemed a valuable place to start so as to give their stories a sense of cohesiveness and to ease them into the interview process.

The interviews were primarily held in the participants’ own homes and a researcher safety protocol (Appendix F) was followed in order to ensure the safety of the researcher. One interview was also held at the participant’s place of work. All venues were the participant’s choice, so as to encourage a sense of partnership to the process for the participants. The interviews were up to 90 minutes in duration and were audiotaped and manually transcribed by the researcher.

Method of analysis

The transcripts were analysed to identify narratives within the women’s stories regarding how they combined paid employment with IVF treatment. However, upon closer investigation, it was felt that the scope of the narratives needed to be widened to include all fertility treatments as for some of the women the IVF treatment itself had played only a small part in their story. For this reason, the scope of the research was broadened at this stage.

Crossley (2000a) defines a personal narrative as the stories that we construct “to bring together different parts of ourselves into a purposeful and convincing whole” (p.67). Following Crossley’s (2000a) suggested process for conducting

the initial phase of the narrative psychological analysis the interviews were first read repeatedly in order to become familiar with the data. In addition to repeated reading, the interviews were also listened to repeatedly, enabling the researcher to become familiar with the tones of speech and intonations used by the interviewees. In this way, it was a form of reliving the interviews, enabling the researcher to develop a sense of emotional engagement with her interviewee's stories with the intention that this engagement would be reflected in the construction of the women's narratives. Furthermore, in so doing, the researcher was able to begin to identify the narrative tones of the story (McAdams, 1997). This phase of analysis also included developing a sense of the relevant imagery and themes that were beginning to emerge (Crossley, 2000a). It was then the role of the researcher to examine and re-examine these elements in order to weave them into a coherent narrative (Crossley, 2000a).

Producing the women's stories as draft narratives was the next aspect of analysis. It is noted that there is a temporal nature of narrative: past, present and future (Crossley, 2000a; Polkinghorne, 1988) as well as that of infertility itself, being "a process with an uncertain trajectory" (Greil, 1997, p.1689). Accordingly, the researcher sought to identify the beginning, middle and end of the women's narratives, mindful that "the researcher does not find narratives but instead participates in their creation" (Neander & Skott, 2006, p.297). Furthermore, approaching the narratives from the perspective of time also created an easily understood plot structure (Connelly & Clandinin, 1990).

Taking into account one's own reflexivity at this stage was considered integral to the process as the researcher was aware of her own role in constructing the narrative, both at the point of interview and at the point of retelling the story. As Riessman (2008) observed, a researcher in the role of interviewer brings herself to an interview and even her presence can shape how and what of a story is told. In addition, in the process of constructing her interviewee's narratives, the researcher brings her own intuitions as well as potential biases and expectations to that process (Elliot, 2005).

Developing the narratives was completed using a holistic-content perspective (Elliot, 2005; Lieblich, et al., 1998). The holistic dimension is defined as the consideration of a person's story in its entirety, seeking to interpret the text within the context provided by the whole narrative. This is as distinct from a

categorical approach that seeks to examine short sections of text clustered from different narratives (Elliot, 2005; Lieblich, et al., 1998). Such a holistic approach was considered most appropriate in the first instance because the similarities between fertility treatment and chronic illness, as previously mentioned, establish a precedent for a form of analysis that respects and focuses on the whole person (Lieblich, et al., 1998). The content orientation of the narratives was defined as a focus on the content of the single narratives, what themes emerged within them and the individual's motivations that seemed relevant (Lieblich, et al., 1998). In addition, attention was paid to conflicting episodes as suggested by Lieblich et al. (1998) and further attention was given to the social context of the narratives (Elliot, 2005). By focussing solely on an individual narrative at a time, the researcher was able to appreciate the unique nature of each person's own story.

Once the narratives had been developed they were sent to the interviewees for their comments, amendments or deletions. This was considered an important phase of the process because it encouraged the co-construction of the narratives (Connelly & Clandinin, 1990; Riessman, 2008) with the aim of further building the sense of partnership that is one of the important aspects of qualitative research. Furthermore, it was hoped that this might help the participants to feel empowerment in the researcher-participant relationship. In taking this step and inviting interaction, the participants also had the opportunity to offer further data by way of their responses. It also formed a final validity check as the researcher was mindful that she had selected what elements of the women's stories were to be included in the rewriting of their narratives. Thus, by having the interviewees' final approval over the narratives, the researcher was ensuring the women felt that the final narratives accurately represented their stories.

Once the final narratives were agreed upon between researcher and participant the final phase of thematic narrative analysis was undertaken. Taking a more categorical-content perspective (Lieblich, et al., 1998) this phase involved gathering and interpreting texts from the individual narratives that were related conceptually and temporally. With a strong focus on maintaining the narrative chapters of the women's stories and honouring the prior knowledge in the field, this phase of analysis was defined as a form of thematic narrative analysis

(Riessman, 2008). Furthermore, acknowledgement of the construction of the 'storied self' (McAdams, 1995) was maintained in this phase of the research so as to continue to enhance the narrative nature of this inquiry. Riessman also notes that by analysing the narratives as a group, the analysis could bear strong similarities to a grounded theory approach. However it is the focus on the preservation of the temporal narrative features and the "case-centered commitment" driving the interpretations by the researcher that justifies this final phase as thematic narrative analysis (Riessman, 2008).

Findings

As noted by Riessman (2008), the first and possibly most crucial step is producing “the texts for inquiry, a task all investigators face even before formal analysis begins” (p.21). Taking into account the temporality of narrative work (Polkinghorne, 1988), the stories appeared to have a natural arc of a beginning, middle and end. For each woman, her story began at the point of deciding to have a child. It encompassed the women’s infertility discovery up to the point of commencing IVF treatment. The middle was clearly delineated as the experience of combining work and IVF treatment. This stage of the narratives traversed both practical and emotional complexities as well as contradictions. Finally came the story’s end in which the women had given birth successfully. For some women, this was a relatively recent event and for other women who were actually pregnant or expecting their next child (through surrogacy), their first fertility treatment had occurred a couple of years ago. All of the women were at a point in their lives where they were now contemplating their future, whether it involved further IVF rounds or career considerations.

As per the suggestion offered by Lieblich et al. (1998) to ‘be’ with the text, rereading it thoroughly and frequently so that “it will ‘speak’ to you” (p.62) each story was considered in and of itself. Drawing on the work of Williams (1984), individual themes and a degree of interpretation were offered throughout the narrative text in accordance with a holistic-content perspective. It seems salient therefore to present each narrative in its entirety, as they formed the initial part of the analysis.

Finally a thematic narrative analysis was conducted to explore common themes that were identified in the women’s narratives. With an awareness that prior or emergent theory will have influenced the researcher’s frame of reference at this phase of the analysis (Riessman, 2008), the themes that identified were similar to those that have been alluded to in previous research. Firstly, attention was paid to overarching themes that had been identified within the collective narratives. Secondly, the focus turned to themes that centred around two areas: the women’s psychological experiences (Brod, et al., 2009; Cousineau & Domar, 2007; Hammarberg, et al., 2001; Peddie, et al., 2005) and their wider experience within a social or organisational context (Balfour, 2010; Brod, et al., 2009; Finamore, et al., 2007; Redshaw, et al., 2007). There was a degree of

crossover at times between these themes but for the purposes of analysis this delineation was selected.

Case study 1: Kathryn's story

A story of performance, persistence, permission, and perspective.

Kathryn is in her early 40s and has been married for four years. Kathryn's first round of IVF treatment resulted in a pregnancy and the arrival of her and her husband's first child, approximately four years after they had started trying for a family.

In the beginning

Kathryn indicates that she had never really thought she would have children, *"up until I met my husband I pretty much thought I probably wouldn't ever have kids"*. Through her 30s she was single, enjoying it and able to focus on a career she was very happy in: *"I was single and had lots of single friends and we just had a good time and I could just concentrate on work which was great and then I started this new job, I could work hard at it, um, was really into it"*. By Kathryn's account, it was a career that was highly successful and she was very proud of her professional achievements, indicating that she feels that she's *"achieved a lot of things I wanted to achieve in my career"*. Looking at Kathryn's career trajectory it would appear that she is a highly motivated, performance-oriented person, a point she even notes herself: *"I'm a sort of goal oriented, quite successful type person"*.

Kathryn observes that when she became romantically involved with her future husband, it took her *"a little while to come round to it"* because she was aware of the potential impact a long-term relationship, such as *"a marriage and kids and stuff"* was likely to have on her career. From Kathryn's perspective there was a strong awareness that *"it would end my career basically"*. For Kathryn there seemed to be two choices: either to pursue a career or motherhood. She had a successful career in which she had been recently promoted and in her words this *"was awesome and it was kind of bad timing in a way because I always knew that... um... that I wanted to try and get pregnant once I got married"* implying almost that in order to achieve one, she had to give up the other.

Thus for Kathryn, the story of her experience of combining work and IVF treatment had a beginning that pre-dated the IVF experience. The beginning of Kathryn's story commenced with her and her husband's decision to start trying for a family. Being in her late 30s, Kathryn states *"it had occurred to me that maybe we might have trouble"* and as a result it would seem that in some way Kathryn had prepared herself for the possibility of not having children by having an alternative plan, that of focussing on her successful career and life with her husband, if that was what her husband wanted: *"I was expecting him to say well maybe we won't have kids, you know, cos we're older and maybe we'll go on having our lifestyle"*. Surprisingly to Kathryn, this was when her husband responded with *"well, we'd just try everything wouldn't we?"*, a comment that Kathryn describes as *"pretty cool"* and which possibly placed Kathryn's husband into a 'hero' role in her narrative from that point on. It also seems that it was at this point Kathryn started to give herself permission to seek motherhood.

Discovering that they had fertility issues was the next part of Kathryn's story. After trying for six months with no success, Kathryn and her husband sought medical advice. One of the key narratives that emerges around this stage of Kathryn's story is one of a need to 'perform well', with Kathryn stating that she was doing everything right in order to get pregnant: *"you know, I was trying to work out when I was ovulating, and you know trying to have sex at the right time and those sorts of things"*. Whilst the idea of achievement had been apparent in Kathryn's career, it emerges here also with Kathryn feeling a need to achieve the goal of motherhood along with a sense of blame for a lack of success in conceiving *"did I wait too long? Am I too old? You know, is it my fault for waiting? Should we have tried earlier? If only we'd found out earlier we wouldn't be having this problem"*. By not achieving her 'performance target' of a successful pregnancy, Kathryn seemed to judge that she was failing, *"the idea that I should be failing at something that appeared to be so easy was just really... terrible"*.

For Kathryn, there was also a sense of shame in that she was failing as a woman in the most fundamental role of all: *"what use am I as a woman, I can't even have a baby, um, that's what I'm supposed to be... that's what women are supposed to be for."* A sense of embarrassment also seems intrinsically linked with Kathryn's achievement focus: *"I found it really personally embarrassing the*

idea that I was this person having fertility problems. I never imagined I would be that person”.

The experience of working when having IVF treatment

There were a number of critical narrative events that occurred for Kathryn and her husband prior to engaging in the IVF treatment. Following blood and sperm tests (“*everything was normal*”) with their GP, they were referred to a fertility clinic. Once within that system, Kathryn and her husband again went through a range of tests, including a hysterosalpingogram which Kathryn was told “*sometimes blows out the cobwebs a bit and some women find they get pregnant after that*”. A pregnancy ensued but it was an undetected ectopic pregnancy, which was described to Kathryn as “*just a random occurrence*”. However, the next time they tried to conceive, the same thing happened thus making Kathryn an “*ideal candidate for IVF because when the originally developed it, it was really good for people with tubal problems*”.

It was at this time that Kathryn’s quest for motherhood started becoming somewhat public in her workplace. The first pregnancy was originally thought to be a miscarriage and so Kathryn had let her boss know this. When it became apparent that it was an ectopic pregnancy she told her boss and one other close friend at work. Kathryn seemed to prefer to keep this event as private as possible, “*so when I came back to work sort of... people didn’t really know why I’d been away*” stating “*at the time it was really awful*” which may suggest that maintaining a level of privacy was her way of containing her grief. However, over the course of the two ectopic pregnancies Kathryn had a considerable amount of time off work, which prompted her to tell her colleagues what had been happening. She notes: “*interestingly enough once I had the second ectopic and was off for another whole bunch of time I starting telling people, they were like... we thought you had tapanui flu or something... people thought I was having some kind of nervous wobbly*”.

Kathryn described this as a very difficult thing to share with people “*I think that is a really difficult thing because you... you either have to come out and tell everyone the contents of... um, the really close thing... the thing that’s really personal to you and the fact that you’ve... and I see it this way... just failed to be pregnant, you know just failed in a major way... um, on top of failing to get pregnant in the first place then you manage to get pregnant and then you failed*

at that... um... so it's really hard to talk about but then again, you don't want people thinking you're a flake or that something... you know... I mean people must talk and people must wonder, I think especially if you're married and you're in your 30s and people must wonder what's going on". Listening to Kathryn's concern regarding the judgements that others may make of her, there seems to be a link between her desire to perform well, or rather not to fail, and how she feels others perceive her. It would also seem that Kathryn's desire to achieve translated into a quality of persistence in that *"the more I failed the more determined I was to succeed"*.

The sense of failing that Kathryn describes regarding the increasingly public nature of her ectopic pregnancies may have prompted Kathryn to closely guard her privacy around her subsequent IVF treatment. It was at this point in her story that Kathryn talked about being deliberately vague with her colleagues about any future attempts to become a mother *"because everyone kept saying to me, oh what's gonna happen now... after I had the second ectopic... I sort of said, oh, they think we might have to have IVF and you know... but I didn't sort of say when... I kept saying to people, oh they say... because the waiting list is 18 months long... saying it could be a long time, you know... we are just going to wait and see, so that people weren't asking all the time"*.

There would appear to be a number of reasons for Kathryn's desire to maintain her privacy at this time in her life. One of the primary reasons in Kathryn's story is the wish not to have to tell people she had failed: *"I just couldn't bear the idea of making it an issue and then having to tell people I failed"*. When asked about what drove her desire to keep the IVF treatment private, Kathryn replied *"I think it is about this sense of failure... I think that I really did begin to feel like... um... there was something wrong with me and that I was failing"*. This may also be linked to a perceived need to achieve, in that if Kathryn did not tell people then they couldn't judge her as failing.

