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RETHINKING REPRODUCTIVE FREEDOM: IN-VITRO FERTILIZATION AND A WOMAN'S RIGHT TO CHOOSE

by

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B.A., University of Regina 1988
Honours Certificate, University of Regina 1990

THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF ARTS

in the Department

of

Women's Studies

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SIMON FRASER UNIVERSITY

July 1992

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ISBN 0-315-83633-4

Canadä

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Degree: Master of Arts

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ABSTRACT

For decades the feminist struggle for reproductive freedom has centred around the principle of a woman's right to choose - a philosophy which has affirmed the ability and right of all women to make conscientious moral choices regarding reproduction. Recent developments in conceptive technology, however, are raising new issues for the pro-choice movement. In particular, there is a growing body of feminist research which highlights the negative impact that highly technological procedures, such as in-vitro fertilization, have on women's reproductive freedom. Based on this research, many feminists argue against any further development or application of IVF. In response, advocates of IVF argue that it is inconsistent for pro-choice feminists to support technology to prevent or terminate a pregnancy and oppose technology designed to achieve one.

It is this apparent contradiction which lies at the centre of this thesis. More specifically, this work is an attempt to re-examine the 'right to choose' approach to women's reproductive freedom. I argue that a political movement based on the individual right to choose is ultimately insufficient to guarantee women's reproductive freedom, and that feminists must now move beyond the issue of who should decide, to consider the reproductive options available to women and the conditions under which they make their choices. The question is no longer whether pro-choice advocates are inconsistent if they do not support any and all technological developments. It is whether certain technological options are consistent with a feminist morality of choice.

Ultimately, I want to affirm that the feminist struggle for reproductive freedom is not simply a demand for the right to choose. It is also a demand for reproductive options which respect the integrity of women's bodies and

the physical and psychological health of women. It is a demand for women's increased control over their bodies, their reproductive processes and their lives in general. Access to any and all reproductive technologies does not guarantee reproductive freedom for women, and pro-choice feminists can consistently question the particular reproductive choices women make, without abandoning a respect for their ability to choose.

ACKNOWLEDGEMENTS

I would like to thank my senior supervisor, Sue Wendell, who always provided me with support, encouragement, and thoughtful criticism and who taught me to have confidence in my work.

Thanks to my friends and colleagues at the Everywoman's Health Centre whose work embodies the principle of empowering women and who gave me the opportunity to put my politics into practice.

My thanks to Susan Nurse, friend, housemate and soul-supporter, who was always there to lend an ear, an opinion and, when I needed it most, a quiet space to work.

Thank you to my husband, Paul Degelman, for always supporting my goals and dreams and for filling my life with laughter and joy.

Finally, I would like to thank my parents, Eunice and Gordon Dohlen, who have always taught me to believe in myself and my ideas. My vision of the future draws its strength from their love.

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INTRODUCTION:

Biological reproduction, that most 'natural' of human activities, is presently the subject of major technological intervention. Although scientific understanding of reproductive processes is still incomplete, it is now possible to apply technology at every stage - conception, implantation, gestation and birth.

The development and expansion of these technologies raises serious legal, ethical, social, political and economic questions, and commentators from a variety of fields, including medicine, science, law, psychology and politics are deliberating over their implications. Feminists in each of these areas are also examining the meaning of these technologies, and what makes their analyses unique is their specific focus on the health and well-being of women.

A feminist approach is based on the recognition that it is women, and not men, who are the primary focus of reproductive medical intervention. Because it is their bodies, rather than their partners', which are examined, probed, poked and manipulated, it is usually women who bear the physical and emotional pain of the new reproductive technologies. Moreover, because it is women who have the primary responsibility for childcare, it is they who will experience the negative familial and social implications of the technologies in the most profound ways. In short, "women have a huge stake in reproduction in general, and in the NRTs [new reproductive technologies] specifically." (NAC, 1990, 12)

A feminist approach is also based on the recognition that a central underlying issue in the debate over new reproductive technologies is women's

reproductive freedom. Infertility technologies, like abortion and contraception, are part of a continuum of technological developments which directly affect how women, whether fertile or infertile, experience their reproductive capacities. Thus, new reproductive technologies, like abortion and contraception, have important implications for the feminist political movement for reproductive freedom. Traditionally, this movement has been firmly based on the principle of 'a woman's right to choose', and historically, the struggle for women's rights to determine their reproductive lives has centred around the right to control their fertility through access to contraception and abortion - that is the right not to become a mother.

Efforts on behalf of women's rights to control their fertility have been based on two ideas essential to the feminist view of reproductive freedom. The first takes into consideration the biological connection between women's bodies and reproduction. Working from the general principles of 'bodily integrity' and 'bodily self-determination,' feminists argue that in order to be free, women must be able to control their bodies and procreative capacities. The second idea takes into consideration the social position of women and the reproductive needs that position creates. Recognizing that, historically, it has been women who have been responsible for the caring for and rearing of children and that, as a result, it is women who are most deeply affected by pregnancy, feminists assert that it is women who must make decisions about when and where they will have children (Petchesky, 1984, 2). Thus, at the very foundation of the political demand for the 'right to choose' is a fundamental affirmation of the right and ability of all women to make autonomous and careful moral decisions regarding reproduction.

The politics of choice has served women well, and significant gains

have been make over the last three decades. Increased access to safe and legal abortions is one example. Recent developments in conceptive technologies, however, are raising new challenges for the reproductive rights movement. Feminists are presently involved in the process of re-evaluating the 'right to choose' as a basis for their political struggle. This thesis is part of that re-evaluation. In particular, I will examine the ways in which in-vitro fertilization, a highly technological means of bypassing infertility, has exposed the limits of the traditional feminist strategy for reproductive freedom. Specifically, I will argue that 'a woman's right to choose', while politically compelling, is ultimately insufficient to ensure the reproductive freedom of all women. It is my contention that feminists must now move beyond answering the political question, 'who should decide,' to evaluating critically the technological reproductive options available to women and the conditions under which they must make their choices.

I have chosen to argue my case with a focus on IVF because it is a procedure which is technologically and socially unique. First, as a medical option, IVF is the most highly technical and physically intrusive means of bypassing infertility. The process begins with the ingestion of superovulation drugs designed to stimulate the growth of several ova. The time of ovulation is then carefully monitored by ultrasound, typically administered at three hour intervals. When ovulation occurs, the ova are surgically extracted and then combined with sperm to achieve conception in the laboratory. A few days after conception, several fertilized eggs are transferred vaginally to the woman's uterus, where, it is hoped, at least one will implant and develop to full-term. IVF's highly technical and intrusive process, coupled with very low success rates - current estimates range from 8 to 15% - combine to make it a

uniquely controversial procedure.

Second, IVF is, at the present time, the technological option which marks the end of fertility treatment. It is the 'last chance' technique which women choose when all other options have failed or have been deemed inappropriate. Thus, many women choose to enter an IVF program with a unique sense of urgency and hope. Having made the decision to try IVF, they know that should it fail, they must face the reality that what remains is the challenge of coping with life without a biological child. To this extent, IVF is psychologically unique - when other techniques fail, there is always the hope that the next one will bring success. When IVF fails, there is no hope left.

Because it is so technologically complex, and because it is a last resort treatment, IVF has become increasingly controversial. In addition to concerns about the safety and health of the women who choose it, there is the broader issue of the implications of this technology for women as a social group. This controversy surrounding IVF raises unique challenges for the feminist 'pro-choice' movement. In particular, the question arises, is women's reproductive freedom guaranteed by a woman's right to choose any technological option available, or do certain choices, made on a claim to the right to choose, actually threaten reproductive freedom?

Ultimately, then, this thesis is about feminist 'second thoughts' on reproductive freedom. It is about the meanings of choice in relation to new reproductive technologies, such as in-vitro fertilization, and old reproductive technologies, such as abortion. Finally, it is about a feminist conception of reproductive freedom that moves beyond the traditional 'woman's right to choose' approach. Ultimately, it is my goal to develop a feminist approach to new reproductive technologies that is both theoretically and politically

consistent with our overall demands for women's reproductive freedom - demands which have been traditionally articulated in the struggle for safe and effective contraception and safe and accessible abortions.

CHAPTER SUMMARIES:

Chapter one provides a review of the feminist research literature on reproductive technologies. Comparing and contrasting radical and socialist feminist critiques on the subject, I attempt to trace the feminist debate on the new technologies as it has developed. In particular, I identify three concerns common to both radical and socialist feminist writings: 1) discriminatory costs and benefits; 2) risks to women's health and well-being; and 3) increased medicalization and male control over reproduction. In addition to identifying this common ground, I also examine the different political implications each of these issues raises for socialist and radical feminist writers.

In chapter two I examine the highly contentious issue within the feminist literature on new reproductive technologies: the ability and right of infertile women to choose technological treatment for reproductive impairments. More specifically, I review and critique radical and socialist feminist analyses of this issue attempting to identify the strengths and weaknesses of each position.

In chapter three I pause from the political debate about technology and choice to consider women's experiences of infertility. It is my assertion that any attempt to understand the implications of the new reproductive technologies for infertile women must include an understanding of their experiences of fertility impairment. To this end, I include a review of the

empirical research on the experience of infertility diagnosis and treatment, paying particular attention to gender differences. Finally, this chapter includes a theoretical examination of why women's experiences of infertility are typically more intense and threatening to their identity than the experiences of their male partners.

In the final chapter, I return to the issue of IVF and the 'right to choose'. In particular, I examine the limits of the traditional feminist strategy for reproductive freedom based on individual rights to choose and argue for the need to develop an alternative feminist ethical framework from which to evaluate various reproductive options. Drawing heavily upon feminist ethical theory by Petchesky and Sherwin, I make an ethical evaluation of IVF. I conclude with a discussion of future political strategies for the feminist movement for reproductive freedom.

CHAPTER ONE

A REVIEW OF THE LITERATURE:

This chapter is an attempt to review and synthesize the vast and growing body of feminist literature on new reproductive technologies. It is important to note, at the outset, that the term 'new reproductive technologies' is somewhat problematic. First, it refers to a wide variety of technological interventions that vary markedly in their purpose. Michelle Stanworth has identified four separate types of intervention: 1) contraceptive techniques; 2) pre-natal monitoring and screening; 3) labour and birth management; and 4) conceptive techniques (1987, 10-11). In addition, within each of these categories there is a variety of technologies which vary considerably in their degree of intervention. For example, both 'surrogacy' and alternative insemination can be practised without medical intervention at all, while in-vitro fertilization [IVF] requires sophisticated medical, surgical and laboratory procedures. Finally, the term 'new' is also problematic. In fact, many of the technologies included in this term are not recent developments. The first attempt at alternative insemination of humans, for example, was reported more than a century ago (Corea, 1985, 12).

Thus, within the literature on 'new reproductive technologies', feminist commentators are grappling with a wide range of issues regarding a wide range of techniques. In order to make the following review more manageable, I have focused on feminist literature on conceptive medicine, particularly IVF. While this focus is analytically useful, it is important to note that it is not always possible to isolate this topic from other related topics. For example, when considering the implications of conceptive technologies,

many commentators base their work in current understandings of other technologies and of the history of medical intervention in general. Thus, where appropriate, I will also take these efforts into account.

DEVELOPMENT OF THE DEBATE:

The structure of this review attempts to trace the feminist debate on reproductive technologies as it has developed. In terms of the history of feminist literature on the subject, radical feminists were the first to develop a critical analysis of reproductive technologies. Often referred to as 'anti-technology' literature, this early and still popular body of work is extremely critical of the technological developments. In the most general terms, commentators from this side of the debate argue that these technologies are developed in the interests of science, profit and patriarchy and will ultimately be used for the benefit of men and to the detriment of all women. More recently, this position has been challenged by socialist feminists, who have, for the most part, developed their position on reproductive technologies in response to the radical feminist literature.

Behind this debate lie radically different assumptions about conceptive technologies. For most socialist feminists, change in the social, economic and political conditions can make reproductive technologies unproblematic, or at least less problematic than at present. For these commentators, issues of unequal access and lack of control by women can be addressed politically. In contrast, radical feminists insist that regardless of progressive social or political change, and even if women controlled them, reproductive technologies would always be harmful to women because they empower the dominating authority of technology. By implication, socialist feminists ask

under what conditions these technologies could enhance women's reproductive freedom, while radical feminists do not even pose the question.

As a reviewer of the literature, my challenge has been to follow the development of this debate, identifying the common ground both sides share and the issues on which they diverge. To trace these developments, I have identified two areas of dialogue. The first can be characterized as common ground - the issues on which both radical and socialist feminists tend to agree - and it is this area of work that is the focus of this chapter. To review these issues, I have divided this chapter into three sections, each of which highlights the major themes of concern within the feminist literature on reproductive technologies: 1) discriminatory costs and benefits; 2) risks to women's health and well-being; and 3) increased medicalization and male control over reproduction. This chapter also examines the different political implications each of these issues raises for socialist and radical feminist commentators.

The second area of dialogue is more controversial than any of these issues, and it is one which has inspired considerable debate within the feminist community. Unlike the common ground which is the subject of this chapter, it is the major point of divergence for radical and socialist feminists. It centres on the question of the right and ability of infertile women to choose reproductive technologies, and it is the subject of chapter two.

FEMINIST COMMON GROUND:

DISCRIMINATORY COSTS AND BENEFITS:

The issue of unequal access to the new conceptive technologies is frequently raised within both the radical and socialist feminist literature. In

particular, feminists from both sides of the issue are quick to point out that scientific and medical efforts to alleviate the suffering of an infertile woman are dependent on her class, race, ability, marital status and sexual orientation (Corea, 1985; Hubbard, 1981; Overall, 1987, Stanworth, 1987). In short, social support for the desire to mother is limited, and at the centre of the technological response to infertility is the will of white, wealthy married women.