Kathryn's focus on performance at work may also reflect a striving to be a 'good employee', an employee who successfully kept her personal and private life separate, without allowing one to impinge upon the other, *"I don't like emotional, personal stuff to get in the way of my work"*. Kathryn seemed to define her success as an employee around her ability to not let her personal circumstances get in the way of her performance: *"I couldn't really use that as*

an excuse for lowering my performance at work, basically I had to maintain my performance at work exactly as it was if I wasn't going through the IVF".

Another important concept that seems to dovetail with the performance and persistence narrative that Kathryn shares is that of control. Kathryn reflects on feeling out of control in her life just prior to starting the IVF treatment *"I actually had a complete meltdown just before I started the injections... cos I felt like I'd lost control of things"* perhaps indicating that she felt the IVF treatment was an experience she had little control over: *"you just can't make any plans and that's really hard from a personal point of view and it's really hard from a career point of view"*.

To counter this, Kathryn seemed to take control in her life where she could, by ensuring that she had *"a B plan"*. This took the form of Kathryn maintaining a sense of control in her work *"I had to go on being good at my job because it might not work and so you weren't able to just put all that aside, you had to think, I've got to keep as much of my life together as I can"* because for Kathryn, if the IVF treatment did not work, she recognised that she needed to have an alternative life plan. Kathryn's desire to keep control of her life also extended to the IVF treatment as much as possible in that Kathryn tried to keep her life going as normal around the treatment, *"we made a plan that on the day that we found out about the blood test that we'd go out for dinner regardless"*.

This also seems to link with Kathryn's sense of identity. Being focused on performance and achievement in her career, it would seem that Kathryn kept that focus in order to maintain her career identity over the course of IVF treatment: *"yeah, I'm proud of what I do, I'm good at what I do, I wanted to go on being good at what I do... I didn't want the experience of having the IVF and going through all of that and the waiting and everything to change me fundamentally, because I knew that if it didn't work I still had to come out the other end and still be me"*.

For Kathryn there were also concerns for her around how she would be treated on a day to day basis if people knew she was undertaking IVF treatment, *"I didn't want to open up that can of worms"*. Kathryn did not want people to *"to judge... or make concessions"* for her, perhaps thereby allowing her focus to remain on performance at work. Whilst Kathryn considers that her workplace would have been supportive, she also had fears that if her boss knew she was

having IVF treatment it could affect her future prospects *“I didn’t want her thinking oh you know, Kathryn’s going to be off here and she’s going to be off there and this might happen... I mean it was bad enough her knowing that I was going to try it at some point and that I might be unwell but I didn’t want her... because like I said, because we were in a work environment where people are thinking ahead a lot and planning ahead I didn’t want her thinking oh, I don’t know if Kathryn is going to be there then or is Kathryn going to be on full form then... I didn’t want her worrying about those things.”*

However, having allowed herself the permission to try for a baby seemed to create an alternative perspective for Kathryn. In her decision to seek motherhood she seemed to allow herself to accept that she would let her career go *“but I guess there just became a point where it became more important for us to have kids than for me to have... well, to have that kind of career”*. As part of the permission aspect of Kathryn’s story, becoming a mother started to seem like an escape route out of work *“if only I could have a baby I wouldn’t have to put up with this shit anymore”*, so it would seem that in some way Kathryn was reframing her career identity to that of potential mother. Furthermore, by focussing her persistence and performance onto achieving motherhood, Kathryn seems to feel that this helped her accept the end of her career: *“the more trouble I had, the more I wanted it and the more sure I was that I wanted it and that kind of helped... I guess, tip me more into coming to terms with the fact that I was going to stop working”*.

The end or new beginnings

Now that Kathryn is a mother and has let her career, in its previous form, go, her perspective has continued to alter. She feels that *“having a child has broadened my interest areas and things... it has made me... yeah, a different person”*. Kathryn notes *“when I left work I was utterly convinced that I would be back but almost as soon as I had him I knew that I couldn’t go back”*. With this shift in perspective has come an acceptance of a different type of career in the future. Kathryn seems to have given herself permission to not be totally focused on career achievement and performance but to allow herself to combine motherhood and career in the future, *“in some other ways it’s set me free... um, how I see the future is actually to stay... to not actually ever go back*

into the office... to stay as a freelancer... and to do my own thing so even when he's at school I can use that time to do my own thing".

For Kathryn too, successfully having a child has been *"a real validation that in fact, I am a functional woman"* which she describes as being *"really, really important"*. Thus for Kathryn it would seem that the success of achieving a child has allowed her to meet her performance expectations through a different perspective. Where once, Kathryn might have judged herself based on her performance in her career, she has now given herself permission to judge herself against a different set of criteria and in that way finds success and achievement in her life *"he is my life's work, you know... no one else can bring him up like I can, you know other people can do my job... I'm the only person that can be his mother"*.

As a consistently high achiever and someone who for many years found the ultimate satisfaction in a career she loved, Kathryn now seems to look upon motherhood as the ultimate achievement *"looking back now I wouldn't... it was nothing, nothing... compared to having this little boy, it was nothing... nothing, I would have gone through anything for this, anything at all."* Her sense of pride and achievement is profoundly reflected in the summation of her son's birth *"I had this amazing, fantastic, natural delivery... it was one of the most amazing days of my life actually and I did it"*.

Case study 2: Renee's story

Vulnerability and protection: from being alone to sharing.

Renee is in her mid 40s, married with one child who was conceived through IVF treatment. Renee's experience of fertility treatment commenced with four cycles of intrauterine insemination (IUI) and culminated in one successful round of IVF. Renee is currently expecting her second child, who was conceived naturally.

The beginning

For Renee, her experience of combining IVF treatment and working seems to have had its beginnings 11 years ago when she started in her current company. Renee describes her company as relatively small and having started in an assistant role, she worked her way up to a more senior position a few years

ago. In talking about her role and the company she is in, Renee seems to appreciate some of the benefits that the role offers her *“I guess we’re quite lucky, in that we work what I would call regular hours overall and we don’t have major stress”*. However, she also highlights less positive aspects of her current company citing the example of a colleague treated poorly once the company had learned she was pregnant, *“I had seen it happen at work, where a former colleague when she got pregnant really sort of experienced quite a nasty reaction from our employer... and they basically tried to find some sort of way to get rid of her”*. It would seem that Renee identified with this event, so much so that she anticipated a similar negative response from her employer even at the point of trying to conceive, *“I was also I guess, quite concerned that my employer upon seeing that I was trying to conceive might try and maybe find some reason to show me the door”*. The response that Renee had observed from her employer towards her colleague seemed to have made an indelible impression on her as she went on to note, *“I guess, always at the back of my mind was... will they want to keep me on if... if I get pregnant”*.

When Renee and her husband decided to start a family, it would seem that Renee anticipated that her journey to motherhood would not be straightforward. This was possibly a self-protective measure should things not go according to plan, as Renee highlights that she was aware of two potential problems with respect to her and her husband’s ability to conceive. The first was one that potentially resided with her husband: *“my husband suspected that there might be an issue with him because he’s been receiving medical treatment for many years and one of the side effects is male infertility, so we knew that there was this possibility”*. The second potential problem was Renee’s age: *“added to that was my age, I was in my late 30s at the time so... we knew that both of them, would obviously make things difficult”*.

By anticipating potential issues, Renee seemed to be giving herself the opportunity to process and come to terms with any problems that might arise, thereby perhaps doing what she could to protect her vulnerability. One of the ways in which Renee seemed to approach this was to be pro-active, for example by the time Renee and her husband went to the fertility clinic they had already started exploring adoption. For Renee the discovery (or confirmation) that her husband *“had pretty much absolute male infertility”* and that they would

require donated sperm for fertility treatment, was perhaps less concerning than it may have been because of the work she had already done in coming to terms with potential issues: *“to me the issue that any child who would result from fertility treatment might not be genetically related to my husband, it wasn’t really an issue”*. Renee appeared to be actively engaged in working through any problems in order to look after herself at a potentially vulnerable time.

The experience of working when having IVF treatment

When Renee and her husband started trying for a baby, her previous observations of what had happened to her colleague in the company may have contributed to her desire to keep her infertility and subsequent treatments private. Renee seemed to have developed a level of anxiety and fear around the possible workplace response, and there is a sense of loneliness that Renee describes as ever present at this point in her narrative: *“it’s a very lonely process and certainly at work... it was just something I didn’t feel that I could just um... sort of talk about”*.

As mentioned earlier, being fearful of her future work prospects certainly appears to be one reason for Renee’s desire to maintain her privacy when she embarked upon IVF treatment: *“I certainly didn’t really feel I could really share... share it with anybody at work because... employers don’t really want to have pregnant women in their workforce”*. Being concerned about potentially losing her job should her employer find out she was trying for a baby may have also been compounded by Renee’s financial concerns regarding paying for IVF treatment. Having had four cycles of IUI, Renee was aware that they *“only had one cycle left on public subsidy to try IVF”*, commenting also that *“we knew it was our last chance”*. Renee notes that after this any subsequent IVF rounds would cost her and her husband approximately \$10,000 a time, which Renee observed was *“an additional burden”*. The financial burden that Renee felt could potentially arise with regard to pursuing further IVF treatment could have added to her fears for the ongoing security of her employment.

However, she also notes that there was another reason for maintaining privacy: *“it’s extremely private and you feel like... well... especially very often you... in a way you’re expecting failure and you don’t really want to have to talk about it afterwards so I guess it’s... in a way, sort of protecting yourself from the emotional load of having to share this information with people at work”*. In this

regard, Renee seems to have been seeking to protect herself from failure – both as perceived by herself and by others. She notes that at times “*some people feel... you know, like a failure*” adding that “*you are also very wary of... in a way, making yourself vulnerable*” and that “*sometimes sharing this sort of information can really be quite painful*”. For Renee, the metaphorical image of building a wall around herself seemed to sum up how she protected herself but perhaps also isolated herself, “*in a way you build a little bit of a wall around you just to make sure that um, if it fails then nobody knows and you can sort of keep going*”.

Interestingly, Renee still looks upon her experience of IVF treatment as being quite fortunate as she “*responded quite well to the treatment, in that I didn't have any sort of bad reaction... I was pretty much normal, not too emotional or anything*”. From that perspective, Renee perhaps indicates that she managed the combination of IVF treatment and working quite well, also suggesting that she feels lucky that she did not have the emotional responses she had seen in other friends which might have necessitated telling her employer.

The concept of being fortunate was also apparent in other areas of Renee's narrative such as the minimal time period she and her husband had to wait for funded treatment: “*we were quite fortunate, we didn't have to wait, what I would call excessively*” through to the success of the first round of treatment “*we felt quite lucky compared to others*”, “*we were very lucky in that we really only did one treatment and it worked*”. By reframing her experience from a perspective of being fortunate, Renee seems to have found a way to reflect on the experience from a positive point of view.

However, Renee does still note that it was a very difficult time: “*it was still very, very hard... it was combining really the privacy of not really wanting to reveal what we were going through with also the impact on work which was that I might have to be late some mornings and I might have to be away to do some scans and that...*” Feeling that she couldn't tell her employer seemed to perhaps compound what was already a very stressful time for Renee. Quite often Renee seemed to feel that she had to make excuses as to why she wouldn't be at work stating that she would “*have to try and... find some sort of lie for work as to why I suddenly had to take off the following day*”, “*I really sort of, really felt... quite sort of... um, my back against the wall at time sort of*

thinking, oh how am I going to find some valuable excuse as to why I have to take time off tomorrow?"

Not only did Renee feel she had to make excuses for absences, there was also a physical component, a sense that Renee felt she had to hide in order to protect herself from questions: *"you have your arms all bruised and you feel, well I really have to cover it, but it's summer and you're hot and people at work are sort of saying why are you wearing a long sleeved top?"* Despite Renee seeming to feel the need to hide herself, she goes on to minimise this experience, making light of it perhaps in order to once again protect her vulnerability: *"needle marks everywhere in your arms and people are going to be asking questions, so it's all these little silly things".*

In the story of Renee's journey through IVF a sense of loneliness and vulnerability pervades and it would seem that at times she expressed that it was also a journey which her husband couldn't fully comprehend: *"I guess, men and women just process things emotionally... sort of differently at times and so... although obviously I could talk with my husband there were times when I just had to um... sort of basically work things out on my own".*

However, in Renee's story the sense of loneliness lightens in her sharing her experience with friends. Whilst her experience of combining work and IVF treatment appeared to be very privately undertaken, Renee found support and comfort from friends who were also going through the same experience: *"I mean I've found with some of my friends... I mean I guess we were sort of quite good friends, but in a way it brought us together".* In addition, Renee was also able to access Internet forums where she could also receive emotional support from other women going through the same experiences. From Renee's perspective, it would seem that she felt only those having a similar experience would truly understand what she was going through: *"it's quite difficult for women who don't really know what fertility problems are about to really be understanding".* Being selective in the support she sought also extended to Renee's family, noting that she did not tell her parents *"because I knew that my parents were quite anxious to have grandchildren and I didn't want to create hopes for them when I knew that the likelihood of it succeeding was actually quite low".* Thus it would seem that Renee was again protecting herself by

protecting her parents so that she wouldn't then have to deal with their disappointment should she not be successful.

For Renee, having *"a few friends around me going through the same experience at the same time"* seemed to be an effective coping strategy. She notes that *"once women start sharing it, it really brings people together"*. Renee also added that by having developed her support network of friends who were also going through IVF treatment she found that *"it can be really helpful"*.

The end or new beginnings

When Renee went on maternity leave to have her child she notes that her employers did not expect her to return to work at all: *"I know that my employer's attitude was that I wasn't going to come back to work... they truly assumed that I was not coming back and they... it affected what they did in terms of hiring someone to cover for my position"*. Whilst Renee does not feel that IVF treatment in anyway impacted upon her career, she does note that had her and her husband had to go through fertility treatment again she may have had to increase the hormone levels she took and she was worried that *"maybe increasing the levels, I would get seriously cranky and unpleasant and that would impact on the home life... and work"*.

Having had a successful experience of IVF treatment may have helped Renee be more open about her experiences: *"if people ask, I'm quite open because I think, I guess since then I feel quite strongly that we need to be more open about IVF and fertility treatment in general"*. Renee also observes that *"now with hindsight and seeing how... how common infertility issues are, I think that we need to be able to be open about it and we need to be able to talk to our employers and say this is what I'm going through"*. However in her own work environment she hasn't really discussed it with anyone: *"I haven't really talked about it at work, I guess I'm not especially close to anybody at work"*. It would seem that Renee had perhaps out of necessity, determined which environments were safe for her to disclose her IVF story in and it is in those environments that Renee was able to bring down some of her walls of self protection and to allow her vulnerability to show. By sharing with trusted friends who could truly understand in light of their own experiences, Renee seemed to have found a way through her isolation and loneliness: *"I think just being able to share it with some close friends is really important"*.