In-vitro fertilization is expensive. According to current estimates, one attempt at IVF conception costs approximately $5,000 (Moss, 1988, 42). At the present time, Ontario is the only province in Canada which covers the cost under the provincial health plan. Thus, for the vast majority of Canadian women, access to this high-tech treatment is directly linked to economic status. In addition, many women who can afford such techniques are denied access on the basis of their marital status, sexual orientation or physical disability. Most IVF clinics and many alternative insemination clinics require that participants be in a stable, monogamous marriage, and this requirement effectively excludes single and lesbian women (Moss, 1988, 43). As Ruth Hubbard insightfully notes, these restrictions indicate that the new technologies are being used to uphold patriarchal values which define motherhood as appropriate for married, heterosexual women only (1981, 262). In addition, conditions of unequal access ensure that these technologies will only exacerbate the inequalities which presently divide women.

While new, high-tech infertility treatments are developed for wealthy women in industrialized countries, involuntary childlessness in the Third World continues to be ignored in the medical and scientific literature. Instead, concerns about reproduction in poverty-stricken countries focus on

controlling fertility. In fact, in the effort to limit female fertility, medicine and science are contributing to higher rates of infertility in these countries. As Gena Corea notes, the medical community continues to push non-barrier contraceptive methods, including the pill, IUD, Depo-Provera injections, Norplant and sterilization, despite the fact that these methods do nothing to prevent the transmission of venereal diseases, a major cause of infertility (Corea, 1988, 82). As the National Action Committee observes:

> At the same time as billions are spent on helping a few infertile women in the First World, women in the third world are used as guinea pigs for drugs (depo-provera), techniques (IUDs) and surgical procedures that in fact make them infertile or sterile. (1990, 17)

Radical and socialist feminists also agree that while few women actually benefit from the new reproductive technologies, physicians and researchers - mostly men and mostly white -make significant gains (Corea, 1985 and 1988; NAC, 1990; Rowland, 1987a and 1987b; Stanworth, 1987). For doctors, high-tech infertility treatment, specifically IVF, is prestigious and profitable. In addition, this field provides a tremendous potential for profit for pharmaceutical and biotechnology companies. According to company representatives and doctors who work in this field, the consumer market for drug therapy is large and expanding, and this represents just one aspect of the treatment process (NAC, 1990, 22). Because infertility treatment is proving to be a very lucrative field, these same companies have a vested interest in maintaining market demand.

To illustrate this point, the National Action Committee reports on Ares-Serono, a pharmaceutical company which manufactures Clomid and Perganol,

and a giant in the IVF field. Serono now owns Bourn Hall, the clinic where the first 'test-tube' baby was conceived and a leading centre in the research and development of new technologies. It funds, organizes and attends all major conferences and colloquia on the new reproductive technologies. Serono also provides funding for academic research and sponsors doctors who attend professional conferences. Perhaps most disturbing of all, Serono has developed a 'non-profit foundation' which funds and participates in infertile women's networks "persuading women that the route to fertility lies through their products." (NAC, 1990, 22)

Labelling this process the "science-push", many critics argue that far too often technologies are developed out of the mutual interests of scientists and corporations and then aggressively promoted in order to create the necessary markets (NAC, 1990, 23). This process has characterized the development and application of ultrasound pre-natal diagnosis and amniocentesis, both originally developed for a select group of women and eventually expanded to routine practices for the majority (Rapp, 1988). It also characterizes the application of IVF, which was originally developed for women with missing or blocked fallopian tubes and is now used on fertile women whose husbands have a low sperm count (Lorber, 1988). It is thus through the profit motive that technologies expand and generalize to touch the reproductive experiences of large numbers of women.

It is important to note that while radical and socialist feminists agree on the issues of discriminatory costs and benefits, they often disagree on the political implications of these problems. In particular, socialist feminists advocate eliminating the profit incentive behind research and development

through public funding. Similarly, they advocate progressive public policies to eliminate restrictions on access, and they favour public funding of services to ensure that all infertile women, regardless of their socio-economic status, can use the new conceptive medicine. The goal of the socialist feminist agenda is to change the political conditions which presently create the problems of unequal access and discriminatory costs.

In contrast, radical feminists strongly oppose any effort to expand the use of these technologies through public funding. They insist that not only would this be a serious misallocation of already limited public health dollars, it would also serve to reinforce the acceptability of these inherently dangerous and experimental techniques. Instead, they argue, the government should be restricting private research and development in this area and banning experimental services such as IVF.

RISKS TO WOMEN'S HEALTH AND WELL-BEING:

A second major theme within radical and socialist feminist literature is the immediate and long term health risks involved in the investigation and treatment of infertility (Conseil du statut de la femme, 1987; Corea, 1984, 1985 and 1988; CRIAW, 1989; Hanmer, 1984; Hubbard, 1981; Klein, 1987; NAC, 1990; Pfeffer, 1987, Raymond, 1984; Rowland, 1984 and 1987a; Stanworth, 1987). Many of these feminist commentators are particularly critical of the intense physical, emotional and spiritual damage the various invasive procedures inflict upon women. They also point out that the long term health consequences of many procedures have not yet been determined. Recognizing the experimental nature of many of the techniques, they

conclude that "the innumerable manipulations of a woman's body and the humiliation, as well as the pain involved in these procedures, threaten her well-being." (Corea, 1988, 88)

Infertility investigations include a variety of painful and intrusive procedures. Typically, women will undergo physical examinations, tubal insufflation (carbon dioxide is blown through the uterus and fallopian tubes to detect a blocked tube), laparoscopies (a telescope is surgically inserted into the pelvic cavity through a small incision in order to observe the reproductive organs directly), and hysterosalpingrams (a dye is injected into the uterus and into the oviducts to identify problems in the uterus or fallopian tubes) (Pfeffer and Woollett, 1983, 40-56).

While the specific medical treatment for infertility depends on the results of these investigations, it most often begins with hormone drug therapy designed to stimulate ovulation. These drugs, including Clomid and Perganol, often cause nausea, hot flashes, drying up of the cervical mucus, mood swings, depression and weight gain (NAC, 1990, 33; Pfeffer and Woollett, 1983, 40-56). While many physicians consider these conditions inconvenient 'side effects', feminist critics point out that they are significant risks to women's health and well-being.

If attempts to conceive are pursued through alternative insemination, the procedures are relatively simple, and while most women seek medical assistance with AI, it can in fact be carried out independently of the medical profession. In contrast, IVF is an extremely high-tech invasive procedure controlled and administered by medical and scientific professionals. Women who enter IVF programs have already been through numerous test and procedures, often over a period of years. Once in an IVF program, women

undergo another long period of numerous pharmaceutical and bio-medical interventions, including more drug therapy, blood work, the closure of the oviducts using high frequency electrical current, ultrasound examinations, surgical removal of eggs, and the transferring of embryos into the uterus.

Critics such as Corea argue that through these procedures, men are experimenting on women in ways more damaging than anyone is willing to admit. She points out that "it may sound simple to just take a few eggs from a woman's ovary, fertilize them, and return them to her uterus, but in fact the manipulations of the woman's body and spirit involved in this process are extreme." (1985, 166) Feminist evaluations of these intrusive procedures are supported by the statements of many infertile women who have been through IVF. In a recent collection of essays written by infertile 'patients', one woman provided a dramatic description:

> doctors always arriving late, women, as usual, sitting for hours half-naked and cold in ill-fitting towelling robes; and unnecessarily frequent blood tests; and vaginal examinations often done by several male doctors one after the other like gang rape. The weekly examinations were tiring, extremely intrusive and physically demeaning. (Humm, 1989, 37)

While many women have eloquently described the pain and humiliation of infertility treatment, this information seldom makes its way into the medical and scientific literature on the subject. Little mention is made of the emotional roller coaster these women experience through investigation and treatment. As Corea points out, "there is a cycle of hopes raised and dashed which harms women in ways the king [doctor] has not bothered to examine." (1988, 86)

While the medical and scientific professionals may ignore women's

experiences during investigation and treatment, a growing number of psychologists and social workers have researched the emotional costs associated with infertility and its unsuccessful treatment (see Appendix A). This research reveals that in addition to 'inconvenient side effects', many women experience infertility as a life crisis, and its treatment as a physically and psychologically invasive process which has profound affects on their lives. For the women who undergo failed treatment for infertility, the experience is typically associated with intense feelings of guilt, depression, stress, hopelessness, anxiety, and feelings of prolonged crisis (Greil, 1988; Lalos et al., 1986; Miall, 1986).

Many feminist writers also point out that in addition to being a painful and humiliating experience, IVF poses serious long term and even fatal health risks for women. The National Action Committee reports that one to two per cent of women treated with ovulation inducing drugs develop ovarian hyperstimulation syndrome - a potentially fatal condition (NAC, 1990, 2). In addition, women face possible trauma to the ovaries, the risks associated with anaesthetics during repeated operations, infection during the transfer of the embryo and possible ectopic pregnancies[1] (Corea, 1985, 71). NAC also reports that the minority of women who complete IVF successfully also face the health risks associated with multiple fetus pregnancies, a condition which occurs in up to 25% of IVF births (1990, Executive Summary, 2).

While the long term health risks of IVF have yet to be completely determined, the World Health Organization has warned that the hormones ingested to induce ovulation will likely predispose women to cancer. In addition, there are concerns about the chromosomal damage and long term intergenerational effects these drugs will have (NAC, 1990, Executive

Summary, 2). Clearly, when the long term health effects are fully understood, it will be too late for those women and their potential children who are being experimented on now. We need only reflect on the development and distribution of the 'old' reproductive technologies, such as DES, Thalidomide, oral contraceptives, depo-provera and the Dalkon Shield, to understand the need for concern about the new technologies - now. Ironically, it is many of these earlier technologies that have directly contributed to high infertility rates at the present time. Unfortunately, feminist commentators note, many women facing infertility feel compelled to seek assistance in conception from the same medical system which caused their infertility in the first place.

Despite years of tremendous emotional and physical costs to women, IVF still remains a highly experimental procedure with an extremely high failure rate. In a recent study of IVF clinics, only 8% of those women who completed treatment cycles carried a pregnancy to full term (CRIAW, 1989, 7). Moreover, one half of the clinics which responded to a success rate survey in the United States reported that they had never sent a woman home with a baby. Despite this obvious failure, many of these same clinics continue to report misleading success rates - anywhere from 18.2 to 25 per cent - which include successful implantations ending in miscarriages (Corea, 1988, 90). In addition, there is ample evidence that as a direct consequence of these false and inflated success rates, many women who enter IVF programs are unaware of the experimental nature of the techniques involved (Conseil du statut de la femme, 1987, 34; Corea, 1985, 168; Pfeffer, 1987, 89).

For feminists on both sides of the debate this problem is clear. Women who consider high-tech treatments for infertility lack honest and accurate

information on the experimental nature of the techniques, on the high failure rates and on the health risks involved. Without this information, it is impossible for infertile women to define their needs, evaluate their options and make wise and informed decisions regarding what treatment they will pursue, if any at all. In addition, it is clear that limiting access to reliable information is one way in which physicians and scientists maintain power over women in the area of reproductive technologies. Without adequate information, women cannot take control of their own reproductive health.

As in the case of unequal access and discriminatory costs, radical and socialist feminists agree on the problem and disagree on the solution. For socialist feminists, there is a variety of practical measures which can be taken to ensure that women who consider IVF have access to accurate information, including feminist health information services, counselling support groups, and government legislation on access-to-information standards. The goal is to provide women with accurate information which will allow them to evaluate the risks for themselves and thus, enhance their ability to make informed choices.

In contrast, radical feminists argue that the serious health risks involved and the experimental nature of the techniques make it impossible for them to lend their support to these technologies - even if women are provided with accurate information. In short, the new technologies represent an unacceptable choice because they "reinforce the degradation and oppression of women to an unprecedented horrifying degree. They reduce women to living laboratories; to 'test-tube' women." (Klein, 1987, 65) From this perspective, the goal of accurate information is to expose the dangerous nature of these technologies and to help infertile women resist them.

INCREASED MEDICALIZATION & MALE CONTROL OVER REPRODUCTION:

Radical and socialist feminists also share a common concern about who controls the development and application of the new conceptive technologies (Arditti, Klein and Minden, 1984; Corea, 1985; Holmes, Hoskins and Gross, 1981; Hubbard, 1981; Rowland, 1984; Stanworth, 1987). Specifically, these commentators point out that although women are the principle consumers of such technology, they have scarcely been involved in making decisions about which ones should be developed, and when and where they should be applied. On the contrary, these technologies have emerged from a science which has been developed by men, according to their own values and sense of reality. More specifically, "the NRTs represent the values and priorities of an economically stratified, male-dominated technocratic science." (NAC, 1990, 27)

Not only are the technologies not controlled by women, but their purpose and effect is to remove women's control over their own reproductive processes. As Ruth Hubbard points out, women who undergo sophisticated infertility treatment, such as IVF, quickly become locked in a high-tech medical system which requires that they and their babies be constantly monitored from before conception through birth (1981, 262). Janice Raymond refers to this as the "chronic medicalization of women's bodies" and argues that the history of the medicalization of pregnancy has clearly demonstrated that as reproductive processes become more technical, control is removed from women and placed in the hands of medical professionals (1984, 428).

The increased medicalization of women's reproductive lives and the

erosion of women's control over these processes have at least two implications. First, as the National Action Committee noted in its Brief to the Canadian Royal Commission on Reproductive Technologies, they have made it more difficult for women to choose alternatives and non-technological options in reproduction (1990, 13). This has been evidenced historically with the increased technical monitoring of pregnancy and labour, and it is characteristic of the development and application of IVF. In the latter case, pressures to provide men with a genetically linked child, and the increased availability of IVF for those who can afford it, have led many women into this extremely invasive procedure, even when less intrusive options, such as alternative insemination by donor, have been available.