Although Renee was still working at the time of this interview, she was due to go on maternity leave for the birth of her second child. Her plans were to return to work following her maternity leave.

Case study 3: Alice's story

Tenacity and humour in the face of the ultimate quest.

Alice is in her mid 40s with one child who was conceived after multiple fertility treatments. Following the stillbirth of her second child earlier this year, her and her partner are currently expecting their third child through surrogacy.

The beginning

Although Alice had been working in a successful career for a number of years, motherhood had always been part of her life plan. When asked about her career she notes that it was never the main thing for her, *“my career was never the mainstay of my identity. It certainly was one of several major contributors but mainstay is overstating it”* going on to say *“it was just that I didn't meet the person that I wanted to have children with until that point in time”*.

Thus the beginning of Alice's story takes place in the UK where Alice first met her partner. At the time she was 38 years old and in her words, *“already conscious by that stage that I was getting on in fertility years”*. Having always planned on motherhood, it would seem that Alice had developed a self-awareness and insight regarding her age and declining fertility. It was perhaps this self-awareness that prompted Alice to be pro-active regarding her fertility and to seek professional advice after six months of trying to conceive.

For Alice, her initial experience of meeting with a fertility specialist was less than satisfactory: *“I had at the time what I thought was an unpleasant experience because I didn't feel that she explained to me what she was going to do or next steps properly... um, she did an ultrasound, said all looks okay to me. That was all she did”*. Alice remained disquieted, perhaps driven by this sense of self-awareness that seems to be part of her story, and as a result sought referral elsewhere. The sense of the tenacity that Alice goes on to display throughout her story also starts to emerge at this point.

The next step in Alice's story was the recommendation by the second fertility clinic that Alice have a hysterosalpingogram. It was at this point that Alice and

her partner began discussing a return to New Zealand as the cost of private treatment in the UK was very high.

It almost seems that Alice was in some way mindful of the road that might be ahead in her quest for motherhood. Whilst the cost of treatment was a consideration for Alice and her partner in returning to New Zealand, there was also an awareness that Alice could perhaps get better support and be more at ease undertaking this journey in New Zealand: *“at that point I said to my partner, you know, my sister’s a health professional back home in New Zealand, I would feel more comfortable if we’re going to embark on this, to move back to New Zealand and have some family support and someone at least with some medical expertise. I knew that she had friends with experience in the fertility treatment field and I thought, good, let me go where I feel comfortable”*. It would also seem that Alice’s early experiences in the UK may have altered her perception and expectations of the level of care and attention she might get there thus compelling her and her partner to move to New Zealand.

Moving back to New Zealand was quickly followed by an appointment with another fertility clinic specialist. It would appear that in spite of Alice’s insight into her own body’s reproductive ability, the medical profession was still responding differently with the specialist in New Zealand perhaps intimating that they were *“worrying prematurely”* by telling them *“50% of people that see me on their first appointment never see me again”* also saying *“go away, wait a couple of months, if nothing’s happened come back again”*. At this point in her story, Alice talks about her experiences in a way that makes light of this part of her journey, perhaps using humour as a coping strategy. It would seem that she is adept at using laughter and lightness as a way to positively reflect on this part of her story: *“I laugh at that now...”, “I know I laugh now, it wasn’t funny at the time”*. However, Alice also notes that her use of humour *“belies the mental and physical health toll that this journey has had on me”* and she fears that *“some of it will never go away”*.

Nevertheless, Alice also maintained an awareness of the impact of her age on her fertility, having been told in the UK, *“you’re never going to be more fertile than you are today”*. For Alice this translated into a sense of frustration at the slowness of the process: *“I was already rather frustrated with the fertility clinic at*

this stage, because I felt that I hadn't been given all of the information up front... and I, at my age had rather hoped that, because I was 40 by the time... time just kept slipping by".

Upon returning to New Zealand, Alice looked for work in her industry. Having had a successful, quite senior and perhaps stressful position in the UK, Alice was mindful that she did not want the same in New Zealand, *"I got a job in New Zealand that wasn't particularly stressful intentionally because I knew that I would have to take time off, I didn't want to have to travel, I wanted to be able to come and go as I chose, I wanted to be able to go home at 5.30"*. Alice seems to have made a conscious decision at this point to shift the balance in her life between her career and desire for motherhood. Interestingly, whilst it was a decision she actively made, she also notes that *"I did feel... especially since my husband and my careers were doing this [one arm up, one arm down] and so suddenly it wasn't me earning double what he earned, it was him starting to earn a lot more than what I earned... so it was all... you know, it was very different for me.... Not that I'm particularly career focussed but I... that's all I knew"*. This would perhaps indicate that Alice was conscious of a shift that was occurring in her sense of identity.

The experience of working when having IVF treatment

As mentioned above, Alice was very deliberate in selecting a role that gave her the freedom to more or less come and go as she needed in order to pursue her motherhood ambition. Therefore when it came to fertility treatment, Alice initially found the process of combining it and working to be relatively straightforward from a practical perspective *"the Clomiphene and the IUI was relatively simple. I would ring and I would say I want my scans and my appointments at 8 o'clock in the morning... and then I would drive straight to work so I would either arrive on time or I'd be a little bit late"*. Six rounds of IUI, three months of Clomiphene, and a laparoscopy later, Alice observes that she was able to successfully keep this part of her fertility journey out of her working life: *"so I don't think I told my boss during the IUI and the Clomiphene that's what I was doing. I think even when I had the laparoscopy and I had to be off work for 2 days I just said I have to have an operation"*. Reflecting on the number of procedures that Alice went through prior to commencing IVF the theme of tenacity that Alice demonstrates in her story is again apparent.

Alice states that she was purposeful in keeping her fertility treatment private at this stage for two reasons. Firstly, she indicates that she did not think “he [her boss] *would understand. His wife was pregnant... he announced it was a mistake so clearly didn't understand at all... he didn't understand that that might not be sort of, appropriate wording*”. Secondly Alice was initially employed in a freelance capacity and was hoping to have the role made permanent as well so as to be eligible in the future for maternity leave, indicating that she was “*worried about the longevity of the job*”.

There seems to have also been a financial consideration to Alice's desire for the role to become permanent as she notes that “*working has paid for all of this, all our money... it all went into fertility treatment*”. Whilst Alice considers they may have continued with their IVF journey regardless, she points out that by earning her own income she felt “*comfortable spending the money on fertility treatment*”. It seems that by continuing working Alice felt able to give herself permission to also continue her quest for motherhood.

Following the unsuccessful rounds of IUI and Clomiphene, Alice and her partner embarked on IVF treatment. Over the next few years, Alice had seven rounds of IVF treatment in New Zealand displaying ever increasing determination in the face of consistent failure: “*felt like I was going above and beyond at this point, but it was nothing on what was yet to come*”.

At some point during their early rounds of IVF treatment, Alice chose to disclose to her employer what was happening. Alice described the prior fertility treatments as quite manageable in terms of time off from work in order to make appointments and scans. However, perhaps because Alice was now needing to take more time off for the more involved process of IVF treatment she felt she needed to let her boss know: “*I wanted to be able to go out for these appointments and not feel that I had to make up lies, that I was going to the dentist or you know, where I was going*”. Choosing to disclose her treatment may also have given Alice a sense of control over a situation in which she felt a degree of disempowerment: “*I mean there was a trip to Australia, at the time I was doing one round of IUI I think and I said to him... I think, I did say I can't go on that trip because I'll be in the middle of a round of treatment*”.

The decision to bring her IVF treatment into the public domain at work did mean that Alice then had to contend with, at times, the unwanted opinions and advice

from others. For example, she relates her employer's response to her news of IVF treatment: *"he said, why don't you adopt?"* Alice describes this as quite a difficult situation to deal with, almost sounding frustrated when she replies *"yeah, we're doing that in parallel as well but it's not that easy... (thinking to herself, 'you idiot')"*. Whilst Alice injects humour when describing her experiences of making her IVF treatment public: *"then you're having to do fertility treatment 101 with the receptionist", "and everyone's saying, I knew someone... I knew someone that put their legs in the air or I knew someone that ate parsley"* there is also a real sense of frustration and pain she felt in having to listen or respond to these opinions, *"I'm thinking you don't know who you're talking to quite frankly... you can't tell me anything I don't know"*. Again, it seems that Alice has found a way to cope with the pain of her journey in using humour to lighten events.

In addition, it would seem Alice worked hard to ensure that her IVF treatment did not impact upon her work in anyway. She recalls a particular occasion when she had received a negative result, *"after one failed round I had to go to a course the next day and I had to sit there at the course, really upset but I thought if I rang him [her boss] and said that I can't go to this course that cost him a lot of money to send me on, he was on it as well, he wouldn't understand"*. Alice was determined not to let what she was going through interfere with her life, seeming to be concerned that it might in some way reflect poorly on her: *"again it would be an example of me performing sub par because I'd be saying... well because of this fertility treatment I can't do this properly, I can't do the job properly"*.

The sense that Alice was determined to complete her quest for motherhood becomes ever more present as her story progresses. The seventh round of IVF was undertaken with donated eggs, which in itself had been a long and arduous process for Alice and her partner to get to: *"so bear in mind the ads went in January and it's now October"*. That round was also unsuccessful and the remaining embryos did not survive thawing for another round. However, Alice's determination to succeed saw her and her partner start looking for an egg donor in the United States. It would seem that Alice had become completely focused on achieving her ambition: *"I said... I'm not giving up on this now"*. This focus and determination also served another purpose, to help Alice cope: *"helping me*

cope with the failure was having something else to get on with and a light at the end of the tunnel”.

In terms of her work at this point in the story, Alice notes that she did feel that to tell her colleagues the full extent of the treatment she was undertaking was perhaps too much, *“I did not want to tell anybody about the egg donation, that was a step too far, that was really private for me and so then I’m compounding a lie with this lie and that lie and I’m having to remember what I’ve said... and why are you going to America... oh well they do things differently”.* Whilst finding the lying stressful, *“I’m trying to think of something that’s kind of honest but you know... so that became stressful as well”*, Alice does observe that *“actually in hindsight, I found it less stressful when people didn’t know because then I didn’t have to... as I said do fertility 101”.*

Alice continued to downscale her career perhaps in order to meet the increasing demands of the IVF treatments she was undertaking. She notes that she *“decided I was going to step it down another gear again and I went to a new job where I told them right from the out, I’m having fertility treatment, I need to take time off and come and go as I please basically”.* It would seem that in her determination to achieve motherhood, Alice was once more trading down what may have been an important contributor to her sense of identity until this point, her career.

In the course of Alice’s story, she has displayed a high level of self-awareness, pre-empting the judgements she seems worried that others might bestow on her by jokingly giving them to herself: *“I was that mental on it”, “I think they thought I was mad, I think they thought I was a bit mental really”, “I know what you’re thinking Serena, she’s mental”.* Whilst Alice mentioned these thoughts in a joking manner, it would seem that in some way she has perhaps asked that question of herself during her IVF journey and again perhaps found humour to be a valuable coping strategy at such times.

The end or new beginnings

Alice’s story did not end with her successful pregnancy. Her tenacity and will to achieve motherhood prompted her to try a further round of IVF following the birth of her first child. Returning to the United States, Alice became pregnant with another child from the same egg donor. However, Alice’s baby had a growth restriction that in turn led to pre-eclampsia and subsequently HELLP

syndrome for Alice, putting her own life in danger. As a result Alice's second child was stillborn at 25 weeks. Because there was up to a 50% likelihood of the HELLP syndrome reoccurring, Alice and her partner elected to use the remaining embryos they had in the United States with a surrogacy. At this point in Alice's story, there was no humour, rather it was a very sad part of our interview process and for Alice quite emotional in the retelling. However, Alice once again was able to focus on the goal ahead, thereby perhaps finding a way of coping through the loss of her second child.

As Alice awaits the birth of her third child she is asking herself what next with regard to her career. Her previous industry is by her own observation *"reasonably ageist... and it's not a 9 – 5 industry"*, which leaves Alice pondering how she might have a career moving forward *"I've started to think about what are some other things that I can do"*.

Alice had worked for a considerable length of time prior to becoming a mother, *"I worked fulltime until the age of 45. It's a long time working, and I tried to explain this to my husband, it's not that I got pregnant when I was 25, that's what I've done my whole life, earning a reasonable income... and now I go to coffee groups, talk crap about... I don't know... potty training, whatever"* and so for her this would seem to be a time of reflection and renegotiation as she tries to work out her next steps.

She also observes *"you see what's different now is the baby is not inside of me, so I could go back to work and get some contract jobs to help pay for all of this"* but is keenly aware that her career as it once was is not necessarily available to her now her life has changed *"the sort of job that I would get for two days a week would be very different from my old job and therefore I kind of need to examine the reasons as to why I wanted to go to work, because it wouldn't be about career so would it just be to give me a break from being a mother or to help supplement the family's income or to give me something else to talk about and do, rather than all things motherly"*. In some ways, Alice seems to be accepting of this noting *"if I was 10 years younger, I probably would be more interested in going back to work"*.

After all that Alice has been through in her quest for motherhood, it would seem that she is now able to redefine her identity, with or without a career, having finally achieved her ultimate quest.

Case study 4: Gabrielle's story

Determined to live up to her life's plan: in the words of her father, "*Gabrielle loves children, let me make that clear, she loves children*".

Gabrielle and her husband have been married for three years. Shortly after they were married Gabrielle learned that she had severe endometriosis and IVF treatment was the most recommended course of action should she and her husband want to conceive. They conceived their first child after one round of IVF when Gabrielle was 38 years old.

The beginning

The impression that Gabrielle gives is that she had always believed she would be a mother. Nevertheless, her story commences with a lengthy discussion about her prior career. Gabrielle had started her working life in a traditionally female dominated industry noting that her youthful fear of going to university had perhaps meant she had missed out on other options, "*had someone actually said to me, 'why don't you want to go to university?' I would have said because it's a big dark hole in the city that I've never really been to and I'm scared*" had perhaps meant she had missed out on other options. However, with maturity Gabrielle came to realise that the work she was engaged in was not what she wanted to do. It was with this fact in mind that Gabrielle went to university to retrain in her current profession. She makes an interesting observation at this point: "*I just thought, one of the many reasons that I changed career... this is about careers, is because I was single and I could. If I had been married, I wouldn't have, it was so expensive and it was so time consuming and stressful and all the long hours and everything about it, there's no way I could have been in a relationship... well, not a relationship, in a married relationship, where you have so many more dynamics going on and potentially a young family, there's no way I could have done it... so I guess in some ways I was a little bit lucky that I could change my career*". Following her studies, Gabrielle found work in a small company in her new profession and had been employed there for three years before she and her husband started to discover their fertility issues. Gabrielle also points out, "*as much as I pursued a career, I've never been a career person*" perhaps indicating that although the

idea of a career had been important to her at that stage in her life, she remained aware that it was not *the* most important thing.

As noted earlier, motherhood was an integral part of the future Gabrielle envisioned with her husband: *"I think always... well, you set out... your intention is to have children when you start trying, I guess. Or get married... my intention was to have a family, for both my husband and I"*. Indeed, it would seem that Gabrielle's desire was well known by those around her, *"even when we got married, I can remember my dad in his speech, one of the things he said was, 'Gabrielle loves children, let me make that clear, she loves children' and everything about our wedding was... there were children everywhere, there were pregnant women everywhere, everybody made comments about children and our children that we would have and my um... my bridesmaid, her speech was about children, to all of it, the whole speech"*.

For Gabrielle, once she and her husband were married the natural next step was for them to start trying for a family, *"we actually weren't going to try until more than a year but then I sort of said... I literally convinced my husband that there's no point in waiting"*. Gabrielle was mindful that her age might be a problem with respect to her fertility but felt that it was something that her husband was less aware of, *"he didn't understand that there might be trouble getting pregnant at my age, that the average time is a year"*. Because Gabrielle was 38 by the time she and her husband started trying to conceive, she was pro-active in seeking help after only a short period of time: *"we had been trying to get pregnant, not for very long actually and because I'm... at the time I was 38 and I thought I don't want to muck around"*.

Following a laparoscopy Gabrielle received the news that she had severe endometriosis. This was, in her words, *"totally not in my realm of thinking, I didn't think there would be anything wrong with me"*. The news that she would not be able to get pregnant as a result of her endometriosis was perhaps even more upsetting, and in telling this part of her story, Gabrielle becomes quite emotional *"oh my goodness, I can't have children... which was awful...um [Gabrielle was quite teary at this point]"*. As a result of Gabrielle's diagnosis she was advised that IVF treatment was recommended as the best course of action, and she was further advised to *"just go privately, just get on with it, don't muck*

around". Receiving this kind of advice may have prompted Gabrielle to feel even more keenly the potential loss of motherhood that she was facing.

The prospect of motherhood seemed to feature quite strongly in Gabrielle's sense of identity, perhaps so much so that to hear this news made her question what value she could offer the world without achieving that role: *"you're told you can't have children, well what else are we here for at the end of the day"*. In many ways it would appear that Gabrielle's view of the world was a relatively traditional one, even seeming to question the point of marriage if it did not result in children. When she talks about her bridesmaid's speech being all about children she goes on to say, *"and then you get told you can't have them... what was the point of all that?"*. The effect on Gabrielle seemed to be profound. She notes that there were times she would even say to her husband *"just go and marry another woman who'll give you children in a flash"* perhaps indicating that Gabrielle felt a real sense of incompleteness as a woman if unable to produce children.

However, Gabrielle was clearly determined to be a mother, *"yet I still was determined to be a mum and I just had to cling to the fact that I knew I was going to be a mum"*. The image of Gabrielle clinging to this conviction is rather poignant as it seems to speak of both her sense of determination and perhaps desperation: *"you know in your heart that nothing's going to stop you and you'll do whatever it takes"*. This determination may have also been a way for Gabrielle to cope with the grief she seemed to be going through, *"I mean, I'd stand in the shower bawling my eyes out, thinking all sorts of crazy things and then just say, well there's nothing you can do... and you know you're going to be a mum so... power on through"*.

The experience of working when having IVF treatment

Gabrielle was very quick to begin her IVF journey following her diagnosis. Even before she had fully recovered from the surgery she was actively seeking professional advice: *"trying to recover from surgery... and um... so I just got on the phone and rang around"*. This was possibly in response to the advice she had been given upon receiving her diagnosis. Gabrielle notes, *"in our journey, some things were so fast, I was genuinely surprised"* commenting *"I don't know if that's good or bad, maybe that's good because you don't get time to think about it"*. From deciding to investigate her fertility through to having a

successful pregnancy, this journey took less than one year. It may be that the speed of the process helped Gabrielle feel she was pro-actively addressing her problem but it also seems to have contributed to a sense of disempowerment which emerges at this point in her story: *“it felt like, um.. what do you call it... like a puppet, a puppet on a string... I had all these things going on”*.

For Gabrielle there was never any thought that she might share her infertility issues with her employer. When asked why she had felt she wanted to keep this information private, she responds: *“I think definitely a major reason was knowing that my boss wasn’t able to have children and was really bitter about it”*. Gabrielle relates that she was pleased to have made this decision because *“with other people at my work... with that kind of whole children thing, he [her boss] just didn’t cope well... at all”*.

Keeping her IVF treatment private was also important to Gabrielle in order to protect her career because she knew that if she did not get pregnant she would have to keep working, *“I suppose if I’d never got pregnant, I’d still be working, still be trudging along doing my career thing”*. Gabrielle was particularly concerned that if her boss knew she was trying to conceive he *“would have written me off straight away”*. From that perspective it was prudent for Gabrielle to maintain her privacy possibly in order to stabilise her sense of job security, *“easier for him to think that I wasn’t thinking about getting pregnant or that it was something that was going on in my private life... that I was there to work and I was doing a good job and I wasn’t having anything else effecting me doing a good job... um... and that he couldn’t write me off, I guess”*.

When the time came for Gabrielle and her husband to commence IVF treatment it was conducted as best as possible outside of working hours. For Gabrielle, this even meant travelling an hour across town to go to a clinic that opened earlier in the morning as well as trying to ensure that *“my appointments, I just tried to make them outside work hours”*. Gabrielle was determined to keep her IVF experience separate from her working life: *“I would just say I’m booked for surgery and I need an operation and this is when it is... kinda thing... or I just told... I just lied to him and said I’ve got a follow up appointment for whatever”, “for the day I had to get my eggs taken, I just called in sick”*.

Gabrielle notes that she was at times quite affected by the IVF treatment itself: *“I put on a quite a lot of weight... and I was pretty moody”, “I used to kind of just*

sit there with tears rolling down my face... dab dab, sniff sniff”, but also observes that she tried very hard to keep her private life and work life separate: *“I did a sort of... private life... [physically indicates separation] work, just go to work, do the job to the best that I would do regardless of what was going on”*. It would also seem that in some ways, work was a welcome distraction: *“I only ever got teary if I read an email or something like that, which wasn’t all the time... you’re too busy thinking... or I was, too busy working, had my head down, bum up”*. Gabrielle seems to have a clear view of how she defines professionalism: *“you don’t cry at work... even though I did... but nobody ever saw it. You don’t cry in front of your boss, you don’t lose the plot, you maintain a professional attitude”* and it would appear this approach went some way to helping her cope.

Paradoxically, at the same time, Gabrielle was also starting feel that pregnancy would be a form of escape route from her working life: *“I did occasionally think... oh... I’ve so gotta get pregnant because I don’t want to do this for the rest of my life”*. It would seem that Gabrielle was possibly now reframing of her identity sans career in light of her determination to be a mother.

Although Gabrielle did not feel support was available to her in her working environment, she did not necessarily find that too hard to cope with, *“it wasn’t so hard not to tell him, because I was the only female (in the office)”*. She was mindful however of the need for some support: *“I did maintain... quite carefully, I did make sure I maintained my friendships and had girl time... I even had a couple of girlfriends come and meet me for lunch... at work, they came across town... which was lovely... um, because otherwise it’s a very quiet, very long day in your own thoughts”*.

Gabrielle attributes her success at coping with *“feeling like I was on a rollercoaster”* and maintaining her privacy, in part, to her positive attitude: *“just a positive attitude... yeah, I think choosing... making a mental choice to be positive”*. She recalls saying to herself, *“ok, I’m feeling really crabby because of the hormones and that’s okay... attitude shift, okay, let’s get going”*. It seems Gabrielle was able to harness a fortunate symbiosis: by keeping her goal in sight she was able to remain positive; and by maintaining a positive attitude and channelling her determination to become a mother she was able to focus on her end goal.

The end or new beginnings

With the successful IVF treatment behind her and a baby later, Gabrielle thinks it unlikely that she would ever return to her previous place of employment possibly because of her boss, *“because actually, now that I’m a mum and my boss is who he is, I don’t think he wants me to come back”* but also because she seems to be relishing her new role *“I’ve never been a career person... only because I knew that I wanted to be a mum”*.

Gabrielle seems content to be a stay at home mother at this stage, although she acknowledges this may in part be because her baby is still young: *“because I mean baby’s not even, you know, he’s not even 4 months old”*. In contrast to her own perhaps more traditional views about women staying at home or going back to work, she indicates though that her husband seems to have other ideas: *“my husband goes on about... oh you know, I’ve seen this great business idea or oh, you know, what about this, what about that, making money blah blah blah... and I’m like for goodness sakes get over it, we’ll be poor, it’s not a problem, you can’t take it with you”*.

Gabrielle seems to be very peaceful and happy in her new identity as a mother and for her the future is all about her family: *“do you know what, it’s a no brainer for me... job can wait, career can wait... family... family’s what it’s all about really”*.

Case study 5: Rose’s story

A story of being good, open and sharing, and the double edge of support.

Rose is a New Zealand born Chinese woman in her mid 30s. She and her husband started trying to conceive in early 2006. After a diagnosis of Grade 4 endometriosis Rose and her husband were advised that IVF was their best course of action. Four years and three rounds of IVF treatment later, Rose had her first child in 2011.

The beginning

“I’m a good person and um... you know and my husband and I, we didn’t live together before we got married because our parents wouldn’t have liked... you know, and we got married and we bought our house and we were married for a

couple of years before we decided to have children, we've got a nice house and it's all set up and we've done everything so blimmin' right".

The beginning of Rose's story has her observing that she had done everything in the 'right' order leading up to having children, so for her the discovery that she had a problem with her fertility was a surprise. She notes that she had always known she wanted children: *"I think I've... we've always known we wanted to have children"* but that it had seemed prudent to wait for a while after she and her husband were married *"so we started trying when I was 30, I probably would have liked... so we had been married for two years, I think I would have liked to have started trying earlier but my husband was like, pay down some of the mortgage yeah, do all that sensible stuff".*

However, after a year of unsuccessfully trying to get pregnant, Rose and her husband sought referral to a fertility clinic. For Rose there was a sense that things were moving quite slowly: *"this all dragged on for quite some time, several months until we got the appointment"*. Eventually Rose and her husband met with the fertility specialist and it was there that she discovered she had Grade 4 endometriosis, a completely unexpected diagnosis, *"that was a shock because I didn't think I had any of the symptoms"*. Following major surgery to address the endometriosis, Rose and her husband were advised that *"your chances of conceiving naturally are 5% or something like that, we recommend IVF"*.

Thus began Rose and her husband's journey through IVF treatment. They were eligible for publicly-funded IVF so that was their first option, but this entailed a long wait: *"so we went on the waiting list for IVF, for publicly-funded IVF and... at that stage, it was... for a first round... it was months, not quite a year but nine months or something like that, so it was a pretty long wait."*

The experience of working when having IVF treatment

Arriving at the next phase of Rose's story, she describes her work environment as very open: *"yeah, we're very transparent... and really... um... yeah, we know what's going on in people's lives um... we don't really have any secrets so... so that was always the set-up, that was always the kind of environment at work"*. Therefore within her workplace *"it was just natural that here I was trying for a baby, people knew I was trying for a baby"*. Rose comments that she was fortunate to have such a supportive team: *"I've just been really lucky that they're*

an awesome bunch of people” but also notes that the industry in which she works attracts caring people: *“I’m lucky in my field, everyone’s there because they’re caring, and everyone’s nicey nice”*.

It would seem that supportive team dynamics Rose describes largely stem from her female boss who has fostered that kind of environment: *“I have a boss who is amazing, yeah... just absolutely amazing, I just couldn’t have done it if I didn’t have her... she’s a mum... and just an amazing woman who trusts everyone in her team”, “I think she has fostered an environment in our team of trust”*. Rose clearly values this: *“my boss is so lovely and caring”* although she did also note that the relationship got a *“a bit blurred at times... because she cared so much for me, and she knew me so well and knew how much I desired a child and all of that”*.

In addition, Rose felt that there were a couple of people at her work *“who really got it”* and whom she could turn to when she needed support. Rose reflects: *“I distinctly remember one morning a friend of mine who’d been in a relationship for about a year and she’d just decided, yeah, I’m going to start trying for a child and she got pregnant within about 3 months or something like that... um... yeah... and then I got to work the next day and she’d sent the group email to everyone and I was in my room in tears and it was just really... um, yeah, lucky that I just kind of went to the room next door, to my colleague and just cried and yeah, she got it and was just... gave me hugs... so I was really lucky that there were people who really, really got it”*.

Because her team had known she was trying to conceive, once Rose and her husband started IVF treatment, this was also in the public realm at work: *“pretty much right from the beginning, my team, immediate team and then over the years, kind of more people... have known”*. For Rose, having her team know was *“quite a relief in a way... it was a bit of a relief telling people rather than holding it, yeah, keeping it all in”*.

In 2008, Rose and her husband had their first round of IVF treatment. It was unsuccessful which meant that Rose and her husband had to go back on the waiting list for their second publicly-funded round. Rose notes that there was still this sense of time moving slowly: *“it was just over six months, something like that, but it was a reasonably long amount of time”*. Because the wait seemed so long, Rose and her husband decided to do a private round of IVF

prior to their next publicly-funded round. Rose states that in her mind this was a bit of a gamble, “\$10,000 for one shot” but it resulted in a pregnancy for Rose and her husband. Rose describes her excitement at week seven in hearing the heartbeat: “we had a scan, there was a heartbeat, and there was this little jellybean of a blob and we were all excited” but goes on to share her devastation when she learned that she had miscarried three weeks later.