The second implication of the expanding medicalization of reproduction is an increased sense of alienation and objectification in the reproductive process for infertile women. "In the midst of the advanced technology, a woman can feel that she is a mere container for the fetus, 'that her body is an inconvenient barrier to easy access and the probing of all those rubber-gloved fingers and the gleaming equipment.'" (Corea, 1985, 250) Again, many feminists draw analogies between the historical medicalization of childbirth and the new medicalization of conception. In particular, Barbara Katz Rothman argues that in both cases medicalization inevitably reifies the separation of the fetus and the mother, leads to women's loss of control over the reproductive process and alienation from their reproductive capacities and labour and, ultimately, serves to "dismember" motherhood (1987, 167).

There is considerable consensus among radical and socialist feminists on the preceding critique of the issue of control. However, efforts to predict the future implications of male control of these technologies have inspired

debate. For radical feminists, the new conceptive technologies will ultimately affect the reproductive consciousness of all women - fertile and infertile (Arditti, Klein and Minden, 1984, 6; Hanmer, 1984, 444). As the medical and hence male control over reproduction is enhanced, and as the ability of all women to control their reproductive capacities is undermined, the new reproductive technologies threaten to remove the last women-centred process that women experience. In the end, radical feminists ask the question: "will the ultimate feat of these technologies be to remove not only the control of reproduction, but reproduction itself, from women?" (Raymond, 1984, 435)

This view has been echoed by Gena Corea, who argues that "through the use of the new reproductive technologies, women's reproduction is being objectified in the same way women's sexuality has been for centuries." (1988, 89) She argues that as reproductive technology expands, all women will become increasingly alienated from their reproductive capabilities. Women of the future, she concludes, "will be divorced from their own reproductive power as we are divorced from our sexuality. They will feel inadequate to reproduce. They will not believe they have the capacity to do so." (1988, 89)

For those commentators who consider this scenario, the possible implications of the technologies are too devastating to risk. No matter how effective it may be and no matter who controls it, any procedure which increases the medicalization and fragmentation of the reproductive process cannot be supported. As Ann Pappert states:

> Even if IVF worked, and produced babies more often than it failed, it would still be a technique that seeks medical control over reproduction, rather than giving more control to women. This separation of reproduction from the bodies of women to the

> laboratories of men, turning babies into products and women into breeding grounds for experimentation, amounts to expropriating women's bodies in the interests of science. (1989, 200)

For their part, socialist feminists take issue with the future scenario developed within the radical feminist literature. In particular, they reject the radical feminist assumption that these technologies are inherently anti-female, and highlight instead the extremely ambivalent effects reproductive technologies have had on the lives of women. They note that, in addition to increasing medical control over women's lives, reproductive technologies have also offered many women the technical possibility to decide if, when and under what conditions to have children. Socialist feminist Michelle Stanworth refers to this dilemma as the "double-edged sword" and argues that, in addition to identifying the negative aspects of these techniques, feminists must acknowledge that due at least in part to technological intervention in human reproduction, women in industrialized countries now have fewer unplanned pregnancies, bear fewer babies against their will, are less likely to die in childbirth and less often experience the death of their infants than their foremothers did. Moreover, technology is only one dimension of the many forces that shape reproduction and influence women's lives.

For socialist feminists, the radical feminist effort to target reproductive technologies as the obstacle to autonomy and reproductive freedom is misdirected. In fact, "for some women, motherhood remains their only chance of creativity, while economic and social conditions compel others to relinquish motherhood altogether." (Stanworth, 1987, 16) Accordingly, if we are going to develop realistic appraisals of the future of women's reproductive

health under the influence of conceptive medicine, we must identify and challenge the problematic social and economic conditions under which these changes take place.

CHAPTER TWO

NEW REPRODUCTIVE TECHNOLOGIES AND CHOICE:

In the preceding chapter, I examined three themes which are characteristic of both the radical and socialist feminist literature on reproductive technologies. In particular, I argued that while they disagree on the political implications of these problems, feminists on both sides of the debate agree that discriminatory costs and benefits, increased health risks and male control of the technologies are problematic aspects of the new conceptive medicine.

In this chapter, I will explore a more contentious issue within the feminist literature - the ability and the right of infertile women to choose conceptive technology for infertility treatment. My goal is to provide a review and critical analysis of both radical and socialist feminists positions on the issue of choice. In particular, I argue that the major strength of the radical feminist analysis is its emphasis on the social construction and political conditions of reproductive choice, which exposes the limits of a political movement for reproductive freedom based on the simple demand for the individual's 'right to choose'. This analysis is weakened, however, by the tendency to view infertile women's desires to mother as socially constructed to such an extent that their ability to make authentic autonomous choices regarding infertility technologies is effectively negated. Drawing upon the work of socialist feminists, I will argue that there is a tendency within the radical feminist literature to deny the agency of infertile women by reducing their desires to products of ideological determinism.

For their part, socialist feminists make a significant contribution to the debate by reaffirming the ability of all women to make moral choices

regarding technology and reproduction, and by identifying the ways in which women do so even under oppressive conditions. The weakness of their position, however, is a continued defense of all technological treatments for infertility - including the highly invasive and physically dangerous treatment of IVF - on the basis of the 'right to choose'. What is missing from this analysis is an acknowledgement that some reproductive choices are not acceptable in a feminist ethic of reproduction, and this weakness is based on the mistaken assumption that to challenge particular choices women make is to challenge the political right to choose altogether.

RADICAL FEMINIST ANALYSES:

Within the popular media image of the new conceptive technologies, infertile women are portrayed as helpless and desperate, willing to go to any lengths individually to have a child of their own.[2] Reflecting on the medical response to these women, radical feminists argue that the physicians and scientists to whom these women turn accept, without question, their desperate state of mind. Assuming that the 'will to mother' is somehow natural, these 'benevolent' professionals fail to consider how the desperation of these women is socially constructed.

For radical feminists, in contrast, the issue of the social construction of the will to mother is crucial, because it brings into question the abilities of infertile women to choose the new reproductive technologies freely (Albury, 1984; Corea, 1985 and 1988; Hanmer, 1984 and 1987; Raymond, 1989; Rowland, 1984 and 1987b). Specifically, these commentators argue that to the extent that a woman's desire to mother is a product of pro-natal,

patriarchal socialization, her decision to use conceptive technologies is so conditioned by the stigma of infertility and the social pressure to fulfil the role of motherhood that, in effect, it is no choice at all.

A central aspect of the radical feminist critique is the critical examination of the intense social pressure put on women to become mothers. These feminists argue that centuries of pro-natal conditioning has taught women that their existence and value is based on their ability to bear and raise children. In this context, women learn that their only route to personhood is through motherhood, and hence, any threat to obtaining this role strikes at their whole sense of self-identity. Referring to how deeply these messages are socially engrained in the feminine psyche, Gena Corea comments, "It is our cell-deep knowledge: We are here to bear the children of men. If we cannot do it, we are not really women." (Corea, 1985, 129)

Corea has written at length about the social construction of the will to mother. She argues that there are numerous ways in which this desire is shaped and controlled (1988, 79-82). First, female identity is reduced and limited to two functions - reproductive and sexual. Of course, different societies use varying degrees of force to achieve this goal. In democratic societies, such as ours, it is achieved by a systematic structuring of women's life choices. Institutions such as churches, schools, media, medicine and language limit opportunities and goals for women, and from the time they are young girls, women learn that in their culture, "'Women are for bearing babies. Bearing babies is women's function in life. Women are for sex. Being sexy for men is women's function in life.'" (Corea, 1988, 79) Over time, each woman internalizes this valuation of herself which, in turn, shapes her desperate will to be a mother.

Second, women's emotions and motivations are manipulated to the extent that once a woman's ability to bear children is in question, she may be threatened by abandonment, isolation, loss of love, rejection from her family and social humiliation. As these emotions are manipulated by either a woman's doctor or her husband, her will to mother is fundamentally shaped. In this context, "the doctor's authority stands behind the notion that it is quite reasonable for a woman to go through any torture in order to fulfill her 'natural' role and bear a baby." (Corea, 1988, 80)

Third, women's desires to mother are shaped and reinforced by false images of the experience of motherhood. The same institutions which serve to limit women's identity also serve to define motherhood as the sphere of "rosy feminine fulfillment" (Corea, 1988, 80). The negative aspects of mothering - the frustration, boredom and exhaustion that all mothers experience - are not part of the social definition of motherhood, and this has the effect of reinforcing many women's false hope of finding self-fulfillment in this role.

Fourth, the social pressure to mother is directly linked to the historical devaluation of women's labour and skills. In all Western industrialized societies, women's labour force participation is primarily low-paying, low-status service work. These limitations make the majority of women dependent on men for their standard of living, and in the process, they come to define marriage as their only source of livelihood. Similarly, the social devaluation of women's creativity and intelligence, and the lack of social support for women who participate in nontraditional careers, all serve to reinforce their will to mother. In short, the desire to mother is structured and reinforced through the systematic limitations of women's life options. As Jalna Hanmer argues: "The under -and devaluation of women as people, our

valuation as wives and mothers, makes women vulnerable to social pressures to reproduce and to go through any torture to be able to do so." (1984, 440)

Finally, Corea argues, women's will to mother is also linked to the pervasive social complacency about violence against women. Specifically, society's failure to challenge adequately violence against women, in all of its forms, including rape, incest, woman-battering, and pornography, serves to reinforce women's lack of self-worth. As Rothman argues:

> Lacking economic power, physical and emotional safety, women can be coerced into motherhood, which seems to offer a power-base from which to negotiate for some degree of status and protection. (quoted in Corea, 1988, 81)

For radical feminists who oppose the new conceptive technologies, the social construction of the will to mother poses serious challenges to the feminist ethic of reproductive choice and the 'right to choose'. In particular, they question the ability of infertile women to make free choices regarding technological treatments. According to radical feminists, so long as patriarchal socialization makes motherhood a woman's primary path to self-fulfillment, her decision to seek high-tech medical intervention for infertility is not a choice of her own free will, and within this framework, coercion becomes a crucial factor. As Sandelowski summarizes:

> despite the expansion of life options for women, coercion rather than choice is an integral part of a pronatalist environment that make true reproductive freedom virtually impossible. Women are not free not to choose cures for infertility given the price they will pay for not trying hard enough to become mothers. The motherhood mandate pervades social institutions and women's psyches, blurring the lines between individual choice and societal expectations. (1986, 446-447)

Thus, according to this position, a woman's decision to become a mother and to use technology, when necessary, to do so, is not a choice but the socially expected and accepted solution to a socially unacceptable problem.

Focusing on the ideological context which shapes women's will to mother and limits their ability to make choices, radical feminists argue that the most appropriate response to infertility is not technology, but a fundamental challenge to pronatalist socialization. Rather than offering infertile women intrusive and painful technological intervention, we should, they argue, be offering women a social context in which they can expand their identities beyond the role of 'mother'. Only in this context, can any notion of free choice become a reality. The assumption here is that if motherhood were not so central to many women's lives, infertility would not pose the life crisis it presently does.

Moving beyond the question of the ability of infertile women to choose freely, radical feminists also challenge the 'right' of infertile women to choose technological assistance for conception. In particular, they argue that even if the conditions of choice were such that infertile women could freely choose reproductive technologies, that choice would be threatening to the social well-being of women as a group, and as such, would not be acceptable. For radical feminists, the new reproductive technologies serve to reinforce male control over reproduction and will inevitably lead to greater social control of all women by men. It is not acceptable for feminists to support an individual women's right to choose the very technology which threatens to harm all women. Thus, not only should we question the ability of infertile women to make autonomous choices in this area, we must also question their individual right to do so.

Recognizing the challenge this position poses for feminist ideology, Robyn Rowland argues that it is time for all feminists to rethink their traditional pro-choice position, which places priority on the individual woman's right to choose over the health and well-being of women as a social group (Rowland, 1987a and 1987b). She states that feminists "must re-evaluate the issues of reproductive freedom and the 'right to choose' in terms of the long term consequences of uncontrolled medical 'advances'." (1987a, 74)

The major strength of the radical feminist perspective on new conceptive technologies is its emphasis on the social construction and political conditions of choice. Highlighting the ways in which women's choices to use infertility technologies are shaped, limited and structured, radical feminists are able to identify the limits of a political struggle for reproductive freedom based on the simple demand for the 'right to choose'. They reveal how the politics of 'individual rights' fails to challenge the conditions which structure women's choices and the impact those choices have on the reproductive lives of all women. Robyn Rowland writes:

> 'choice' and 'freedom' as a continuing ideological base in the area of reproductive technology may eventually entrap women further and limit their choice to say 'no' to increased male control of the reproductive process. (1987b, 74)

On the same issue, Rothman writes, "The individual right to choice is an absolute necessity, but alone not sufficient to ensure an ethic of reproduction." (1984, 23)

From the previous review of the radical feminist literature, it becomes clear that two different arguments underlie their critique. First, by identifying

the pro-natalist context in which women make their reproductive decisions, radical feminists argue that the choice to use reproductive technologies is so socially constructed that it is no choice at all. In this sense, radical feminists make questioning the ability of infertile women to choose a fundamental element of their critique. From this perspective, they also raise the question of the appropriateness of providing technological solutions to what they define as a social problem.

Second, by examining the social implications of uncontrolled medical advance in this area, they argue that the technologies under review are so dangerous to the health and well being of women as a group, that even if women were able to choose them freely, their individual right to do so must be superseded by the interests of women as a group. By examining the ways in which the reproductive choices women make as individuals shape the reproductive freedom of all women, radical feminists challenge other feminists to incorporate a critique of the 'right to choose' any and all reproduction options into their political movement for reproductive freedom. The strength of their analysis is that it calls into question the priority of individual rights over the social well-being of women, and it is this strength that I will draw on in my analysis of IVF.