Initially, Rose had told only her immediate team that she was having IVF treatment, but after the second round of IVF and subsequent miscarriage it became more public. Rose states that she “made a conscious decision... I don’t want to go back to work because everybody’s going to go, where have you been Rose... so I actually asked my boss to send an email to then a wider group and say I’d miscarried”. There had been one positive outcome for Rose from the miscarriage in that it had made her “hopeful in a way, so we thought okay, we can get pregnant, we just need to continue”. This hopefulness may have made Rose feel less vulnerable about sharing the fact she was undergoing IVF with a wider group at work: “from that moment I think I actually then started telling a lot more people that I was doing IVF”.

Nevertheless, telling people was not without anxiety and Rose shared two concerns in that regard: “how people would take it and also I think the more people know, the less in a way... the less control you have over it”. So whilst common knowledge at work about her IVF treatment gave her some relief and support, it also meant that Rose perhaps felt more vulnerable once her treatment became more public.

There were further difficulties for Rose in combining IVF treatment and work which she identifies as twofold: practical and emotional. From a practical perspective, there was the issue of juggling work and treatment: “you can be doing blood tests every morning and you have to be down at that stupid lab before 7.30 or whatever, some ridiculous time and getting scans early in the morning, um... yeah, so there’s that side of it, picking up drugs during the day, getting phone calls during the day with whatever the result was of the blood test”. This issue seemed to particularly difficult for Rose because of her desire to be a good employee: “I’ve always been a really ‘good girl’ and I remember I used to get to work five minutes late and go in and apologise to her [her boss]”.

Rose also commented on the time-consuming nature of IVF, *“I find IVF quite consuming in that... having to think about it all the time, yeah, it’s not something we can just let go of because you have to, you have to take the drugs and do it at the right times for it to work”*. This meant that oftentimes Rose seemed to feel a pressure again to ‘be good’, *“there’s so much at stake so you have to... well, I found I had to get it right”*.

Rose also found it be very emotionally demanding from a work perspective: *“it’s all consuming and that just... it’s all I... you can kind of think about”*. She gave the following example: *“so you wait from say after 1pm you’re just on tenterhooks ‘cos you’re waiting for a phone call and that gets... you know that’s disruptive, you know, so I’m working and I’ve kind of got my phone on silent and after I’m like oh, gotta check my phone and doing phone tag in between... yeah, clients, meetings, whatever”*. It appears that for Rose the constant juggling between work and IVF treatment sometimes felt very difficult, *“it’s just all these mind games”, “it’s an absolute rollercoaster”*.

Another emotional by-product of the IVF treatment for Rose was a sense of guilt. Perhaps related to her desire to always ‘be good’, Rose talked of often feeling guilty that the IVF treatment was interfering with her working life: *“I did feel guilty for impacting on others if I had to take time off work”*. It would seem that Rose’s focus on ‘being good’ includes a strong work ethic. As a result her perception that she might be causing more work for her colleagues was another stress for her at this time.

Rose also notes that the longer the fertility treatment took the harder it became for her to remain positive: *“there were so many times I was just so angry and um... this went on more as we went on... as we got into like the third cycle because I remember thinking... just getting so angry because I’ve always been a bloody good girl”*. For Rose, there seems to have been a tension between ‘being good’ and feeling anger at the unjustness of the situation.

Throughout the treatment, Rose had the support of her colleagues and boss but she observes that there was a double edge to this support, *“I actually think there’s a flip side to that as well... actually that they know so much and that they’re super supportive”* and that she sometimes felt that it led to *“them almost telling me what to do”*. For example, Rose reflects that her boss would often suggest that she cut down to part-time hours: *“so she’s always harped on to*

me, not a very nice word, harped on, but she did... she was like do you need to be working fulltime?”. Whilst Rose acknowledges that she did find that option helpful in the early stages of IVF treatment, as time progressed she felt that work allowed her to focus on something other than the IVF treatment: “the IVF was taking over so much of my life already, yeah, in some ways cutting down at that stage... um, yeah... it was kind of... that it’s... I don’t know if it’s admitting defeat or... yeah, it’s kind of giving in to it”.

Whilst Rose felt that at times the support she received from her boss overstepped her boundaries, she notes that she was mindful of the difficult balancing act she faced in asserting her preference to keep working full-time: *“the risk is then losing her support... it was a really tricky one, because I really needed her support and if I told her to kind of back off would I lose that support?”*

However, Rose did appreciate her boss’s advice to seek professional counselling and she states that this was a most valuable coping strategy: *“I ended up seeing a counsellor for... oh my gosh, I ended up with her for about four years... and that was... probably... looking back it was probably one of the best things I ever did for myself”.* For Rose there were a number of benefits to having counselling support in that she learned it was *“okay to not have to be perfect and good about everything and yeah, putting myself first, actually putting my needs first”.* She notes: *“I grew up in a family where it was always... um, yeah... selfish is a bad... can’t be selfish, got to put others first”* and so for her it was important learning to be able to take care of herself first, also appreciating that IVF, by necessity, requires one to put oneself first.

Rose recollects that as time went on she wanted to reclaim some of her privacy, *“I think towards the end of it... even some of my colleagues I was starting to tell less and less... I was starting to get a bit more vague”.* It would seem that as the pain and grief of failure mounted, Rose wanted to protect herself and perhaps others from the burden of that pain, *“it was heartbreaking telling people... that it hadn’t worked”.* As her story progressed it seems that there was a real sense of Rose trying to reverse the public knowledge of her IVF treatment, whilst at the same time realising she no longer had that control: *“I think we told less and less people, it’s interesting, more and more people knew,*

as time went on, more people knew we were doing IVF... but the... when we were doing the treatment itself we started telling less and less people”.

Rose’s frustration and resentment towards work also started to feature as time progressed without success. Rose observes that there were times when she used to think *“I shouldn’t bloody be here doing a planning retreat or I shouldn’t be sitting here having a Christmas lunch with you people, I should be at home with a baby this year”*. It would seem that for Rose the experience of combining IVF treatment and working was a myriad of contradictions and that even with the support she received there were times of great difficulty.

The end or new beginnings

For Rose the beginning of the end of her story came with her third cycle of IVF which resulted in a successful pregnancy. In contrast with her first pregnancy, when she and her husband had told people from about eight weeks, Rose and her husband were more guarded this time. Having been through the loss of their first pregnancy, they did not want to get too excited: *“I don’t think there was ever a time in that whole eight months where we weren’t nervous”*, and perhaps to further protect themselves they *“didn’t tell anyone oh, until 14 weeks or something like that, well after that first 12 week scan”*. It seems that Rose was also afraid to get too involved with her pregnancy should she suffer another miscarriage, *“we waited until we were 20 weeks until I bought something... we force ourselves to buy something to acknowledge we were having this baby... and even then it was two little items of clothing because I thought if we lose it now, I can shove it in a closet”*.

Rose and her husband are considering a future round, or rounds, of IVF treatment. As such, Rose has come to the view that she cannot return to work at this stage in her life. She seems to feel that it is one or the other at this point *“if it was just part-time work and being a mum... I think it would be doable... um... but putting that third factor of IVF, I just... I do not see how that is going to work”*. It would seem that Rose accepts that her immediate future does not include her career: *“pretty much we’ve made the call that I won’t be going back”* but it also leaves her conveying a sense of loss as she leaves her career for now, *“I don’t like thinking about not returning to work because I love it and I love my team and I love my boss and I love where I work, it’s an awesome job and I feel, I really don’t want to let it go, I don’t want someone else to take my job, I*

love my job and... I just know I wouldn't be able to do it justice... anything justice".

Summary

In the initial phase of analysis presented above, individual themes and motivations were considered in the development of the women's narratives. By presenting each narrative and the early stages of interpretation contained therein, space has been made available to the reader to contemplate and hopefully understand each woman's story within her own context (Elliot, 2005). Furthermore, from the women's perspective, presenting their narratives would seem to have been a positive experience for them. Feedback from number of the women regarding the development of their narratives suggests this is true: *"you have done a really good job telling my story. I had a wee tear in my eye at the end :-)"*; *"I've read what you've written, and it's great. You've really captured the essence of my story - thank you"*; *"I still find it amazing how much I have forgotten! I'll have to keep this story to remember!! - so thank you! It all looks good to me"*. This hopefully indicates that the aim of empowering the women by the sharing of their stories, as opposed to any reliving of the trauma of infertility, has been met.

Overarching narratives

Important overarching concepts were identified that overlaid the women's narratives. Whilst the experience of combining work and fertility treatment was the intended focus, it formed only part of the women's stories, stories that spanned the infertility journey in its entirety, from trying for a baby through to successfully achieving their ambition. Within the entirety of these stories, a range of narrative types seemed to occur. These narrative types, whilst not a specific focus of this research, highlight fundamental themes which underpin everything the women experience in the course of their narratives.

Primarily, and perhaps as a result of their successful outcomes, the women's stories were largely retold as a form of quest narrative: in the face of adversity and challenge the women were active in their pursuit of motherhood: *"you know in your heart that nothing's going to stop you and you'll do whatever it takes"*. They clearly rose to the challenge of their infertility and through their journey sought to overcome it using the medical technologies available to them. As a

result, it almost seems as if their paid employment became a hurdle that they had to navigate in order to continue on their uncertain quest.

A type of restitution narrative was also identified in the women's stories: *"it's just a period of time, it's not the whole... I look back and think it's just something that happened"*. It is important however to draw a small distinction at this stage. From an illness perspective, the restitution narrative focuses on the transitory nature of illness and a return to 'normal health' (Frank, 1995). However, from an infertility perspective there is no return to 'normal health', rather advancement to another state of being: that of mother. So whilst the women, did seem to follow a restitution trajectory of illness to remedy to health (Kalbian, 2005), for them the outcome of health was not a return to status quo but rather the embracing of a new role. Taken from this perspective, the women's restitution narratives also seemed closely aligned to a hope narrative: the faith that they would ultimately become mothers as demonstrated by their persistence *"I'm not giving up on this now"*. Finally, this belief that motherhood would be their reward seemed to drive these women through their pain and despair, both representations of the chaos narrative that also seemed to occur. Ultimately however, for all of these women there was an undeniable tone of positivity threaded through their narratives. Perhaps it was as a result of their success with fertility treatments but it would seem that all of the women's stories had an arc that started with hope, followed by despair but ended with the ultimate prize, *"it was nothing, nothing... compared to having this little boy, it was nothing... nothing. I would have gone through anything for this, anything at all"*.

Thematic narrative analysis

Further categorical-content analysis has also been conducted to determine common themes that were present within the women's narratives. Whilst not seeking to generalise, this presentation of the women's experiences collectively may resonate with some women. From that perspective, this study could assist mental health professionals working with this cohort to have a more in-depth insight into some of the experiences of women combining fertility treatment and paid employment.

In addition, as noted by Riessman (2008), there may be value in the exploration of the "connections between the life worlds depicted in personal narratives and

larger social structures” (p.76). By considering the narratives within a wider framework, sociocultural factors including societal expectations, social mores and judgements, gender inequalities, and organisational contexts may also be observed.

It is also prudent to examine those conflicting events or stories within the women’s narratives in order to garner some understanding of how their experiences might have differed and what may have contributed to those different experiences (Lieblich, et al., 1998). By exploring those experiences that are different, it may be possible to develop insight into how personality differences and different social contexts may affect a woman’s experience.

In order to maintain the narrative focus of this study, the temporal or plotted nature of the women’s stories will be maintained for this section of the analysis. The themes that have been identified do not always fit neatly into each stage of the analysis as there is a degree of crossover for many of themes as well as slightly differing processes for each woman. However there was sufficient similarity between each woman’s story to enable this approach. Interestingly, this also seems to fit with Greil’s (1997) assertion that the infertility experience is a process, one that each woman will experience differently and not a fixed point in time experience.

Themes at the beginning of the women’s narratives

The importance of the women’s careers prior to having children was one of the early themes to be identified. In the women’s narratives having paid employment or a career would appear to have been an important focus of their lives prior to having children. One woman commented that she hadn’t thought she would have children and it seemed that as a result she had focussed her energies on her career: *“I could just concentrate on work which was great and then I started this new job, I could work hard at it, um, was really into it”*. For another woman, her passion for her career was evident in these words: *“I love it and I love my team and I love my boss and I love where I work, it’s an awesome job”*.

Interestingly, one participant noted that whilst her career was important, it had never been the most important thing to her, *“my career was never the mainstay of my identity. It certainly was one of several major contributors but to say*

mainstay is overstating it" with another woman observing, *"as much as I've pursued a career, I've never been a career person"*.

Thus it would seem that for these women there was an awareness of the contribution if not importance of their career in shaping their early adult identities but balanced by some of them noting that it had never been the most important aspect of their being. It would also appear that the women felt they had successfully achieved their career identities by the time they were ready to have children, thereby possibly enabling them to begin the process of re-visioning themselves as mothers.

For one woman, despite her career success she noted: *"I've never been a career person... only because I knew that I wanted to be a mum"*. And for another there was an awareness, and even acceptance that to have children might mean for her an end to her career: *"I took a little while to come round to it (having children) thinking... oh, right... partly because I knew it would send my career effectively... it would end my career basically"*. It is perhaps salient to note that even at this early stage of deciding to become a mother, for some there seemed to be a sense of motherhood or career imperative and that in some way one would preclude the other as noted above. From a life stage perspective, it would seem that for some of these women there was a sense that in order to achieve the next phase of their life, that of 'generativity', they felt they had to turn away from their career identity.

For a couple of the women there was also the sense that they may have made their career choices partly based on the ability of their role to become more part-time in the future: *"I think I'm lucky I guess, in the work I do as well that you can work part-time because I think there's lots of jobs where it's just impossible to work part-time"*. Another woman talks about registration in her profession as important because *"it opens up your door for being a mum and doing what you want to do later in terms of your career"*, noting that for her the ideal was *"maybe work from home or maybe go back, maybe part-time or maybe just do consulting type work"*. It may be that for these women the concept of 'having it all' in terms of both a career and a family (Raskin, 2006) was one that they had already in some way discounted.

When it came to thinking of motherhood, each of the women seemed to feel they had made an active decision to start trying for a baby: *"so after being with*

him [her partner] for a year, I convinced him that we needed to get on with it"; "and we actually weren't going to try until more than a year but then I sort of said... I literally convinced my husband that there's no point in waiting"; "we started trying to conceive even before we married"; "we agreed that when we got back from honeymoon that I'd take the IUD [intrauterine device] out and we'd start trying"; "so my husband and I started trying to conceive in early 2006". It is perhaps interesting to note the use of the word 'convince' by two of the women, who both felt their partners had no understanding of the age/fertility conundrum they were potentially facing.