While the issue of the individual rights of women is a compelling aspect of the radical feminist literature, the question of the ability of infertile women to 'choose' reproductive technologies is problematic. It is to this issue that my critique will now turn. Drawing on the work of socialist feminists, I will argue that the tendency within the radical feminist literature to negate the ability of infertile women to make autonomous moral choices regarding reproduction is inconsistent with a feminist view of women as moral agents,

and in this sense, "echo[s] the very views of women and motherhood which feminists have been seeking to transform." (Stanworth, 1987, 16-17) Moreover, it overlooks the fact that all reproductive choices are socially constructed to some degree, and that the ability of an infertile woman to 'choose' technology to achieve a pregnancy is no more or less socially constructed than a woman's choice to use technology to terminate one.

SOCIALIST FEMINIST CRITICISMS:

According to socialist feminist critics, the radical feminist assumption that the desire or will to mother is solely a product of patriarchal conditioning reduces infertile women to 'brainwashed' victims of pro-natal ideology (Fine and Asch, 1985; Gerson, 1989; Menning, 1981; Petchesky, 1987; Pfeffer, 1987; Rapp, 1988; Sandelowski, 1990; Stanworth, 1987; Zipper and Sevenhuijsen, 1987). As Sandelowski puts it, far too often the infertile woman is depicted as the "dupe of patriarchal efforts to disable women as a group." (1990, 40) Socialist feminists argue that this "victimization" approach has several problematic implications.

First, within the radical feminist literature, "infertile women are viewed as neither authentically wanting nor freely choosing medical/technological assistance to reproduce." (Sandelowski, 1990, 40) To the extent that this position translates the infertile woman's will to reproduce into patriarchy's mandate that she reproduce, it denies women any free will. It "permits women no volition, no agency at all" (Sandelowski, 1990, 40; see also Zipper and Sevenhuijsen, 1987). According to the socialist feminist critique, radical feminism ignores the ways in which infertile women make rational

assessments of their options and priorities and then act upon them; women's resistance to external control and, equally important, their complicity in it, are completely lost (Fine and Asch, 1985, 8; Petchesky, 1987, 72).

To support this point, socialist feminists identify the ways women do take an active role in resisting 'male' medical control over their bodies. They concede that this is not to imply that women have significant control over treatment processes, such as IVF. Rather, it is to argue that infertile women are not so emotionally desperate that they become passive recipients of these technologies. There is resistance at the individual level, and this is evidence of women's ability to take control of their lives.

Attempting to reclaim agency for infertile women, socialist feminists point specifically to the ways in which women resist by actively setting their own limits to medical intervention. Setting limits is an active personal choice, which is based on careful thought and a rational evaluation of priorities. In this evaluation process, infertile women develop an awareness of the problems associated with infertility treatment, and they are critical of many of the procedures (Lewis, 1984, 26; Conseil du statue de la femme, 1987, 32-33; Pfeffer, 1987). For example, Margaret Lewis recalls:

> I decided not to try IVF because it got to the stage where my life was completely centred on my body, on having a baby....I realized that I've been poked around and pulled at so many times that I was losing...that I had lost...that part of my body which was mine alone and private. (1984, 26)

For socialist feminists, this resistance and critical thinking are acts of self-determination, not victimization.

Recognizing that women have generated demands for conceptive

technologies provides a further challenge to the victimization theories (Gerson, 1989, 51; Petchesky, 1987, 72). Women actively seek medical intervention in the reproductive process. Acknowledging this fact does not imply that the technologies offered to women have always met their needs to their satisfaction. It merely identifies the demands women have made. Clearly, these demands are expressions of women's desire and ability to take control of their reproductive destiny. As Deborah Gerson argues, "the reality is that many women aggressively seek out infertility treatment, and that their use of such services correlates with increased social power rather than with powerlessness." (1989, 51)

In addition to denying women's agency, the radical feminist position also, according to the critics, dismisses and trivializes women's desires by reducing them to products of ideological determination. "Critics of conceptive techniques do not allow that female desires can be anything other than a response to or a reflection of masculinist ideology and socialization." (Sandelowski, 1990, 41) Stanworth supports this analysis and argues that while women's choices and desires may be shaped by patriarchal socialization, they are not determined by it. For Stanworth and other socialist feminists, the radical feminist overemphasis on ideology has several problematic political implications.

First, by focusing on the need to unmask patriarchal ideology, radical feminist analyses detract from the important goal of understanding and changing the material conditions which make the conceptive technologies problematic. According to socialist feminists, we must demand and work towards ensuring the social conditions which will allow women to use this technology in a way that will truly expand their choices. As Rosalind

Petchesky points out:

> the view that the existence of a technique limits
> choice because it compels its use...is an antitechnological form
> of technological determinism, attributing to the technique
> magical power over people's relation to it....The very real
> potential for abuse, on the other hand...is a function not of the
> technique but of the organization and politics of existing medical
> care. (Quoted in Gallagher, 1987, 146)

Second, the radical feminist position makes the false assumption that infertile women are incapable of autonomous, conscientious decisions regarding their reproductive health, and this assumption creates a serious contradiction within the radical feminist analysis. On the one hand, radical feminists insist that women have the ability to make responsible, autonomous decisions regarding the use of technology to prevent and terminate pregnancies. On the other hand, they deny that women are capable of responsible and autonomous decisions regarding medical assistance for conception. Ultimately, this contradiction seems to call into question women's ability to make any moral reproductive choices. Yet, the ability to make moral choices is part of the basic view of women which underlies the feminist ethic of reproductive freedom.

Understanding the conditions under which women presently make their reproductive choices is an essential task of any feminist analysis, one which radical feminists have appropriately defined as a priority. However, it does not follow that the oppressive conditions which these feminists have identified negate women's ability to make moral choices. It is possible to recognize and challenge the oppressive conditions under which women choose, without denying women's ability to make choices. In fact,

acknowledging and insisting on women's ability to make choices based on a rational assessment of their material, social, and psychological conditions is a non-negotiable premise of a feminist conception of reproductive freedom.

Finally, as we consider and challenge the conditions of choice for infertile women, we must also keep in mind that the reproductive choices of these women are not uniquely constructed. In fact, as Rothman points out, all reproductive choices are socially constructed to some degree, and all technological developments both expand the realm of choice by offering new possibilities and at the same time close off certain options (1984). In this sense, infertility technologies are not unique, and we can raise concerns in other areas of technological intervention in reproduction that are exactly parallel to radical feminists' concerns about the inability of women to say 'no' to conceptive technologies. We need only consider, for example, the ways in which women's political demand for the right to control their fertility has raised serious questions about the right NOT to control fertility. Abortion provides an excellent example here, for at the same time as the demand for 'the right to choose abortion' gains public support, we create the conditions in which the decision not to abort becomes extremely difficult for some women.

To make this point Rothman gives the following example:

> A woman I see each summer was pregnant this year. Again. It was her fourth baby in five years. I know that she is having problems with money (and who wouldn't be, with four kids?). I know she is overworked and tired, trying to find affordable child care so she can work part time. Four babies, I thought. My god....This last pregnancy, the doctor said, C'mon, I'll abort it right now, you can go home not pregnant and forget it.' She was tempted, sorely tempted. But no, she chose not to abort. She

> really didn't want to have an abortion....It was a choice she made, an unpopular reproductive choice, one which is not, in her community of friends, socially endorsed. (1984, 27)

The young teenager or the poverty-stricken woman of colour who finds herself pregnant, with little or no financial support and no educational or occupational opportunities, provides a similar example. In each case, the social, legal and political climate which has enhanced the availability of abortion has also served to define certain pregnancies as social problems. In the absence of social measures designed to improve the material conditions of single, poor and teenaged mothers, the socially sanctioned solution is a technological one - abortion.

I am not suggesting that fundamental changes in social conditions will eliminate the need for abortion. Nor am I advocating only social solutions to the problem of unwanted pregnancies - an approach often taken by anti-choice groups. Rather, I wish to distinguish between an unplanned pregnancy which, under better material conditions, would not be defined as problematic, and an unwanted pregnancy which remains a problem, regardless of the material conditions. Many teenaged or low-income women choose abortion and experience this choice as an aspect of their reproductive freedom. However, others in this situation make that 'choice' out of necessity, and far from feeling free to control their reproductive decisions, they feel compelled to do what is socially sanctioned. As Toronto film-maker Christene Brown comments, "'It's a middle-class thing to have choice. For the poor woman, there is no choice." (quoted in Menzies, 1991, 18)

The fact that access to safe and legal abortion is a social need of all women does not negate the fact that many women are pressured into a

technological solution which they do not experience as reproductive freedom. Of course, as Rosalind Petchesky points out, "the difficult task here is to sort out the relationship between freedom and necessity in women's attempts to negotiate their reproductive decisions." (1984, 374) However, as we attempt to sort out this relationship, it is important to keep the 'freedom and right to choose' in perspective. "While on the one hand we worry, with very good reason, about losing the option of legal abortions, on the other hand we are losing the option not to abort." (Rothman, 1984, 27)

This then is the common ground which both infertility technologies, such as IVF, and contraceptive technologies, such as abortion, share. In both cases, "As 'choices' become available, they all too rapidly become compulsions to 'choose' the socially endorsed alternative." (Hubbard quoted in Rothman, 1984, 27) For those who want what society wants them to want, the experience of choice and reproductive freedom is real. For those whose choices do not meet social expectations, the experience is far from freedom. As Franklin and McNeil argue, "more choice does not necessarily guarantee more freedom or control", and this is true not just for infertile women, but for all women (1988, 553).

Politically, this has important implications, for while we will have to continue to make necessary demands for information and choice, "we will [also] have to lift our eyes from the choices of the individual woman, and focus on the control of the social system which structures her choices, which rewards some choices and punishes other, which distributes the rewards and punishments for reproductive choices along class and race lines." (Rothman, 1984, 33) What I have tried to illustrate here, is that the present conditions of choice for infertile women which radical feminist insights identify, are

characteristic of all reproductive decisions. Restrictions on choice are not unique to infertile women, and we have to keep this in perspective when developing a political agenda for new reproductive technologies. In particular, we must have a clear vision about the implications of this agenda for the reproductive rights of all women, including those who are seeking to prevent or terminate a pregnancy.

STRENGTHS & WEAKNESSES OF SOCIALIST FEMINIST ANALYSES:

The strength of the socialist feminist position is the assertion of the ability of all women, including the infertile, to make responsible moral choices regarding technology and reproduction. In particular, socialist feminists appropriately emphasize the fact that many infertile women do place limits on the technological intervention they seek, and they also make real demands for technological assistance in reproduction. Both of these exemplify their ability to make choices - albeit within restrictive and oppressive conditions.

What is particularly appealing, then, about the socialist feminist analysis, is that it recognizes and challenges the social conditions which limit and shape women's reproductive choices without challenging women's abilities to make responsible moral choices. Paraphrasing Marx, Petchesky writes:

> women make their own reproductive choices, but they do not make them just as they please; they do not make them under conditions they create but under conditions and constraints they,

> as mere individuals, are powerless to change. That individuals do not determine the social framework in which they act does not nullify their choices nor their moral capacity to make them. It only suggests that we have to focus less on 'choice' and more on how to transform the social conditions of choosing, working and reproducing. (1984, 11)

Socialist feminists have made an important contribution to the feminist debate on reproductive technologies by reaffirming women's abilities to make authentic choices. Their analysis is weakened, however, by a continued defense of all technological treatments for infertility, - including the highly invasive and physically dangerous treatment of IVF - on the basis of the demand for the 'right to choose'. Ultimately, in defending women's ability and right to choose, these feminists fail to analyze critically both the limits of a political movement based on individual rights and the social implications of the particular reproductive choices women make.

The socialist feminist position on choice and conceptive technologies is perhaps best summed up in Barbara Menning's critique of radical feminist opposition to reproductive technologies. She argues that "pro-choice advocates are inconsistent if they are willing to apply technology for contraception and abortion, but not for procreation." (1981, 263)

For critics like Menning, the radical feminist assertion that infertile women must find social ways to mediate their pain rather than technological ones, is, in effect anti-choice. It also employs a dangerous rationale which is inconsistent with the historical pro-choice position within feminist thought and which could be used to deny women access to abortion services. It may be argued, they point out, that the same patriarchal socialization which makes infertility a problem also makes teenage pregnancy one. The logical

extension of this argument is that if technology is not an appropriate response to infertility, then how can it be an appropriate response to unwanted pregnancies?

Countering this anti-technological position, in an attempt to overcome the dangerous political implications they identify, socialist feminists maintain that whether a woman wants to prevent, terminate or achieve a pregnancy, she has a fundamental right to control her reproductive capacities and to use technology to do so.

The problem with this approach, however, is that it ignores very significant differences between various conceptive technologies. Conceptive technologies vary considerably in their degree of intervention in the reproductive process and in the degree to which they threaten the health and well-being of women, and these differences must be taken into consideration when feminists attempt to determine whether or not they are acceptable choices. Alternative insemination, for example, is a safe and easy procedure which can be and often is carried out without physician assistance. Women are simply required to chart their ovulation and then 'artificially' inject medically screened sperm near the cervix, typically with the use of a sterile syringe. IVF, in contrast, is an extremely high-tech invasive procedure, controlled and administered by medical and scientific professionals. As I have explained, women who undergo IVF treatment experience countless pharmaceutical and bio-medical interventions.

Consider also various methods of birth control. Consistent with a pro-choice philosophy, feminists defend and demand a woman's right to control her fertility and to use technology to do so. However, we do not defend a woman's right to choose the Dalkon Shield or Norplant, both of which are

associated with serious health risks. Meeting safety standards has become a central criterion for a feminist defense of any technology, and this should be true for both contraceptive and conceptive techniques. The socialist feminist argument that we must defend a woman's right to use any and all conceptive technologies, in order to preserve the philosophy of pro-choice, ignores the fact that some of these techniques pose serious threats to the health and well-being of infertile women.

Finally, this socialist feminist position mistakenly assumes that to challenge a woman's particular reproductive choice is to challenge her right to choose altogether. That this assumption is false is perhaps most clearly evident in the issue of sex-selective abortion. Defending a woman's right to terminate an unplanned pregnancy does not commit us to defending a decision to abort a fetus on the basis of its sex. This example reveals that, in addition to demanding a political right to choose, feminists must also develop an ethic of reproduction - one which will provide a basis for evaluating reproductive decisions and technologies according to feminist values.

The purpose of this chapter has been to review and critique radical and socialist feminist analyses of choice concerning reproductive technologies. Ultimately, my goal is to identify and bring together the strengths of each position into one coherent framework. It is important to recognize, as radical feminists have, that the politics of individual choice as a basis for a movement for reproductive freedom are limited. Similarly, it is important to recognize, as socialist feminists have, that all reproductive choices are socially constructed to some degree, and that denying women reproductive options because of this may threaten the political gains we have made so far.

What we can learn from both the radical and socialist feminist work in

this area is that reproductive freedom is not simply the ability to say no to reproductive technologies, nor simply the right to say yes to them. The challenge for feminists who struggle for true reproductive freedom is to move beyond examining the individual choices women make to reveal and change the oppressive material and ideological conditions under which they are made. To quote Petchesky,

> There are no individual solutions to the dilemmas posed by reproductive politics because 'choices' are not merely the product of self-motivated desires but depend on conditions existing in the society. The ultimate dilemma for those who seek to enhance reproductive and sexual freedom is how to create a sense of collective purpose - of feminist and socialist solutions - concerning matters that seem so intrinsically personal and private. (1984, 384)

CHAPTER THREE

THE EXPERIENCE OF INFERTILITY:

Feminist efforts to come to terms with the social and political implications of new infertility technologies are relatively new, and both the empirical and theoretical research to date has largely focused on the specific technologies - where they originate, how they work or don't work and how they affect the lives of all women, infertile or not. While some feminist commentators also consider the experience of technological treatments, what is missing from many of the thoughtful feminist critiques of conceptive technologies is an understanding of women's experiences of infertility.

In this chapter, I want to pause from the political issue of choice which surrounds the technologies to examine women's psycho-social experience of the diagnosis and treatment of infertility. In particular, I want to acknowledge the very real crisis infertility poses for many women, and to integrate an understanding of that experience into my analysis. Ultimately, I hope to achieve a balance between a thoughtful critique of the technologies and an empathetic understanding of the pain and sorrow the women who seek out these technologies experience daily.

There are several reasons why this process of integration is important. First, by acknowledging women's experiences, feminists can reaffirm the principle that the personal is political. More specifically, this approach recognizes that the forces which shape women's experiences of infertility are political ones, and just as these women's personal experiences are political experiences, so are their choices to use certain technologies political choices. Second, by failing to incorporate their experiences, feminists run the risk of alienating infertile women from our work. A common assumption of many

infertile women, at the present time, is that feminists who are critical of reproductive technologies do not represent their interests. If we are to overcome this assumption, we must be able to speak to their experiences. Third, only by examining the social and psychological forces which shape the experience of infertility, can feminists hope to understand why infertile women make the choices they do regarding technological treatment. Finally, by acknowledging women's experiences of infertility, I identify an obligation, within the feminist political movement for reproductive freedom, to care for those who suffer from infertility. "It is the responsibility of those who oppose further implementation of this technology [IVF] to work toward the changes in the social arrangements that will lead to a reduction in the sense of need for this sort of solution" (Sherwin, 1987, 280). I maintain that with a strong understanding of how the crisis of infertility is experienced, feminists will be better prepared to challenge the social and psychological factors which give shape to it.

RESEARCH ON THE EXPERIENCE OF INFERTILITY:

While feminists have not made the experience of infertility a priority in their work on reproductive technologies, there is a growing body of research literature in this area. Much of this work has been done by psychologists and social workers who are interested in examining the ways infertile men and women cope with diagnosis and treatment. This work is supplemented by that of infertile women who have recently begun to articulate their experiences for themselves. Two notable examples are The Experience of Infertility by Naomi Pfeffer and Anne Woollett, and Infertility: Women

Speak out about their Experiences of Reproductive Medicine, edited by Renate Klein. In each of these books infertile women are exploring the factors which shape their experiences of infertility and the technologies used to treat it.

What has become increasingly clear from this work is that infertility is experienced by many as a life-crisis. More specifically, the research has shown that the ability to conceive is closely related to self-esteem, identity, sexuality and body image. These studies also show that this is more often the case for women than for men. (Baram et al., 1988; Brand, 1989; Conway and Valentine, 1987; Dennerstein and Morse, 1988; Greil, Leitko and Porter, 1988; Lalos, Lalos, Jacobsson and Von Schoultz, 1986; Mahlstedt, 1985; McEwan, Costello and Taylor, 1987; Shaw, Johnston and Shaw, 1988). As one infertile woman describes her crisis,

> My infertility is a blow to my self-esteem, a violation of my privacy, an assault on my sexuality, a final exam on my ability to cope, an affront to my sense of justice, a painful reminder that nothing can be taken for granted. My infertility is a break in the continuity of my life. It is above all a wound - to my body, to my psyche, to my soul. (no identity, quoted in Mahlstedt, 1985, 346)

While the experience of infertility is recognized as extremely traumatic for many women and men, what is noticeably absent from the research literature is a theoretical framework for understanding why women have more intense and profound reactions than men to involuntary childlessness. In this chapter my goal is to address this theoretical gap by providing a framework for understanding gender-specific responses to infertility.

I will first argue that infertility is not only a physiological condition, but

also a socially and psychologically constructed experience and one which is mediated by various factors, including gender. Then, using Chodorow's theory of gender development, I will argue that through the developmental process, women come to want and need primary relationships with children in ways that men do not. Specifically, the capacity and need to mother are built developmentally into the feminine psychic structure, and thus, infertility poses a more fundamental challenge to women's identity than it does to men's. These differences are ultimately reflected in their different responses to involuntary childlessness. Ultimately, understanding what factors contribute to women's more profound experiences of infertility will provide the means to discover any necessary gender specific means of resolving this life crisis.

INFERTILITY AS A SOCIAL PROCESS:

In order to understand gender differences in reactions to and coping with involuntary childlessness, it is important to understand infertility as a social process. In their research on gendered infertility, Greil et al. make the distinction between infertility as a medically diagnosed physiological characteristic and infertility as a socially constructed reality (1988, 173-174). From this perspective, it becomes important to attend to both the medical and physiological experiences of reproductive impairment, and to the social experience of infertility, including how individuals experience it and how various social factors condition or mediate that experience.

In particular, Greil et al. describe the experience of "becoming infertile" as a dialectic process in which each partner interprets, responds to and gives meaning to the physical symptoms and physiological conditions (1988, 174). As partners come to define their experience of involuntary

childlessness, their understanding is shaped, but not determined, by health care professionals. According to these authors, either partner may try to manage information in order to influence their physicians' diagnoses, or they may disbelieve their doctors' interpretations of their experience altogether (Greil et al., 1988, 174). In the end, the decisions they make in an effort to resolve their infertility - such as whether to undergo testing and treatment, whether to stop treatment at a particular point, whether to pursue adoption or consider a high-tech treatment such as IVF - are not medical at all. They are social-psychological decisions based on a variety of non-medical factors including, but not limited to, ethnicity, race, religion, age, personality, socio-economic factors, support networks, sexual orientation, and gender.

Not only is the reaction to and resolution of infertility socially shaped, but in many ways even the diagnosis is not solely a medical process. For example, although the medical definition of infertility is the inability to conceive after 12 months of regular, unprotected sexual intercourse, many people *feel* infertile before the 12 month period. Although they do not meet the medical conditions, socially and psychologically they experience the same thoughts, emotions and self-definitions as individuals who have been officially diagnosed with a reproductive impairment. Conversely, a physiological condition that makes conception unlikely, does not necessarily precipitate a state of crisis. For example, a woman who is not committed to having a child may not endure the social experience of infertility and may simply think of herself as voluntarily childless.

> From a social constructive perspective, Greil et al. conclude: infertility is not to be viewed as a static *condition* with psychosocial consequences, but as a dynamic, socially

> conditioned *process* whereby couples come to define their inability to bear their desired number of children as problematic and attempt to interpret and correct this situation. The infertility process is collective in that the experience of being infertile is negotiated between the couple and is influenced by physicians, friends, relatives and - possibly -psychotherapists. It is also an open ended process characterized by alternating hope and disappointment and by constantly changing medical definitions of the situation. (1988, 175)

It is from within this framework - the social construction of infertility - that the role of gender can be examined as a mediating factor in the experience of involuntary childlessness. More specifically, this framework provides a theoretical basis for the hypothesis that men and women interpret and react to infertility in different ways, with women's psychological, emotional and social experiences being more extreme than men's. This framework does not, however, explain *why* these gender differences exist. Before addressing this question, however, I will review the research literature on gender differences in response to infertility, paying particular attention to women's unique experiences.

GENDER DIFFERENCES IN RESPONSE TO INFERTILITY:

There is a large body of empirical and anecdotal evidence which suggests that involuntary childlessness has far-reaching effects on individual life satisfaction, self-esteem and emotional and psychological well-being. The majority of this research explores whether psychological states cause infertility, psychological reactions to the diagnosis and treatment of infertility, and the various coping mechanisms employed to come to terms with

involuntary childlessness. Few studies, however, examine specifically the gender differences in reaction to and coping with infertility. Of the 49 articles on the relationship between psychology and infertility which I reviewed, only four specifically focused on the influence of gender in this relationship.[3] However, this limited information is supplemented by ten other studies which identified gender differences even though this was not their intended focus.[4] All of the research indicates that women are more likely than men to experience prolonged and intense emotional responses to infertility.[5] In addition, women are more likely than men to remain in a chronic state of crisis or sorrow. Researchers identified intense or extreme feelings of shock, anger, denial, guilt, depression, stress, isolation, loss, hopelessness and grief. To review these research results, I have identified three general themes along which gender differences were found: responsibility; psychological and emotional responses; and coping mechanisms.

RESPONSIBILITY:

Many authors have identified the social tendency to blame women for reproductive failures (Anderson, 1989; Miall, 1986; and Valentine, 1986). This is true despite the fact that the causes of infertility are evenly distributed among men and women who seek diagnosis and treatment (Valentine, 1986, 61). In the research literature on infertility and gender differences, responsibility is a major theme. In fact, Lalos et al. found that 80% of the women and 50% of the men in their study assumed, prior to medical investigation, that the woman was responsible for the inability to conceive (1986, 201). The majority of women in this study also confirmed that the

assumption of women's responsibility inevitably leads to intense feelings of guilt and self-blame (1986, 201).

Anderson argues that the sense of responsibility is rooted in an emerging theme in current popular thinking about infertility - that the reproductive impairment is a disorder that individuals, and particularly women, choose by virtue of having made certain lifestyle choices (1989, 9). Her point was supported by research results. Specifically, 50% of the women had serious feelings of guilt and lack of self-confidence after the diagnosis of tubal damage, and many of these women reproached themselves for previous actions including abortions, use of oral contraceptives or IUD's, and contact with sexually transmitted diseases (Lalos, et al., 1986, 201)

In complete contrast, there were no reports of feeling guilty or responsible by the men in Lalos et al.'s study. Although it may be argued that the absence of feelings of responsibility is attributable to the locus of impairment in the female respondents, other studies reveal that even when there is clearly a male reproductive impairment, there is still a tendency for women to feel guilty about the problem and to view the situation as their responsibility (Greil et al., 1988; Miall, 1986). For example, Greil et al. found that in all cases in which the men had been diagnosed as infertile, women harboured the suspicion that their bodies also worked imperfectly. In addition, all the data showed that wives were willing to take responsibility for their husband's reproductive impairment and reported that they thought of themselves as being infertile, although, physically, this was not the case (Greil, et al., 1988, 184).

PSYCHOLOGICAL AND EMOTIONAL RESPONSES:

Overall, research revealed that in all areas of emotional and psychological reactions to infertility, women were more likely than men to experience prolonged and intense responses. The intensity of the initial disappointment was significantly greater for women, and they were more likely to be traumatically affected by involuntary childlessness and to remain in a chronic state of crisis.

Perhaps the most significant finding in this area was that infertility had a greater emotional impact on women, regardless of which partner had been diagnosed with the reproductive problem. Women described their experience of infertility as a catastrophic role failure - a challenge to their womanhood. Most women reported that infertility came to permeate every aspect of their lives. It was something they felt they could not escape, and women were more likely than men to think about infertility all of the time (Greil et al., 1988, 180-184). Of the various emotional and psychological responses identified in each of the studies on gender differences, the three most intense and prevalent were depression, stress and feelings of crisis.

Depression: Studies of both tubal surgery patients and IVF participants revealed that women are more likely than men to experience intense and multiple episodes of depression. Two years after unsuccessful tubal surgery, 93% of the women felt desperate, extremely sad and disappointed at the start of each menstruation, and when menstruation was delayed, these feelings were greatly exacerbated (Lalos et al., 1986, 201). Explanations for their depression included unfulfilled longing for a child, the loss of the lifestyle associated with the parent role, and the loss of the physical experience of pregnancy and childbirth. At the most extreme, one

woman revealed that she had suicidal thoughts during the two years following surgery, and one woman attempted suicide six months following her operation (Lalos et al., 1986, 201).