Furthermore, for most of the participants motherhood was something that they had always planned for themselves: "I think I've... we've always known we wanted to have children", I knew that I wanted to be a mum". In contrast however, one woman observed: "up until I met my husband I pretty much thought I probably wouldn't ever have kids". For two of the women, there was also the sense that they may have felt in part the societal expectations to have a child: that it is the purpose of females to bear children: "you're told you can't have children, well what else are we here for at the end of the day", "what use am I as a woman, I can't even have a baby, um, that's what I'm supposed to be... that's what women are supposed to be for". Thus it would seem that the experience of infertility was, at least in part, a socially constructed notion in that its emergence as an issue was only observed as a result of deciding to try for child and being unable to conceive (Greil, et al., 2011).

For four of the women, another theme that was apparent was a keen awareness of the role that their age might play in their fertility. These four women were in their late 30s by the time they started trying to conceive and were cognizant of their declining fertility: "there might be trouble getting pregnant at my age, that the average time is a year", "it had occurred to me that maybe we might have trouble", "I met my partner when I had just turned 38 and I was already conscious by that stage that I was getting on in fertility years", "I was in my late 30s at the time so... we knew that both of them [referring to another fertility issue with her husband] would obviously make things difficult".

Perhaps compounding this sense of the problem of their age were some of the messages the women received from other sources. One participant recalled being told "time is essential and that the more we leave it the longer it's going to

take because obviously as a woman our, um... reproductive system is getting less efficient". Another woman described this advice after she had had surgery for endometriosis: *"the surgeon said to me at the time, you could go on... you're eligible to go on the public waiting system for IVF but my advice to you is just to go privately, just get on with it, don't muck around".* Yet another woman recalls being told from 'the fertility experts', *"you're never going to be more fertile than you are today"*. There would seem to have been an implicit pressure applied on the women to make haste in their attempts to conceive and this sense of urgency seemed to compel one woman to private IVF ahead of the publicly funded round she was eligible for, *"you can be pregnant next month, which was really great news for me but then in the next breath it was sort of you know... front up with ten grand and so we decided that we would do it"*.

One of the woman was in her early 30s at the time she started trying to conceive. For her, whilst age was not an identified contributing factor, she was the one person who also noted how slow the process seemed to be for her leading up to IVF treatment and between cycles. This sense of slowness seemed to drive a decision to have a private round of IVF in between public rounds *"the waiting time was... it was just over six months, something like that, but was a reasonably long amount of time and we just thought we don't really want to wait, so we decided to pay for a private cycle in between"*. Thus, for all of the women, there was a sense of 'no time to waste' and a strong desire in them to get the process going and perhaps over and done with in order to resolve the ambiguity that had entered their lives.

Upon discovering their infertility a number of psychological themes seemed to take on some importance and whilst these concepts cross over the temporal boundaries of the women's stories, it is at the beginning that these themes were perhaps most evident. One theme that started to be observed was that of shame, which seemed to often appear in conjunction with a sense of failure. Whilst these concepts perhaps strengthened as time went on (and as such will be discussed in subsequent sections) they were also there for some of the women from early on in their infertility journey. One participant noted: *"I found it really personally embarrassing the idea that I was this person having fertility problems"* going on to also observe, *"the fact that you've... and I see it this way... just failed to be pregnant, you know just failed in a major way"*. For one

woman there was a sense of shame in that she did not want anyone to know they were having trouble conceiving, *“early on when we were first trying, we hadn’t told anyone and then we were starting to think in that first year, oh we might have problems, we didn’t want anyone to know”* with another woman noting: *“some people feel... you know, like a failure”*. Thus it would appear that for most of the women, the sense that they weren’t living up to their own or society’s expectations of them as a woman, left them like failures in the most ‘fundamental role’ of all, perhaps leading to subsequent feelings of shame.

There were also indications at this stage of the women’s stories of the grief experienced upon discovering their infertility. This too was a theme that appeared to develop over time but once again had its genesis at the same stage in several of the women’s stories. One participant shared her grief quite openly becoming distressed at even recalling it: *“I realised, oh my goodness, I can’t have children... which was awful...um [Gabrielle was quite teary at this point]”*. Similarly, another woman observed, *“it was quite hard in a way because you’re going through tests and you’re going through an emotional process, which can leave you at times quite distressed”*. It is perhaps interesting to note that for one woman, her grief was perhaps masked by her tendency to use humour when telling her story. However, she did note in a subsequent email interaction: *“I think the humour I use belies the mental and physical health toll that this journey has had on me. I fear some of it will never go away”*. Whether explicit or implicit there was the impression of grief as an early feature of these women’s experiences, as they learned of their infertility and imagined what this might mean for their future.

Lastly, at this stage of the women’s stories, some coping strategies that would accompany them throughout their journey were also identified. As mentioned above one of the women seemed to use humour as a way of retrospectively looking at her experiences. For her, the journey had been a long and arduous one with multiple rounds of fertility treatment and it seemed that in using humour she was perhaps re-storying her experiences: *“I know, I laugh now, it wasn’t funny at the time”*.

Another coping strategy that seemed to be employed by more than one of the women was a determination to never give up. For one woman, there was never any doubt in her mind that she would succeed: *“I still was determined to be a*

mum and I just had to cling to the fact that I knew I was going to be a mum”.

For another woman, the determination seemed to be a response to failure, *“the more trouble I had the more I wanted it [a baby] and the more sure I was that I wanted it”.* Thus the focus of these women on achieving their goal appeared to assist them in coping with the difficulties that were to follow.

Themes regarding the experience of combining fertility treatment and working

Once the women reached the point of engaging in fertility treatment a number of themes were identified. One of the most important themes appeared to be that of disclosure of the women’s stories within their working environment; specifically whether to maintain privacy regarding their treatment or to bring their experience into the public domain in the workplace. The decision to have either a public or private narrative was fraught with contradiction and complexity for the women in this study. One woman eloquently summed it up thus: *“to tell or not to tell your employer about your fertility treatment in my mind is very much a Catch 22. If you do you have to be prepared to field unwanted questions and advice and to not tell means effort in having to cover your tracks”.* For another woman there was a sense that she would have liked to have shared a little more by way of explanation for her behaviour but that it contradicted a simultaneous desire to maintain her privacy, *“wanting to share things and wanting to make people aware that sometimes the way you were reacting or behaving was because of what you were going through but at the same time wanting to keep things private really”.*

Two of the women shared their fertility treatment within their workplaces. Whilst this had been a purposeful decision on their parts, they both went on to note that the public nature of their treatment had a double-edge to it. For one of the women it had seemed natural to share with her colleagues, *“we don’t really have any secrets so... so that was always the set-up, that was always the kind of environment at work and so it was just natural that here I was trying for a baby, people knew I was trying for a baby and it just followed on from there that they knew”.* However she found that the public nature of her treatment had unintended consequences: *“there’s that flip side of people knowing that much, they feel they can kind of try and give advice... because they want to help, they end up kind of telling you what to do”.* Similarly, for the other participant who

had shared her treatment journey with workmates, albeit at first only with her boss: *“because I was with that employer for four years, at some point I then said to him, look, I’m having IVF”,* she too commented on the boundaries that were then overstepped: *“he said, why don’t you adopt”.* She also observed the ongoing discomfort at having to constantly explain herself to people: *“you explain it all to people, then it’s out there, then they’re asking you, how’d you get on, you know and then you’re having do fertility treatment 101 with the receptionist... so I think it’s a really difficult decision to tell people or not to tell people because once you put it out there, it’s out there”.* The benefits of sharing seem to be precariously balanced with the negative consequences. As one participant noted: *“I’ve just been really lucky that they’re an awesome bunch of people and... so it was... working and doing IVF was hard enough and if they hadn’t known, I just don’t... I don’t think I could have done it”.* At the same time she also notes: *“in some ways telling people... you’d have less control over it cos kind of keeping it shut off and not letting people in, you can kind of control it more”.*

Conversely, three of the women attempted to maintain a level of privacy regarding their fertility treatment, perhaps as a means of retaining some sense of control in an otherwise uncontrollable situation: *“in a way you’re expecting failure and you don’t really want to have to talk about it afterwards so I guess it’s... in a way, sort of protecting yourself from the emotional load of having to share this information with people at work”.* In a situation that perhaps imbued the women with a sense of disempowerment: *“it felt like little, um... what do you call it... like a puppet, a puppet on a string”* controlling what they told people may have been one of the most empowering things they could do.

In addition, driving many of the women’s decision to maintain their privacy were fears around job security or future prospects. Despite legislation in New Zealand designed to protect working mothers, all of the women raised concerns about their jobs as a result of trying to conceive. For one woman, there was concern that if her employer knew she was trying for a baby she might even lose her job: *“I was also I guess, quite concerned that my employer upon seeing that I was trying to conceive might try and maybe find some reason to show me the door. I had seen it happen at work, where a former colleague when she got*

pregnant really sort of experienced quite a nasty reaction from our employer... and they basically tried to find some sort of way to get rid of her”.

For other women, concern centered on protecting their future within the company, particularly should their IVF treatment be unsuccessful: *“I kept thinking, will I be at work? I don’t know... do I need to care about this? If I’m not going to have a child then yes, I need to go on caring about this because it will be my job”.* There was also a sense for some women, that had their employer known they were trying to conceive it may have resulted in being treated differently: *“if you’re a boss you’ve gotta be thinking it... you must be thinking, if that person’s had a miscarriage they’re probably trying again and that person’s having fertility treatment and it means that eventually that may work... your boss can’t help but factor that in and I know that if I was an employer, you’d have to factor that in and consider it and it would make you feel differently about those people”, “I totally understand about the glass ceiling now”.* Another woman noting *“I think my particular boss if he had known that I’d been trying for a family, probably would have written me off straight away... most definitely”.* It would seem that for some of the women in the study there was an implicit awareness of the difference an individual in an organisation can make to one’s experiences regardless of any legislation designed to protect women in the workforce.

As well protecting their jobs, a number of the women spoke about a form of compartmentalisation of their lives whilst undergoing treatment, *“I did a sort of... private life... [physically indicates separation] work”* perhaps as a means of proving that fertility treatment would not undermine their professionalism. The women made various observations regarding maintaining their levels of performance and professionalism: *“basically I had to maintain my performance at work exactly as if I wasn’t going through IVF”;* *“by not going on the course, then I’m failing to fulfil an obligation as an employee because of my fertility treatment, it would be getting in the way of the job”;* *“you’ve got to perform and everybody’s got to perform in the same way”;* *“you don’t cry in front of your boss, you don’t lose the plot, you maintain a professional attitude”.* There seems to have been a genuine concern shared by these women that to not meet a certain, abstract standard of professionalism would in some way reflect badly on them.

Perhaps also contributing to the pressure to maintain professionalism, was the concurrent need for these women to attend to the practicalities of their fertility treatment. Appointments were often conducted as much as possible outside of office hours or in lunch breaks and events that required more time off work, such as egg harvesting, would often be lied about: *"I just lied to him and said I've got a follow up appointment for whatever"*; *"I had to throw a sickie when I had the hysterosalpingogram"*; *"I would have to try and... find some sort of lie for work as to why I suddenly had to take time off the next day"*. So it would appear, that for some of the women there was a conflict between their desire to be professional and not let their fertility treatment impact upon their work and the sense that in order to maintain their privacy they had to lie and keep their appointments hidden. Perhaps a 'good employee' versus 'good patient' tension (Payne, Goedeke, & Balfour, 2011) was occurring at this stage for some of these women as they tried to meet the demands of both roles.

The stress of maintaining secrecy around treatment for some of the women may have compounded what was already an emotionally-charged time in their lives. As noted earlier, themes of shame and failure continued throughout this phase of the women's narratives. These were also often inextricably linked with the women's desire to maintain privacy, *"I just couldn't bear the idea of making it an issue and then having to tell people I failed"*. As the journey of their fertility treatment progressed, some of the participants seemed to feel an increasing sense of failure as women: *"I think I really did begin to feel like... um... there was something wrong with me and that I was failing"*; *"just go and marry another woman who'll give you children in a flash, what's the point of even being married if we can't have a family"*. As discussed earlier, the pronatalist assumption of a female's role in life to bear children seems to have been embedded in these women's narratives particularly in relation to their sense of failing as a woman.

Determination was another theme that continued through this stage of the women's narratives. In the face of multiple failures, one woman noted: *"I'm not giving up on this now... helping me cope with the failure was having something else to get on with"* and similarly for another woman: *"the more I failed the more determined I was to succeed"*. For one woman also, she noted that it was her positive focus that helped her through, *"saying, oh, ok, I'm feeling really crabby*

because of the hormones and that's okay... attitude shift, okay, let's get going". Both approaches would appear to have been forms of coping strategies employed by the women at different times, throughout their narratives. In contrast, when reviewing another of the women's narratives, there was less of a sense of determination or positivity and for her the focus of her story was on the loneliness of the journey. It would therefore seem that determination and positivity could be valuable focal points with respect to assisting women to find methods of coping with fertility treatment.

Another theme that appeared to assist the women through their experiences of combining fertility treatment and working was the mindful development of support networks. One of the women whose narrative was quite public within the workplace noted the value of the support she received within that environment: *"I've just been really lucky that they're an awesome bunch of people"*. For other women the value of friends was also observed: *"you need a girl to bat things off and I did maintain... quite carefully, I did make sure I maintained my friendships"*. Sharing with friends who were also experiencing fertility treatment seemed especially useful: *"I've found with some of my friends... it probably brought us together... we felt that we understood what we were all going through"*. Interestingly, two of the women who had been particularly mindful in developing their support networks amongst their friends noted that sometimes their husbands did not always seem to understand: *"the woman's perspective on fertility treatment, I think is sometimes quite hard for the partners to fully understand"*; *"your husband... I mean he's not that medically minded"*.

One participant acknowledged the value of counselling support throughout her journey *"I ended up seeing a counsellor for... about four years... and that was... looking back it was probably one of the best things I ever did for myself"*. She also noted that her counsellor was not a fertility counsellor but someone with medical knowledge, perhaps indicating that the value of counselling lies less in the specifics of the infertility issues these women face and more in the therapeutic alliance that can be developed.