In contrast, the men in this study reported significantly fewer depressive symptoms, and the general impression from the interviews was that the men were more likely to suppress or deny their emotional reactions (Lalos et al., 1986, 201). Interestingly, feelings of grief increased from 50% before their wife's surgery to 88% two years after surgery (Lalos et al., 1986, 201).

In the IVF study, women (66%) were more likely than men (40%) to report profound feelings of depression following unsuccessful treatment. Eighty two percent of those women who reported depression also reported multiple separate episodes of depression compared to only 56% of depressed men. Finally, men (44%) were more likely than women (18%) to resolve their depression after only one episode (Baram et al., 1988, 185). Participants in the IVF study were also asked to rate their depression at several intervals after unsuccessful treatment. Both men and women reported a decrease in the severity of their depression over the time period; however, at each interval, significantly more women than men were depressed, and the severity of their depression was significantly greater for women than for men (Baram et al., 1988, 185).

Finally, following unsuccessful IVF treatment, women (94%) were more likely than men (60%) to experience somatic and psychological symptoms of depression and anxiety. The most common feeling experienced after IVF failure was sadness. Participants also reported feelings of helplessness, loss, guilt and being out of control. Although these feelings

were reported by both men and women, all of them were noted more often by women. Women were also more likely to report feeling disgusted with and betrayed by their bodies following unsuccessful IVF (Dennerstein and Morse, 1988, 165). In addition, 13% of the women in this study reported thoughts of suicide, while none of the male participants did so (Baram et al., 1988, 185).[6]

Stress: Research results revealed that during pre-treatment counselling interviews for IVF, 50% of the women considered infertility to be the most upsetting experience of their lives, while only 15% of the men felt this way. Only three life events were ranked more stressful than infertility by the female respondents. These were death of a family member, divorce or marital separation. In contrast, the male participants also ranked unemployment, financial problems, and job change as more stressful than infertility and its treatment (Baram et al., 1988, 181).

IVF participants were also asked to evaluate their stress levels at each of the various stages of infertility treatment, starting with the diagnosis of a reproductive impairment and ending with the completion of their IVF treatment. According to the results, the two most stressful periods for both men and women were waiting to see if the IVF treatment was successful and discovering that it was not. More significantly, however, at every stage of infertility evaluation and IVF treatment, women reported higher stress levels than men (Baram et al., 1988, 187). This could perhaps be attributed to the fact that IVF treatment is focused almost exclusively on the woman's body. However, it should be noted that even during the stages prior to treatment, including discovery of an infertility problem and undergoing infertility evaluations, women experienced more stress than their partners.[7]

Crisis: In addition to finding more intense feelings of depression and

stress among women undergoing tubal surgery, Lalos et al. also found that women were more likely to remain in a prolonged or chronic state of crisis than men (1986, 205). In particular, these researchers identified four phases of crisis reaction: 1) the *initial* phase, characterized by shock, surprise, and denial; 2) a *reactive* phase, characterized by frustration, anger, guilt, grief, depression and isolation; 3) an *adaptive* phase, characterized by acceptance; and finally, 4) a *resolution* phase, which involved the planning for future solutions and long-term coping mechanisms (Lalos et al., 1986, 203-204).

In the study of tubal surgery patients, Lalos et al. concluded that the majority of women, before the surgery, were in the reactive phase and many of them remained in this second phase of crisis reaction for two years or more. For these women, they argue, the crisis of infertility differs significantly from the common traumatic crisis during which the typical reactive phase lasts six weeks or less (Lalos et al., 1986, 204).

In comparison, men were more likely to be at the initial reaction stage before their wife's surgery, and many, like their partners, remained in the second phase two years later. In contrast, however, many men were able to report no symptoms of crisis reaction at the end of the two year period, while no women were able to report this (Lalos et al., 1986, 204).

COPING:

Research on coping strategies reveals significant gender differences as well. In particular, Brand found that women not only discussed their infertility more often than men did, but they also found it easier to talk about their fertility problems with people outside the marriage (1989, 130).

Greil et al. also examined gender differences in coping. Their results revealed that men were less likely than women to avoid child-centred activities or to feel that infertility was something they could not escape. Men were more likely to find relief in sports, hobbies and their work (Greil et al., 1988, 186). Other studies on coping confirm these findings. Men were more likely to rely on the routine of their job and daily life to cope with the stress of infertility diagnosis and treatment. In contrast, women were less able to use job routine as a coping strategy, despite being employed (Dennerstein and Morse, 1988, 168).

For the women in Greil et al.'s gender difference study, infertility presented itself as an intolerable, identity-threatening situation, and they were willing to do whatever it took to get out. In contrast, men tended to see infertility as an unfortunate event that was to be put into perspective and then ignored. For women, the problem centred on the inability to have children and to be mothers, and the solution was treatment. Conversely, for the men the problem focused on the disruptions the infertility had caused to their home lives, and the solution was to achieve stability, either by pursuing treatment or by ending it and moving on to other things (Greil et al., 1988, 191-192).

This review of the research provides strong evidence that men and women react to infertility in profoundly different ways. The question which remains, however, is why these gender differences exist? In what follows, I will argue that object relations theory, and in particular, the Nancy Chodorow's work on gender development and mothering, provides some insight into these differences.

EXPLAINING GENDER-SPECIFIC RESPONSES TO INFERTILITY:

Within the radical feminist literature on new reproductive technologies, considerable attention is given to the intense social pressure placed on women to become mothers. What is particularly appealing about this work is its emphasis on the ways in which social definitions of 'personhood' for women are based primarily on 'motherhood'. In addition to these social theories of the experience of infertility, however, it is important to consider the psychological factors which contribute to women's experiences. In this section I want to move beyond the theories of socialization which underlie radical feminist analyses and use Nancy Chodorow's theory of gender development to argue that women's profound and intense responses to involuntary childlessness are rooted not only in the intense social pressure placed on women to become mothers, but also in the developmental process through which men and women emerge with different orientations towards heterosexual relations. Chodorow argues that women feel less complete and emotionally satisfied within heterosexual relationships than men do, and because of this, women come to need and want primary relationships with children. I think an understanding of the fundamental difference in men's and women's orientation toward parenting contributes significantly to our understanding of why infertility is more identity-threatening and hence, more painful and traumatic, for women than for men.

Chodorow uses both object relations and feminist theory to examine the ways the social organization of the family, where women are primarily responsible for childrearing, produces fundamental differences in masculine and feminine identities. In particular, she argues that through the process of

identity formation, boys and girls develop different orientations to relational issues. Girls, because they are parented by a person of the same gender, do not develop a sense of self as separate, and they remain preoccupied with relation and connection. In contrast, boys, because they are parented by a person of the opposite sex, develop a sense of self based on differentiation and repress their capacities for relation and connection.

> Girls emerge from this period with a basis for 'empathy' built into their primary definition of self in a way that boys do not. Girls emerge with a stronger basis for experiencing another's needs or feelings as one's own....From very early, then, because they are parented by a person of the same gender...girls come to experience themselves as less differentiated than boys, as more continuous with and related to the external object-world and as differently oriented to their inner-object world as well. (Chodorow, 1978, 167)

Chodorow argues further that these relational differences, and specifically girls' mothering capacities and needs, are reinforced during the oedipal period, which boys and girls also experience differently. Contrary to traditional psychoanalytic theories, the girl does not reject her mother completely during the oedipal period. Rather, the primary intense relationship between mother and daughter continues to be significant throughout the girl's development, and her oedipal attachment to her father does not replace it but is, instead, added on to it (1978, 129). As a result, girls come to define themselves in a relational triangle.

> A girl retains her preoedipal tie to her mother...and builds oedipal attachments to both her mother and father upon it....She retains the internalized early relationship, including its implications for the nature of her definition of self, and

> internalizes these other relationships in addition to and not as replacements for it. (Chodorow, 1978, 192-193)

According to Chodorow, the oedipal relational triangle has important implications for women's experiences of heterosexual relationships in adulthood. First, women emerge from the oedipal complex oriented toward men as erotic, more than emotional, objects. Second, although most women emerge from the oedipal complex with a heterosexual orientation, the heterosexual relationship is experienced differently by women than it is by men. In particular, men experience the heterosexual coupling as both emotionally and erotically satisfying. In contrast, for women, men remain emotionally secondary. Women "experience heterosexual relationships in a triangular context, in which men are not exclusive objects for them." (Chodorow, 1978, 193)

Because heterosexual relationships do not fulfill women's emotional needs, and because adults desire to re-create their early relationships with their mother, women seek to complete their relational triangle with a third person. According to Chodorow, the most obvious way women choose to complete this relational triangle is through the mother-child relationship. She concludes:

> Women come to want and need primary relationships to children. These wants and needs result from wanting intense primary relationships, which men tend not to provide both because of their place in women's oedipal constellation and because of their difficulties with intimacy. Women's desires for intense primary relationships tend not to be with other women, both because of the internal and external taboos on homosexuality, and because of women's isolation from their primary female kin (especially mothers) and other women. (Chodorow, 1978, 203-204)

Of course, the desire and the need to mother, which are built developmentally into the feminine psychic structure, are further reinforced through the socialization process. That women feel extreme social pressure to fulfill the primary role of wife and mother is reflected clearly in the social stigma attached to childlessness, whether voluntary or involuntary (Miall, 1986). For most women, other roles, including those within the labour force, are viewed as secondary, and Gilligan's research on gender differences reveals just how deeply these ideas are engrained. Women are more likely than men to provide self-definitions based on their relationships with others, and this is true even when these women are working outside the home. In contrast, men rarely define themselves in relation to others and are more likely to form their identities around their activities and personal achievements (Gilligan, 1982, 160-163).

Gilligan concludes:

> 'women stay with, build on, and develop in a context of attachment and affiliation with others,' that 'women's sense of self becomes very much organized around being able to make, and then to maintain, affiliations and relationships,' and that 'eventually, for many women, the threat of disruption of an affiliation is perceived not just as a loss of a relationship but as something closer to a total loss of self.' (Gilligan, quoting Miller, 1982, 169)

Thus, women come to define themselves in relation to others, and from the time they are young girls, most come to expect that those relations will include that of mother and infant. In fact, at a psychological level, according to Chodorow, women *need* the mother-infant relationship. Chodorow's theory is supported by Notman, who argues that the significance of this relationship

is closely related to the feminine body image (1982, 15-24). Specifically, Notman argues that "girls are brought up with the expectations of the inner potential, which are learned later; that is, they know [from the experience of having a female body, that] they are capable of bearing children....This knowledge and this expectation also form part of the feminine self concept." (Notman, 1982, 15) Furthermore, because she will carry the infant intimately, a woman's capacity to create life has a greater impact on her than a man's capacity has on him.

Notman identifies the *capacity* to create the mother-infant relationship and the *expectation* of realizing that capacity as extremely important to feminine identity. "The role and importance of childbearing in feminine identity have always been assumed. A women's expectation of being able to bear children has been considered critical in the development of gender identity, femininity and self-esteem." (Notman, 1982, 22)

Notman's emphasis on the physical ability to bear children is particularly relevant for the issue of infertility. Most women are shocked to learn that they are not physically capable of bearing a child. In fact, many women spend years prior to diagnosis using some form of contraceptive under the assumption that they are fertile. Having learned that they are in fact not fertile, many women come to question their sense of womanliness - they often feel physically incomplete. "It seems likely that the capacity to bear children is significant, whether or not it is acted upon as an adult choice. It is important to know that one's body can 'work right'." (Notman, 1982, 23)

The experiences of the women in the tubal surgery study presented earlier in this chapter speak of this. After corrective surgery, the majority of women reported feeling more feminine and complete as a woman. Moreover,

half of these women felt that even if they did not have children following the operation, it would be easier to deal with because of this new sense of feminine completeness (Lalos et al., 1986, 202).

Thus, more than any other relationship, the mother-infant relation and the capacity to create it are central to many women's self-identity. Infertility signifies the loss of that capacity, and because of it, one of the most significant relationships which many women expect and need to develop is left unrealized. If, as Chodorow's theory of gender development suggests, a woman's sense of self is based on recreating the oedipal relational triangle with a child, then it is not possible for her to experience this significant loss without it challenging her identity. Women who experience infertility have not only lost a potential relationship, they have lost a sense of who they are.

In contrast, a man's sense of self is based on separation, and he is more likely to define himself in terms of what he does than who he is in relation to others. Moreover, through the developmental process, his identity is based on a relational stance which remains dyadic. As a result, he is more likely than his partner to experience a sense of completeness and satisfaction within the heterosexual relationship without a child. Thus, while his experience of infertility - as an unrealized parent-child relation - is painful, he is more likely to emerge from that experience with his identity intact. We can conclude that if women's responses to infertility are more profound than men's, it is because the threat to their identity is more profound. As Silverman summarizes:

> Because of the centrality of relationships to a woman's identity, because she so much sees herself in terms of her relationships with other, the refusal to accept such a loss [as the mother-infant relation] may be more urgent for her than it is for men. (1981, 29)

It is important to emphasize that although my analysis focuses on the psychological factors which shape women's experience of infertility, there are several social forces that reinforce the importance of motherhood for women. As radical feminists point out in their analysis of the social construction of the will to mother, women are socialized from a very young age to believe that their most important purpose in life is to bear and raise children. This belief is reinforced by the absence of opportunities for women to find fulfilling and self-affirming lives in work outside the home. For too many women, "children remain the one hope for real intimacy and for the sense of accomplishment which comes from doing work one judges to be valuable." (Sherwin, 1987, 277)

In addition, the need to mother is reinforced by a cultural view of children as commodities, a view which defines the value of children in chromosomes and genes rather than who they are as human beings. Finally, nuclear, heterosexual family relations, which are at the core of Chodorow's theory, are in themselves social arrangements. The fact that women in our society are primarily responsible for childcare is a social construct, and in this sense it is "social arrangements and cultural values that underlie the drive to assume such risks for the sake of biological parenthood." (Sherwin, 1987, 276-277) Clearly, "there is something very wrong with a culture where childrearing is the only outlet available to most women in which to pursue fulfillment," (Sherwin, 1987, 277) and ultimately, both the social and psychological forces which contribute to this situation must be challenged, if we are to reduce the demand for potentially dangerous conceptive technologies.

REPRODUCTIVE FREEDOM - MAKING THE CONNECTIONS:

As a final note, it is important to draw the theoretical and political links between women's experiences of infertility and their experiences of unplanned pregnancies, for it is only with these connections that feminists can hope to develop a political movement for reproductive freedom that addresses the needs of all women. In fact, there are significant parallels between women's experiences of infertility and their experiences of unplanned pregnancies resolved through abortion. First, there are common underlying social values about what makes a woman suited for motherhood. The cultural belief that motherhood is a legitimate and desired goal for married, heterosexual women, but not an appropriate goal for unwed, teenaged, lesbian or poor women, informs the experiences of both infertile women who feel pressured to choose conceptive technologies and many women who feel pressured to choose abortion.

Second, for both infertile women and women choosing to terminate a pregnancy there is no formal, socially sanctioned mourning process. Unlike women who lose a pregnancy to miscarriage, for example, infertile women and women who have had an abortion do not receive social acknowledgement of their emotional and physical suffering. This is reflected in the common feeling of isolation among these women. As one woman who had an abortion describes, "My cousin had a miscarriage and everyone sent her a card saying, I'm so sorry, and she got all this affirmation, like it was okay for her to be feeling really bad, and we all felt bad with her. But my feeling bad was isolated, taboo." (speaker not identified, quoted in Menzies, 1991, 13) Similarly, many infertile women complain that they lack emotional support from their friends and family. In fact, many people find it very difficult and

awkward to console infertile women through their experience, and tend instead to make light of their situation by encouraging them to "relax and take a vacation."

As we begin to take women's experiences of their reproductive lives into account, it is becoming increasingly clear that the lack of formal, socially sanctioned mourning processes interferes greatly with the ability of some women to reach a point of resolution. For both the woman who is unable to achieve a pregnancy and the woman who chooses not to continue one, the experience remains shrouded in secrecy and guilt, and the lack of social support for her experience only adds to these feelings.

Finally, in both cases, the daily experiences of these women tend to get lost within the political discussions surrounding the issues of treatment. As I pointed out in the beginning of this chapter, the pain and sorrow of infertile women in crisis have not adequately been incorporated into feminist analyses. Similarly, as Heather Menzies argues, the experiences of women who terminate pregnancies have also been ignored within feminist analyses. "Their experience and their perceptions are silenced. They're made to disappear under the placards, the voices on the news, in Parliament, the Senate and the courts, turning abortion into an issue of black vs. white, good girl, bad girl..." (Menzies, 1991, 13) The tendency to ignore women's experiences within feminist political discourse is rooted in the very nature of political struggle. As Menzies argues,

> For years, feminists kept silent on women's grief over abortion for fear of ceding ground to 'the other side' in the abortion debate. Taking the high road of 'rationality' against the extremism of anti-choice crusaders, we've proclaimed abortion a

> woman's right to do what she wants with her own body. We've talked about abortion as just another medical procedure and stress the fact that with modern technology, it can be over in two and a half minutes. (1991, 14)

Similarly, within the feminist political discourse on reproductive technologies, there has been a tendency to overlook women's intense despair over their inability to bear children or to dismiss it as a symptom of oppressive patriarchal pressure to become a mother. Rather than incorporating that experience into our analyses and examining ways in which infertile women might cope with their desperate reality, feminists have tended to focus instead on the specific technologies presently available.

The danger with this approach, as Menzies has identified on the issue of abortion, is that feminists have "abandoned women's own perceptions as the touchstone of a truly woman-centred, feminist position" (1991, 14). She concludes:

> We've lost the power to speak for women in return for the chance to represent the official women's position in the debate. Feminists have become accomplices in the silencing of women by letting women's often contradictory thoughts and often ambivalent feelings disappear from public view....And so, even today when there are no laws dictating women's choices about abortion, women are not free to grasp the issue to use the technology on their own terms. (1991, 14)

If we hope to develop a political movement for reproductive rights that addresses the needs of all women, then we must break this pattern and develop an approach that incorporates women's experiences at the foundation of our work. In this chapter, I have examined the experiences of infertile women in an effort to make this much needed connection between personal experience and political demands. In the next chapter, I will to return to the

political issue of choice, and it is my goal to carry my understanding of infertility as a painful and identity threatening experience into my analysis.

CHAPTER FOUR

FEMINIST ETHICS AND CONCEPTIVE TECHNOLOGIES:

Up to this point, my goal has been to review and evaluate feminist analyses of new reproductive technologies, with a particular focus on in-vitro fertilization. Having identified the strengths and weaknesses of various positions, my challenge now is to develop my own systematic approach to the issue of IVF and choice. To do this, I will draw heavily upon feminist ethical theory, in particular, the work of Rosalind Petchesky on the subject of abortion and the work of Susan Sherwin on the issue of IVF. Like Petchesky, I will argue that the feminist political movement for reproductive freedom now faces the challenge of moving beyond the traditional individual rights approach to address the "moral questions about when, under what conditions, and for what purposes reproductive decisions should be made." (Petchesky, 1984, 7) And, like Sherwin, I will argue that this effort will require "a systematic theoretical evaluation of IVF from the point of view of a feminist ethical theory." (1987, 266)

In this chapter, I will consider whether my own feminist ethics should encourage, tolerate, or work toward modifying or restricting in-vitro fertilization as a reproductive option for women. I will try to reach this decision within a framework that is theoretically and politically consistent with feminist demands for reproductive freedom for all women, whether infertile or not. Therefore, I will assume that it is not acceptable to threaten the reproductive freedoms women have gained through the politics of choice. Equally important, I will try to develop this political strategy with an acknowledgement that women are capable of making sound moral decisions regarding reproduction and with an understanding of the very real pain and

suffering infertile women experience.

LIMITS OF A 'RIGHT TO CHOOSE' APPROACH TO REPRODUCTIVE FREEDOM:

A central aspect of the feminist struggle for women's equality has been identifying and creating the material and ideological conditions for women's reproductive freedom. It has long been argued by feminists of all persuasions that until such conditions are realized, women's equality in all areas of life, including work, education and family will remain unrealized. In this section, I will examine a feminist view of reproductive freedom and consider the political limits of the right to choose approach which has historically held a primary place in the feminist struggle for social, political and economic equality for women.

According to Rosalind Petchesky, there are two ideas which are essential to the feminist view of reproductive freedom. The first takes into consideration the "biological connection between women's bodies, sexuality and reproduction" (1984, 2). Working from the general principles of 'bodily integrity' and 'bodily self-determination,' feminists argue that in order to be free, women must be able to control their bodies and procreative capacities. The second idea takes into consideration the social position of women and the reproductive needs that position creates. Recognizing that, historically, it has been women are responsible for caring for and rearing children, and that, as a result, it is women who are most deeply affected by pregnancy, feminists assert that it is women who must make decisions about when and where they

will have children.

For Petchesky, these two ideas highlight the social and individual nature of reproduction. As she states,

> The first appeals to a 'fixed' level of the biological person, while the other implies a set of social arrangements, a sexual division of labor, developed historically, that may be changed under new conditions...one is rooted in the conceptual framework of 'natural rights,' while the other invokes the legitimating principle of 'socially determined needs.' (1984, 2)

Working from this analysis, Petchesky concludes that "reproductive freedom - indeed, the very nature of reproduction - is social and individual at the same time; it operates 'at the core of social life' as well as within and upon women's individual bodies." (1984, 2)

Recognizing the dialectic nature of reproductive freedom, Petchesky argues that using "'a woman's right to choose' as the main principle of reproductive freedom is insufficient and problematic at the same time as it is politically compelling." (1984, 6-7) Like radical feminists, Petchesky argues that this approach fails to challenge the conditions of rights. In particular, she notes that a political demand for women's exclusive control over reproduction is potentially dangerous to the extent that it can be used to reinforce the view that reproduction is women's special, biologically destined sphere. By failing to challenge the sexual division of labour in reproduction and thus reinforcing women's responsibility for pregnancy and children, the 'right to choose' approach to reproductive freedom "lets men and society neatly off the hook" (Petchesky, 1984, 7).

Like radical feminists, then, Petchesky argues for an approach which considers carefully the conditions under which women make their choices,

and she understands that "the 'right to choose' means little when women are powerless." (1984, 11). In addition to this criticism, however, Petchesky also argues that the rights approach is limited to the extent that it assumes a woman's right to control her body is absolute; this is a position which ignores the dialectic nature of reproductive freedom, and one which ultimately "evades moral questions about when, under what conditions, and for what purposes reproductive decisions should be made." (1984, 7) In this analysis, answering the political question, who should decide, "does not tell us anything about the moral and social values women ought to bring to this decision." (Petchesky, 1984, 7)

For Petchesky, then, the feminist movement for reproductive freedom must move beyond defending the right to choose, to develop an ethic of choice based on a coherent set of feminist values. This approach, I believe, will provide pro-choice activists with the basis for evaluating various reproductive options and for defining certain choices as problematic. *The question is no longer, as Barbara Menning would phrase it, are pro-choice advocates inconsistent if they do not support all conceptive technologies, but rather are certain conceptive technologies provided in certain contexts inconsistent with a feminist morality of choice?*

FEMINIST ETHICS & A NEW APPROACH TO REPRODUCTIVE FREEDOM:

Within this new framework, the challenge is no longer to defend any and all reproductive choices, but to articulate those feminist values against which each reproductive option can be evaluated. Having said this, I will

devote the next section of this chapter to this challenge. In particular, I will draw upon the work of the Canadian philosopher, Susan Sherwin, who argues that feminist moral theory is uniquely appropriate for evaluating reproductive options because, unlike traditional moral theories, feminist ethics builds upon the insights of feminist theory in general and incorporates women-centred concerns into its framework. As she summarizes, "It has as a model an inter-connected social fabric, rather than the familiar one of isolated, independent atoms; and it gives primacy to bonds among people rather than to rights to independence." (1987, 279) By implication, it is a moral theory which highlights the context or conditions of these relationships, and in the case of IVF, the relational context in which reproductive options are provided. "From the perspective of feminist ethics, ...reproductive technology is not an abstract activity, it is an activity done in particular contexts and it is those contexts which must be addressed." (1987, 282)

By recognizing the importance of interdependence among individuals, Sherwin's theory speaks directly to the relational issues that are central to my analysis of women's experiences of infertility. More specifically, this theoretical approach accommodates the work of Chodorow, Gilligan, Notman and Silverman, who emphasize the ways women develop their identities in relation to others. By focusing on the "bonds among people", Sherwin's work provides a theoretical basis for considering the ways in which various relationships, including those between parents and children and between men and women, shape women's experiences of involuntary childlessness.

Sherwin's focus on concrete situations and the relations among people has important implications for an analysis of IVF, infertility and choice. First, it includes an acute understanding of the unequal social, economic and

political position of women in capitalist, patriarchal society, and as such it is a feminist theory which "attends to the implications of actions or policies on the status of women" (1987, 279). For my purposes, this lays a theoretical foundation for considering the ways in which the present application of IVF affects the position of all women in our society. More specifically, it allows feminists to ask "how IVF contributes to the general patterns of women's oppression" (Sherwin, 1987, 270)

Second, Sherwin's feminist ethics gives primacy to "woman-centred values, such as nurturing, empathy and cooperation." (1987, 280) By implication, it is a moral theory that commits to empathizing with and caring for infertile women and men whose physical and psychological pain is a central issue in this debate. Within Sherwin's framework, we "see their reality as our own and address their very real sense of loss." (1987, 280) Ultimately, this allows feminists to maintain a critical analysis of IVF, while at the same time accommodating an understanding of the despair, loss and grief infertile women face. From this perspective, feminists can also consider the ways that providing high-tech solutions to infertility may increase women's suffering. On this issue, Sherwin writes, "While meeting the perceived desires of some women - desires which are problematic in themselves, since they are so compatible with the values of a culture deeply oppressive to women - this technology threatens to further entrench those values which are responsible for that oppression." (1987, 280) Thus, Sherwin's feminist moral theory allows us to consider both the needs of infertile women and the implications of addressing those needs with a controversial technology.

Finally, Sherwin's feminist ethics attends to "the nature of the

relationships among those concerned." (1987, 281) More specifically, it considers who holds the power in a particular relationship and how that power is used to benefit one person at the expense of another. The doctor-patient relationship is the most obvious example in the case of IVF, and Sherwin's approach demands that we consider the ways doctors may use their power to exploit women. For Sherwin, the issue of trust is fundamental here. "I believe" she writes, "a feminist ethics must address the question of the degree of trust appropriate to the relationship involved." (1987, 281) The history of the medicalization of childbirth highlights the fact that women's interests are not always a priority for the medical establishment. "Frequently, the fetus-mother relationship is medically characterized as adversarial and the physicians choose to foster a sense of alienation and passivity in the role they permit the mother." (Sherwin, 1987, 282) Within Sherwin's framework, we may ask in what ways IVF contributes to this general tendency and whose interests are being served.

Using Sherwin's feminist ethics as a theoretical framework, I want to now return to Petchesky's demand to consider the moral and social values women ought to bring to their reproductive decisions. In particular, I want to argue that decades of struggling for access to abortion have revealed that for a reproductive option to be consistent with feminist values, it must respect the integrity of women's bodies and psyches, and it must enhance women's control over their reproductive processes and their lives in general.