Finally, a note on the construction of pregnancy as an escape route from the women's careers. This was a theme that was observed in three of the women's narratives: *"if only I could have a baby I wouldn't have to put up with this shit"*

anymore”; “*I shouldn’t bloody be here... I should be at home with a baby this year*”; “*I’ve so gotta get pregnant because I don’t want to do this for the rest of my life*”. For these women there became a sense of the imperative for them to achieve pregnancy to be able to leave their careers. It would seem that this theme could bear relation to the women’s shifting identities, perhaps enabling them to envision a future with less of a focus on their careers. Taken from a life stage perspective, it would seem that for these women, achieving generativity was their current focus and their careers were possibly associated in some way with a sense of stagnation. It may also be that as a means of processing the pain and stress of their experience, and managing the ongoing stress of both, they transferred their frustration to their workplace.

Themes for the future: the end or new beginnings

For all of the women interviewed for this study, their successful pregnancy heralded the conclusion of their experience of combining fertility treatment and working. Whilst one woman had returned to work following the birth of her first child, the remaining four women were either still on maternity leave or had resigned from their jobs. For one of the women who had recently resigned she noted that she would probably continue working in a freelance capacity for her old company as time progressed. However, for these four women there was a definite sense that their careers as they had been, were now behind them and the future involved more flexible working hours, freelancing, contracting, working from home, or being stay-at-home mums. Some of these women also noted that their current financial position with their partners enabled them to consider these options: “*the big thing is I’m lucky that financially I don’t have to go back to work*”.

The concept of ‘having it all’ seemed to be something far from these women’s minds at the time of relating their narratives. One woman noted the difficulties of undertaking any future rounds of IVF treatment whilst working and parenting: “*if it was just part-time work and being a mum... I think that would be doable... um... but putting that third factor of IVF, I just... I do not see how that is going to work*”. For another the future could not contain her previous career because “*the industry that I work in is reasonably ageist as well and it’s not a 9-5 industry*”. There was a sense for some of the women that to them the importance of raising their child superseded any notion of ongoing career: “*he’s*

my life's work", "he's not even four months old and my husband goes on about... making money, blah blah blah... and I'm like for good sakes get over it, we'll be poor, it's not a problem". Perhaps the challenges these women had experienced in achieving motherhood had led them to re-evaluate their futures, though perhaps such a re-evaluation was not without conflict. For one of the women at least, her career seemed to be something she left behind with some sadness, "it's an awesome job and I feel, I really don't want to let it go, I don't want someone else to take my job, I love my job and... I just know I wouldn't be able to do it justice". Thus it would seem that for some of these women the future may include a sense of conflicted achievement (Raskin, 2002, 2006), a desire to achieve both motherhood and a career and perhaps a sense that they cannot do either justice.

Discussion

The focus of this research has been to offer some insight into the experiences of women combining fertility treatment and paid employment, through the presentation of their narratives and the concurrent themes that were identified. Themes of interest have included those related to the psychological experience of infertility and fertility treatment and the experiences as they occurred in a sociocultural context, primarily that of a work environment.

Polkinghorne (1988) speaks of the “pervasiveness of narratives” (p.14) in that the schemata of narrative are all around us and that narrative is how we make sense of ourselves, other people, and the world in which we live. This was clearly reflected in the women’s narratives of this study. Whilst the focus of the research was defined as the events and psychological experiences surrounding a particular aspect of fertility treatment, namely its combination with paid employment, for the women interviewed their narratives had a beginning and ending that was much wider than just this experience.

Furthermore, in this way, the women appeared to be interpreting and redefining their experiences predominantly in the form of quest narrative (Frank, 1995). However, other narrative types, such as restitution, hope and chaos were also identified which would support Frank’s (1995) assertion that many narrative types are likely to be woven throughout a person’s story.

The identification of a quest narrative in women’s stories of fertility treatment has been suggested previously (Kirkman & Rosenthal, 1999). However, the authors identify the quest as beginning at the point of actively deciding to start trying for a baby. Whilst this premise was also the starting point of these women’s narratives, it would seem that the true nature of a quest narrative really began in the face of adversity, specifically their discovery of their infertility. In this way, the women’s quests were more akin to those as proposed by Frank (1995), as once faced with the diagnosis of infertility the women’s quest truly commenced. Furthermore, the quest narrative was defined by what there was to be gained from the experience of infertility and fertility treatment: namely a baby (Frank, 1995). Aspects of a hope narrative were also present in the women’s stories, in that the women hoped for a successful outcome and believed fertility treatment would deliver this to them. This may lend some preliminary support to Kalbian’s (2005) suggestion that a

hope narrative may be a more relevant type of narrative for women undergoing fertility treatment, although she does also note that it is primarily and perhaps only relevant for women who have been able to achieve a successful pregnancy. The presence of other narrative types in this study, such as chaos and restitution (Frank, 1995), as well as the complexities and vagaries or their occurrence, would perhaps give greater credence to the notion of many narrative types occurring in the course of a woman's infertility journey.

When focussing on the question initially posed by the research, that of the experience of women combining fertility treatment with paid employment, the findings of this study illuminated complexity and variation in the women's experiences yet, simultaneously, moments of similarity. Possibly one of the more complex yet most commonly discussed experiences with respect to combining fertility treatment with working, was the notion of 'public versus private narratives' (Kirkman, 2001). Kirkman identified that there were differing degrees to which women with fertility issues shared the story of their infertility, with a prevailing bias towards privacy. However, she noted that when fertility treatment was sought, the women often felt compelled to make their stories more public. Notably though, for the women in this study their fertility treatment narrative was also subject to different levels of disclosure, which appeared to be dependent on a number of variables, such as perceived work support (Finamore, et al., 2007) as well as the likelihood of needing longer periods of time away from work for more complex treatments (Payne, Goedeke, Balfour, & Gudex 2011). Thus it would seem that the participants in this study were actively engaged in managing the visibility of their fertility treatment (Throsby, 2004).

Furthermore, the tensions that Kirkman (2001) alludes to in her research also seemed to be active in these women's narratives. For them, these tensions seemed to arise from the difficult choices they commonly felt they were faced with: to disclose their fertility treatment potentially exposed them to unwanted opinions, advice and judgements from others but it also gave them the opportunity to receive support; or to maintain privacy meant lying and hiding one's true self from people but also enabled the women to feel less vulnerable and perhaps more 'normal'.

As with quantitative research undertaken concerning the social concerns of women experiencing fertility treatment (Finamore, et al., 2007), further tension was also observed in this study regarding how disclosure of fertility treatment might impact upon some of the women's future career prospects. The concern raised by these participants seemed to be that if a supervisor knew that a woman was trying for a baby (through fertility treatment) then she might not be considered for future promotion, because of the expectation that she would eventually take maternity leave or leave work permanently. This finding reflects observations by Finamore et al. (2007) who found that of the women in their study who chose not to disclose their treatment almost 20% were worried that their chances of future promotion may be hindered. Moreover, Throsby (2004) also noted related concerns for women in her research regarding IVF treatment and similarly, in a qualitative study by Peddie et al. (2005), missed professional opportunities by way of promotion were also mentioned with respect to women undergoing fertility treatment.

Furthermore, for two of the women in this current study, genuine fears existed that disclosure of fertility treatment in their work environment could jeopardise their current role as it was at the time. This may indicate that whilst legislation does exist to protect women in the workforce from discrimination (particularly regarding pregnancy), it is the enactment of such legislative measures through individual supervisors that has the greatest effect upon the experiences of women in the workforce. This finding also bears some resemblance to the findings of Mäkelä (2011) in her Finnish study which discusses the prevalence of pregnancy-related discrimination in the workplace between pregnant women and their immediate supervisors. From a feminist perspective, it seems salient to ponder whether there still is a prevailing ideology in New Zealand around traditional gendered roles for women with regard to raising a family and having a career.

In this current study, tension inherent in deciding whether to disclose information about their treatment or not, was often further compounded by negative consequences once those decisions had been made. For those women who chose to disclose their fertility treatment to the workplace, their experience of people within their organisations 'overstepping the boundaries' was an added stressor. Unwanted advice and opinions were often cited as

examples by participants as the negative consequences of sharing their infertility journey with colleagues or supervisors. In this way, this study has replicated the findings of previous work (Harwood, 2007; Imeson & McMurray, 1996; Throsby, 2004). For those women in this study who were less able or willing to disclose their fertility treatment, there were also negative consequences. There was a sense of stress and tension involved with the careful balancing that was necessary of the two competing requirements (work and fertility treatment) in the women's lives whilst maintaining secrecy. Such stress and tension arising from the conflicting demands of working and fertility treatment has been previously noted (Hammarberg, et al., 2001; Laffont & Edelmann, 1994; Redshaw, et al., 2007).

For the women in this study who maintained privacy through their fertility treatment, there were also consequences of a more practical nature. For these women, absences from work such as time away for appointments or time off for procedures posed a conundrum. In order to meet the requirements of fertility treatment these women were frequently in a position where they felt compelled to lie to their employers regarding their reasons for being absent. The stress and sense of social isolation that lying to one's colleagues or employer can cause has been previously discussed (Hammarberg, et al., 2001; Kirkman, 2001) and the findings in this study would appear to support that suggestion.

Thus it would seem that the decision to have either a public or private narrative with respect to fertility treatment in the workplace is fraught with anxieties and tensions. The women in this study exemplified these tensions with a mix of public and private narratives that resulted in varying degrees of comfort and success.

The physical challenges of juggling working and fertility treatment were not only restricted to women who maintained their privacy. For all of the women, this was identified as a complicating and stressful factor, with many of them observing that they tried to ensure their treatment could not be perceived as affecting their work performance, again replicating findings in previous research (Kirkman, 2001; Redshaw, et al., 2007). These difficulties could also be viewed in the 'good patient' versus 'good employee' paradigm that Payne et al. (2011) suggested was a challenge for working women undergoing

fertility treatment. Indeed for the women in this study, a tension between a desire to be a good employee and a good patient did appear to exist as they struggled to juggle both roles and to maintain performance levels in each.

The tensions created in trying to achieve both roles may have contributed to a sense of failing that women spoke of in this study. It is salient to note however, that the concept of failing would seem to be far more complicated and pervasive than simply as a result of juggling two roles. Rather, the concept of failing has been frequently referred to in previous research (Boden, 2007; McCarthy, 2008; Shaw, et al., 1988; Ulrich & Weatherall, 2000) with its complex genesis inextricably linked to a myriad of sociocultural and individual factors. Similar to previous research, (Brod, et al., 2009; Daniluk, 1997), for the women in this study, the concept of failing was often linked to a sense of shame that they were failing as a woman. This sense of failing in the most 'fundamental role' of all, that of a woman's biological role to produce children would suggest that the sense of failure for these women was far more widespread than the experience of combining work and fertility treatment. However, it would seem plausible to consider that this may have been a contributory factor and indeed the women's expressed desires to not 'fail' at work because of their fertility treatment may lend support to that supposition. Similar to the findings of Parry (2005) many of the women in this study sought to validate their social worth by maintaining and focussing on their careers and trying to ensure that fertility treatment did not interfere in their work environment.

Indeed the sense of failure often mentioned seems inextricably linked to a woman's sense of identity. The 'storied self' (McAdams, 1995) that the women in this study created by virtue of their narratives was one in which failing as a woman was a critical theme. This observation is highly reflective of previous work suggesting that motherhood is a core identity for women and that the disruption brought about by infertility can manifest negatively in a woman's sense of identity (Arendell, 2000; Haelyon, 2006; Parry, 2005; Riessman, 2002; Ulrich & Weatherall, 2000). The prevailing pronatalist ideology (Parry, 2005) was also present in the narratives of the women in this study suggesting that there was a sociocultural context to the women's

constructions of their identities as they compared themselves to others and what 'was expected of them as women'.

In consideration of Marcia's (2002) concept of constantly reconstructed identity through the lifespan, the women in this study seemed cognizant of their identity development having stalled. Reflecting back on their careers, they appeared to construct their career identity as largely 'complete' and identified the need to move on to the next phase of their development, that of motherhood. From this perspective, it would seem that achieving generativity was inextricably linked to achieving motherhood (Erikson, 1980). Ultimately, for the women in this study it would seem that to finally achieve motherhood was a validation of their status as functioning women and a positive reinforcement of their core identity.

This may precipitate the need to consider the possibility of conflicted achievement (Raskin, 2002; 2006). As noted, the women had previously constructed meaning and a sense of identity from their careers. When they chose to have children, a number of the women seemed to choose to forgo their career in favour of an identity that embraced motherhood. The purposeful approach to this was evident in the women's narratives as they faced infertility, with their careers being a hurdle that they needed to overcome in order pursue motherhood. However, the women in this study were in a double bind. Whilst a motherhood identity was their desired role, throughout fertility treatment they also needed to maintain their career identity as a form of safeguard should their treatment be unsuccessful. It would seem that for the women in this study, conflicted achievement is a valid description for their sense of identity as they attempted to balance the combination of working and seeking motherhood. Furthermore, there was an implication that the women felt they had made an agentic choice (Plunkett, 2001) over the decision to move their career aside for motherhood and they almost certainly seemed to be of the mindset that they could not 'have it all' (Raskin, 2006; Tong, 1998). This perhaps leads to the question, what will the future hold for these women if they consider returning to their careers and how will they balance this with the demands of motherhood?

From another perspective, as some of the women were reconstructing their identities as mothers 'sans-career', there was possibly a sociocultural input

occurring via their workplace, with subtle or institutional messages regarding the place of working mothers. This could echo previous research which has found that there is often a stigma attached to women who take advantage of work-life policies in an employment setting (Shapiro, et al., 2008).

Reflecting upon the psychological experiences of grief, anxiety and depression as they were constructed by the women in this study, the findings demonstrated the pain and sadness that became part of the women's identities in their infertility journey. With respect to grief, it was a strong narrative thread through the women's stories, however their successful outcomes appeared to have mitigated this somewhat. Nevertheless it was noted that for all of the women the grief and pain had in some ways remained a part of their story and perhaps part of their future identity. This finding is reminiscent of previous research that has found that even women who have a successful experience of fertility treatment may still bear grief and pain as to unfairness of what they went through (Redshaw, et al., 2007).

This research did not specifically focus on increased levels of anxiety or depression. Rather, it was hoped that the study would contribute to an understanding of the particular stresses involved for women combining working and fertility treatment, including those related to identity issues as well as the more practical facets of the experience. Understanding these stresses may help mental health practitioners when dealing with issues of anxiety and depression in relation to fertility treatment, as it would seem plausible that the added stress and tension of the combination of the two could be a potentially contributing factor to any mental health issues.

Finally, it was also observed that the women in this study developed a narrative that reflected positively on their experience, drawing on a range of coping strategies. For the women in this study, this was reflected in their positivity in the face of adversity and determination to succeed. It is salient to note that this was possibly mitigated by the fact that these women had successful outcomes from their fertility treatment, nevertheless they appeared to draw on these strategies to cope. These findings support that of previous literature which has suggested women engage in positive self-talk as a form of coping strategy (Lukse & Vacc, 1999). Furthermore, the positive effect of psychosocial counselling was also observed in this study, offering support for the many

studies that have advocated this approach (Anderson, et al., 2003; Beaurepaire, et al., 1994; Cousineau & Domar, 2007; Kainz, 2001; Peterson, et al., 2007; Redshaw, et al., 2007; Slade, et al., 1997).

Limitations and reflections

As with all research, it is important in this study to offer some reflection regarding the process and findings offered. Being a limited study conducted as part of the requirements for a university degree, the number of participants was limited to five. This was in order to adequately consider each woman's narrative and afford it the space it deserved within this report. It is noted that such a small group of participants greatly limits any forms of generalisation often sought in psychological studies. However, it is also noted that qualitative research lays no claim to generalisability, rather that the interest is in the lived experience of the individuals spoken with. For that aim to be achieved, in depth conversations and a narrative approach were deemed most appropriate when working with this particular cohort.

Another obvious limitation of this study was the self-selected nature of the participants. Once again, limited by the requirements of the course of study, expedience in finding participants was necessary and to simplify a potentially protracted and complex ethical process, the decision was made to advertise through a channel that would most likely be subscribed to by mothers. Therefore, the women who did self-select were mothers who had experienced success with their IVF treatment, which may have yielded a more positive impression of the experience, including recollections of working. However, such a purposeful approach was intended to mitigate any possible risks associated with interviewing a potentially vulnerable population: women who had not succeeded in their IVF treatment.

Furthermore, for some of the women in this study, financial considerations were less compelling in that they were able to pay for private treatment if necessary. This might suggest that the nature of this research perhaps appealed more to women who were less economically disadvantaged and thus able to stay at home following the birth of their child, thereby enabling them the freedom and time to participate in this research. Women in greater economically disadvantaged situations may not have considered that they had the time to be involved in this research. However, this limitation could also be a reflection of the fact that ARTs are predominantly the domain of more educated, and therefore often more financially secure, individuals (Harwood, 2007).

As interviewer I was aware of my presence as part of the research, that the person I am and who attended those interviews may have affected the story that was told to me (Riessman, 2008). To this end, at the commencement of the interviews, some time was spent in introductory chat in which I talked about myself and my study interests in the experiences of working women. I would also note that the interviews were a co-constructed event and I have made considerable efforts to ensure my engagement with the women was as empowering and empathic as possible. To facilitate these endeavours, interviews were conducted in the women's venue of choice. Furthermore, the interview schedule was developed in reference to previous research in this area (Balfour, 2010). Finally, the opening invitation that framed the interview as a narrative process was issued in order to encourage the women interviewed to present their own story as it mattered to them.

Furthermore, as researcher, and therefore co-author of the women's narratives, I was mindful of my own biases that might lead me to consider parts of narratives as important or unimportant to the overall arc of the story. As a means to counter this risk, the narrative process as suggested by Crossley (2000a) and Lieblich (1998) of constantly engaging with the text and allowing it to 'speak to you' was consistently followed. Furthermore, as researcher, I remained present to my reflexivity, constantly examining and re-examining my interpretations as I progressed. Finally, the ongoing open dialogue with the participants by way of sending them both transcripts and draft narrative along with the invitation to make any changes that they wished was another method employed to mitigate the effect of my own biases. A clear audit trail of the process has been left by following these steps, thereby strengthening the study's credibility.

Conclusion and recommendations

This study has sought to offer some insight into an area of interest in the fertility treatment arena that has previously been referred to but not often specifically focussed upon, namely the experiences of women who have combined working and fertility treatment. The qualitative, exploratory nature of the research has allowed for a deeper explication of the social concerns that women undertaking fertility treatment may face (Finamore, et al., 2007). It has highlighted some of the challenges and complexities involved when navigating this path as well as

the potential implications for a woman's sense of identity at this particular juncture in her life.

The high response rate that was observed in the recruitment phase of this research, has possibly indicated the importance of continuing to focus on the experiences of women combining fertility treatment and paid employment. As such, it has been considered of value by the researcher and her supervisors to seek to undertake further study with this population. The application of different theoretical lenses to such research could assist in building a greater understanding of the multidimensional experiences of combining fertility treatment with working.

Future research would also be recommended for a range of other similar or related areas. Of particular interest would be how women who were unsuccessful in fertility treatment have constructed their identities with respect to their careers. Their views of the experience may be significantly qualitatively different to those of the women in this study who had achieved their ambition.

The women in this research all had relatively long tenure in their careers and as a note, appeared to be well educated and in relatively senior positions within their work environments. Research that also explored the experiences of infertility and fertility treatment combined with working for women in less senior roles may also yield different experiences.

Finally, whilst fertility treatment is experienced most significantly by the woman undertaking it, its impact on a wider group is a distinct possibility when that woman is in paid employment, as it may impact on her productivity in the workplace, either through time away or emotional factors. Possible research could also be undertaken exploring employer's views of and responses to fertility treatment in the workplace. This might also assist with the development of appropriate workplace policies that could be designed to support and assist women undertaking fertility treatment whilst working.

Ultimately, any future legislation that might aim to assist or support women undertaking fertility treatment is at the whim of those charged with enacting it. Without increased conversations that highlight the tensions and difficulties associated with this experience, it can be expected that little would change. This research has hoped to offer some contribution to that conversation, with the aim of perhaps encouraging future consideration of development of

workplace policies. Furthermore, from a mental health practitioner's perspective, it is hoped that by offering some insight into the possible experiences of women undertaking fertility treatment whilst working, practitioners might feel further enlightened as to the ongoing complexities women in this situation might face.

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Appendices

Appendix A

Glossary of terms

The definitions provided below were adapted from material available online at www.advancedfertility.com.

Clomiphene – an oral medication that is used in Ovulation Induction to induce or regulate ovulation.

Hysterosalpingogram – a procedure that is used to determine infertility.

“Radiographic contrast (dye) is injected into the uterine cavity through the vagina and cervix. The uterine cavity fills with dye and if the fallopian tubes are open, dye fills the tubes and spills into the abdominal cavity.” (Advanced Fertility Centre of Chicago, 2011). This procedure will determine whether the fallopian tubes are open or blocked and where any blockage might be situated.

Intrauterine insemination (IUI) – a procedure in which the sperm is deposited into the uterine cavity via a catheter.

Reference:

Advanced Fertility Centre of Chicago. (2011). Hysterosalpingogram - HSG - fertility test for tubal patency and normalcy of the uterine cavity. Retrieved 11 November 2011, from <http://www.advancedfertility.com/hsg.htm>

Appendix B

MEMORANDUM

TO	Serena Walker
FROM	Kevin Baker
SUBJECT	Psychological support for research participants
DATE	15 th April 2011

Dear Serena

I would like to confirm that Health, Counselling and Wellbeing are able to offer confidential counselling support for the participants in your AUT research project entitled:

“The experience of combining IVF and paid employment: women’s narratives”

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

Yours sincerely

Kevin Baker
Head of Counselling
Health, Counselling and Wellbeing

Appendix C

SEEKING WOMEN WHO COMBINED IVF TREATMENT WITH PAID EMPLOYMENT.



Hi, I am Serena Walker and I am a Masters student at AUT University. As part of my Masters in Health Science, I am completing a research project for my dissertation entitled “**The experience of combining IVF and paid employment: women’s narratives.**” and I would very much appreciate your help.

The purpose of this research is to understand the experiences of women combining IVF treatment and paid employment. Research has often alluded to the challenges experienced by women combining IVF and paid employment. However, no targeted research has focused specifically on this. It is hoped this research may assist psychologists/counsellors in further developing their understanding of how to offer support to women at this critical phase in their lives and may offer insights into appropriate work-place policy development.

So how can you help? In one of two ways:

1. You may have experienced IVF treatment whilst maintaining paid employment. If so, would you care to share your experiences? Attached is a participant information sheet that lets you know how to get in touch with me and gives you some more detail on the research. I would love to hear from you.
2. Do you know other women in this position? Perhaps they would be interested in sharing their experiences? If you know anyone that has had IVF treatment whilst maintaining paid employment, please forward them this newsletter so that they can consider this invitation and also review the participant information sheet.

I am happy to discuss further should you have any questions, otherwise, I hope to hear from you soon.

Best wishes
Serena Walker

Please note: Your privacy will be respected and protected at all times should you wish to participate by disguising any identifying information in the report. This information will be available only to the Principal Researcher and will be stored in a locked office within the Department of Psychology at AUT.

Appendix D

Participant Information Sheet



Date Information Sheet Produced:

20 April 2011

Project Title

The experience of combining IVF and paid employment: women's narratives.

An Invitation

Hello, my name is Serena Walker and I am doing a research project as part of my Masters of Health Science programme.

You are invited to participate in this study, which seeks to explore your experiences of combining IVF treatment with paid employment. Participation is voluntary and you may withdraw, without any adverse consequences, from the research at any time, prior to the completion of data collection.

What is the purpose of this research?

The purpose of this research is to understand the experiences of women combining IVF treatment and paid employment. Research has often alluded to the challenge for women combining IVF and paid employment. However, no targeted research has focused specifically on this. It is hoped this research may assist psychologists/counsellors in further developing their understanding of how to offer support to women at this critical phase in their lives and may offer insights into appropriate work-place policy development.

The results of the research may also be published.

How was I chosen for this invitation?

Fertility New Zealand and the Parents Centre have kindly sent you this invitation via their own networks. You may have directly received this invitation or someone you know may have forwarded you this information if they think you might be interested. The first 5 women who volunteer for this research will be selected for participation.

What will happen in this research?

If you wish to participate in this research, you will be asked to meet at a time convenient for you, to take part in an interview with the researcher. The interview will take place at a mutually agreed venue, either an office venue or at your home. The interview will be semi-structured in that the researcher will have an interview schedule with some topics for conversation but you will be able to speak as much or as little as you wish to on any topic. It is anticipated the interview will last for up to 90 minutes. The interview will be audiotaped to make sure your experiences are accurately recorded. Once the interviews have been transcribed, you will have the opportunity to read, review and make any changes or add any comments to your interview.

What are the discomforts and risks?

There should be very little risk to you participating in the research. However, sometimes, talking about your experiences may evoke some emotions. You do not have to discuss anything you are not comfortable talking about and can withdraw at any time without giving any reason. If after participation, you experience any distress or discomfort you will be able to access AUT Counselling Services for three free sessions.

How will my privacy be protected?

Your privacy will be protected by disguising any potentially identifying information in the report. To ensure that you are comfortable that privacy has been maintained, you will be given the opportunity to read your interview transcript and the analysis as it appears in the final report.

What are the costs of participating in this research?

There are no costs involved, other than approximately 90 minutes of your time for the interview.

How do I agree to participate in this research?

If you would like to participate, please contact me by email: wvc0029@aut.ac.nz or you can text or call me on 021 500404 within the next three weeks of receiving this information sheet. I will then contact you to arrange an interview time.

If you do agree to participate, you will also need to sign a consent form to show that you agree to take part in the research. This will be posted or emailed to you prior to the interview. Please read it carefully, and bring it along with you to the interview.

Will I receive feedback on the results of this research?

A copy of the final report will be made available to you.

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, *Sonja Goedeke*, sonja.goedeke@aut.ac.nz, 921 9999 ext 7186.

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEK, Madeline Banda, madeline.banda@aut.ac.nz, 921 9999 ext 8044.

Whom do I contact for further information about this research?

Researcher Contact Details:

Serena Walker, Postgraduate Student

Address: Department of Psychology, AUT University, Private Bag 92006, Auckland 1142

Email: wvc0029@aut.ac.nz

Mobile: 021 500 404

Project Supervisor Contact Details:

Sonja Goedeke, Senior Lecturer

Address: Department of Psychology, AUT University, Private Bag 92006,
Auckland 1142

Email: sonja.goedeke@aut.ac.nz

Phone: 921 9999 ext 7186

Approved by the Auckland University of Technology Ethics Committee 3 June 2011, AUTEK
Reference number *11/105*.

Appendix E

Interview protocol

The interview will begin with introductions and the researcher will explain the purpose and nature of the research project. This will be done by working through the participant information sheet and by answering any questions the participant may have. The semi-structured nature of the interview will be explained as will the type of narrative analysis to be used at the end of the data collection. Privacy and confidentiality will be discussed and the participant will be assured that they will have final approval on the transcripts when they have been transcribed.

The participant will be encouraged to only discuss that which they feel comfortable doing so in order to ensure their wellbeing as much as possible. They will also be advised that if they do feel uncomfortable at any point in the interview, they can ask that the interview be stopped.

The research will commence with an invitation to the participant to tell her story of her experience of combining paid employment and IVF treatment.

Topics that will be explored include, but may not be limited to:

- Infertility history
- Career history
- Public versus private narratives around infertility
- Experience of IVF treatment
- The workplace response to IVF treatment – working patterns, flexibility, support
- Career development and promotion
- Self-fulfillment and satisfaction
- Coping strategies
- Challenges
- Other issues

Supportive encouragers will be used in the interview process to keep the interviewees talking. The interview will be brought to a close by thanking the interviewees for their time and letting them know the researcher will be in touch when the interviews have been transcribed to allow them the opportunity to review the transcript and amend or remove any information they wish. The participants will also be reminded they can contact the researcher or her supervisor if they have any questions or concerns regarding the research. Finally, they will also be advised that three free counselling sessions are available to them if they experience any discomfort or distress as a result of this interview.

A follow up email will also be sent further thanking the participants for their time and also providing them once more with contact details should they require them.

Appendix F

Researcher Safety Protocol: Serena Walker

There is a possibility that the women who meet the criteria for this study may have had children and it is possible that they may not have returned to paid employment. In this instance, it may be most appropriate to interview the participants in their homes.

The following protocol will be observed:

- A colleague will be informed of the research interview schedule dates, times and venues. The researcher will check in with this colleague before and after each interview by text message.
- The researcher will take her mobile phone to interviews and will have it on (silent) at all times.
- The researcher will exercise cultural and social sensitivity towards participants.

Should any safety issue arise, the researcher will immediately call her supervisor and or the appropriate agency.

Should the researcher fail to check in with her colleague more than 2.5 hours after the interview commenced, the colleague will contact the appropriate agency and provide them with details of the address given.