Demands for access to safe and legal abortions have been based on the understanding that reproductive options contribute nothing to women's reproductive freedom if they threaten the health and well-being of women and if they diminish women's control over their reproductive capacities. When

provided by qualified and caring personnel, abortion is a safe and simple procedure. When offered legally and affordably, the vast majority of abortions are performed in the first trimester, using the simple vacuum aspiration technique. The whole process at this stage takes less than ten minutes, is often performed under local anaesthetic and involves minimal recovery time. Complications from abortions are rare, and those few that do occur are typically associated with the relatively few late-term procedures.

Abortion is not simply a safe means for controlling fertility, it is also a means by which women obtain some control over their reproductive process and their bodies in general. As Petchesky notes, "while access to abortion services and contraception hardly guarantees 'upward mobility'...those services provide on important material circumstance that can broaden a woman's range of possibilities and give her a little more control over her life, especially if she is poor." (1984, 161) Writing on the same issue, Taub argues, "The degree of control women are able to exercise over the reproductive lives directly affects their educational and job opportunities, income level, physical and emotional wellbeing, as well as the economic and social conditions the children they do bear will experience." (quoted in Rothman, 1984, 26) In the very broadest sense, abortion provides women with greater control over their lives. It is part of the material conditions which contribute to women's greater control over their work, their education, their economic independence and their sexuality.

The political struggle for abortion services has shown that safety and control are two necessary, although not always sufficient, criteria against which reproductive options must be measured. The question which remains is, how does IVF measure up on both of these counts?

IVF is not a safe conceptive technique. As I reviewed in Chapters Two and Three, the physical and psychological costs of IVF are considerable. In addition to the immediate and short term side effects of hormone therapy, women undergoing IVF are subjected to repeated anaesthesia and operations, intrusive and taxing physical exams, and the increased risk of cancer, ectopic pregnancies, multiple pregnancies, premature delivery, and spontaneous abortion. Moreover, as Christine Overall notes, recent studies suggest that the children conceived through IVF face increased rates of perinatal death, birth defects and low birthweights (1991, 389). These physical health risks are compounded with what research has revealed to be serious psychological and emotional costs of IVF treatment, including anxiety, stress, depression, low self esteem and guilt.

Added to these disturbing features is the fact IVF remains a highly experimental technique with a low success rate. The long-term implications for the women undergoing this treatment and for the children born by it are simply not known. With alarming parallels to the development and application of DES, what we do know is that IVF was never adequately tested before being introduced as a therapeutic infertility technique, that the medical profession continues to apply this technology without adequately informing women of it risks, and that its use continues to expand to include healthy fertile women (Overall, 1991, 389-390).

On the issue of control, there is considerable agreement that not only are women not in control of the technology of IVF, but its effect is to remove control of reproduction from women. As Sherwin summarizes, "The problem with reproductive technology is that it concentrates power in reproductive matters in the hands of those who are not directly involved in the actual

bearing and rearing of the child; i.e., in men who relate to their clients in a technical, professional, authoritarian manner." (1987, 281) One of the most telling signs of the lack of women's control in IVF processes is the discriminatory screening practices of such programs. For the medical professionals who provide IVF, it has become clear that lesbian, single, economically disadvantaged, or disabled women need not apply.

As Overall points out, there are at least three reasons why screening for IVF is, from a feminist ethical point of view, morally suspect. First, individuals who do not suffer from any reproductive impairment are not subjected to a screening process to determine their eligibility for parenthood, and thus it is discriminatory from the start. In addition, not all forms of infertility treatment are applied under such restrictions (Overall, 1991, 386). Second, it is clear that some characteristics used to determine eligibility are not easily or accurately measured. Marital stability or aptitude for parenthood are difficult to define, let alone measure, and it is even more questionable whether IVF clinicians are the most appropriate individuals to make such evaluations (Overall, 1991, 386). In addition, Overall states, "it is essential to challenge the moral legitimacy of discrimination on the basis of characteristics such as sexual orientation and marital status. Such discrimination is founded upon false assumptions about the nature and abilities of single and lesbian women, and about the kind of mothering they can provide." (1991, 386-387). Finally, IVF screening further entrenches the false notion that marriage, heterosexuality or financial stability necessarily make women better mothers.

Even without discriminatory access policies, however, the highly technical nature of IVF makes it unlikely that it could ever be applied in a

manner that would enhance women's control over reproduction. Because of this, it is only reasonable that feminists will remain sceptical of its potential to contribute to women's reproductive freedom.

> We must recognize that women's existing lack of control in reproductive matters begins the debate on a pretty steep incline. Technology with the potential to further remove control of reproduction from women makes the slope very slippery indeed. This new technology, though offered under the guise of increasing reproductive freedom, threatens to result, in fact, in a significant decrease in freedom, especially since it is a technology that will always include the active involvement of designated specialists and will not ever be a private matter for the couple or women concerned. (Sherwin, 1987, 284)

Using Petchesky's and Sherwin's framework, I have tried to illustrate that the feminist struggle for reproductive freedom is not simply a demand for the right to choose. It is also a demand for reproductive options which respect the integrity of women's bodies and the physical and psychological health of women. It is a demand for women's increased control over their bodies, their reproductive processes and their lives in general. Unlike abortion, which today is relatively simple and safe, IVF is highly invasive and dangerous. Unlike abortion, which more often than not provides women with increased control over their bodies and their lives, IVF means less control for women and more control for physicians and other medical professionals. Using the two basic criteria of safety and control then, it is clear that IVF is incompatible with a feminist ethic of choice. While feminists must and will continue to support the right of infertile women to choose technological and medical intervention to conceive, we cannot consistently support the particular choice of IVF, which is so inherently invasive and dangerous.

Having identified a particular reproductive option, in this case IVF, as inconsistent with feminist values, the question remains what political strategy should feminists adopt to voice their objections to its development and application? Do we demand a complete ban on IVF or do we look for ways to limit women's needs or desires for it? More importantly, which of these strategies will respect the experiences of infertile women and empower them in their decision making? It is to these issues of political strategy that I now turn.

FUTURE POLITICAL STRATEGIES:

Like radical feminists, I believe the strength of feminist critiques of IVF lies in their recognition of the materially and ideologically oppressive conditions under which women make their reproductive choices. However, like socialist feminists, I believe that this is true for all reproductive decisions, and that to ban IVF on these grounds would not only endanger other reproductive rights, such as access to abortion, but would also ignore women's abilities to make conscientious moral decisions despite these conditions. As Christine Overall points out,

> Even if the longing felt by infertile women is socially produced, it is nevertheless real longing. Furthermore, that longing cannot be assumed to extinguish women's autonomy. Women who are 'trying everything' in order to obtain a baby are not necessarily less autonomous, less free from social conditioning, than women who gestate and deliver without technological intervention, nor less free than the feminists who call into question infertile women's motivations." (Overall, 1991, 391)

Freedom and the ability to choose is not "an all or nothing affair" (Overall, 1991, 391). More specifically, reproductive choices are not, as radical feminists analyses would portray them, an impossible goal for women in a patriarchal society. Nor are they, as some socialist feminists would argue, simply a reflection of women's free will. Rather, the nature of choice, if we consider the work of Chodorow, is somewhere between these two positions. That is, women's choices, while not totally socially determined, are shaped by both social and psychological factors which are beyond women's control and which ultimately become part of the very structure of their psyches. In this sense reproductive choices are no more nor less free than any other choice a woman makes under the present conditions. In the end, "we can rarely be completely free of unjust or inappropriate social and economic pressures, but we can sometimes make sound and appropriate decisions, in the light of our own circumstances." (Overall, 1991, 391)

Ultimately, what my position demands is an inherent respect for women's abilities and experiences. It is vital that feminists first affirm women's abilities to make sound reproductive choices, and second avoid denying or belittling the desires and needs of infertile women. This does not mean that feminists cannot be critical of the social and psychological processes which shape those needs and desires. Nor does it mean that we cannot challenge unsafe and disempowering means of meeting them. We must do both.

What it does mean, however, is that we can use our analyses of this technology to "expose the harm of IVF to the women themselves most likely to be affected by it, and then let them make the decision about whether to seek access nevertheless" (Overall, 1991, 392). We can tell women what we

know about IVF. We can tell them that it is an unsafe and experimental technique which threatens to remove women's control over reproduction at the same time as it reinforces patriarchal ideas of women as childbearers. We can inform them that IVF, as it is presently made available, reinforces the racist, sexist, classist and heterosexist assumptions in our culture about what makes women good mothers. And we can reveal the ways that any technology which threatens women's autonomy to redefine their roles in society also threatens the well-being and reproductive freedom of all women.

Ultimately, what this approach assumes is that "when women are provided with complete information, real choices and full support with regard to artificial reproduction, they will be empowered to make reproductive decisions that will genuinely benefit themselves and their children" (Overall, 1991, 393) and, I would add, all women whose reproductive freedom is affected by their decision.

Our goal should not be to limit the supply of reproductive technologies such as IVF, so much as to limit the demand. We will not achieve this by banning access. As Christine Overall, who also opposes bans on IVF argues,

> I cannot agree with those who wish to ban IVF to protect women from the dangers of coercive IVF, any more than I can agree with so-called 'pro-life feminists' who wish to ban abortion to protect women from the dangers of coercive abortions. It is not the role of feminist research and action to protect women from what is interpreted to be their own false consciousness. (1991, 392)

Ultimately, feminists will have to move beyond addressing infertile women to challenge the cultural beliefs and practices which make the inability to bear children so unbearable. For example, if my analysis of the

experience of infertility in Chapter Three bears weight, this will mean challenging traditional means of childrearing in which women are primarily responsible for the care of children. It will also mean even stronger efforts to improve the status of women and the opportunities available to them to develop identities beyond the role of mother. On this point, Sherwin comments:

> we must continue the social pressure to change the status of women and children in our society from that of breeder and possession respectively; hence, we must develop a vision of society as community where all participants are valued members, regardless of age or gender.
> (1987, 280-281)

In the end, these changes will not only serve to reduce infertile women's desire or need for IVF, but they will also contribute positively to the material and ideological conditions necessary for the reproductive freedom of all women.

CONCLUSION:

Through my analysis of choice and reproductive freedom I have tried to show that pro-choice feminists can consistently question the particular reproductive choices women make, and that we have a responsibility to do so. Ultimately, however, we must move beyond examining the individual choices of women to challenge the oppressive material and ideological conditions under which women make them. What we have learned is that reproductive freedom is not guaranteed by access to any and all reproductive technologies, or by banning particular choices. Reproductive freedom is about creating a social, political and economic environment which empowers women to make choices that will contribute to their physical and psychological well-being. In an even broader perspective, "It is the freedom to redefine our roles in society according to our concerns and needs as women." (Sherwin, 1987, 282)

> When an environment more hospitable to women's freedom of conscience and expression has been created, a genuine articulation of choice can finally begin. For choice doesn't mean one particular choice for all women. It means the freedom for every woman to think and feel her way through to what the most appropriate choice is for her. This would include refusing to participate in no-choice choices, and demanding the resources for genuine choice. (Menzies, 1991, 18)

FOOTNOTES

1. While the embryos are placed in the uterus through the cervix, there is still a risk of ectopic pregnancies in the IVF procedure. Estimates from the UBC IVF program range from 2 to 12 per cent. Women most at risk for ectopic pregnancies are those who have blocked or damaged tubes at the "distal" ends, or near the ovary, and this risk is higher if the fallopian tube is dilated with fluid. (Department of Obstetrics and Gynaecology, 1991, 4)

2. While I have been unable to locate research on the portrayal of infertile women within the mass media, I have personally listened to several radio and television documentaries on the subject, and the common theme throughout the interview-based programs with infertile women is the desperation they experience.

3. The four articles with a specific focus on gender differences in response to infertility are:

    1. Baram, D.; E. Tourtelot; E. Muechler; and K. Huang (1988).
    2. Brand, H.J. (1989).
    3. Greil, A.; T. Leitko; and K. Porter (1988).
    4. Lalos, A.; O. Lalos; L. Jacobsson; and B. Von Schoultz (1986).

4. The ten articles which identified and documented gender differences even though this was not their intended focus are:

    1. Connolly, K.; R. Edelmann; and I. Cooke (1987).
    2. Conway, P. and D. Valentine (1987).
    3. Daniels, K. (1989).
    4. Dennerstein, L. and C. Morse (1988).
    5. Leiblum, S. (1988).
    6. Mahlstedt, P. (1985).
    7. McEwan, K.; C. Costello and P. Taylor (1987).
    8. Miall, C. (1986).
    9. Raval, H.; P. Slade; P. Buck; and B. Lieberman (1987).
    10. Shaw, P.; M. Johnston and R. Shaw (1988).

5. A Note on Methodology:

There are significant differences in the research samples of the four studies which examined gender-specific response to infertility. The study on tubal surgery (Lalos et al., 1986), by definition selected only couples in which the woman was diagnosed with an fertility problem. Similarly, neither the IVF study (Baram et al., 1988) nor the study on the acceptance of infertility (Brand, 1989) controlled for which partner was diagnosed with the reproductive impairment.

Although all of these studies found significant gender differences in response to infertility, it may be argued that women's more profound reactions are due not to gender, but rather to the fact that the women in these studied were undergoing invasive treatment and knew that they, and not their partners, were infertile.

In fact, however, research by Greil et al. (1988) supports the hypothesis that gender is the key variable in these situations and suggests that these methodological problems may not be as significant as they appear. In particular, Greil et al. controlled for the locus of infertility under the assumption that gender differences may be mediated by the knowledge of which partner has a reproductive impairment. They found, however, that gender differences exist regardless of which partner is infertile and undergoing treatment. Their results also suggest that locus of infertility does not outweigh gender as an independent variable because of the tendency for women to feel psychologically and socially responsible for the couple's infertility regardless of which partner is diagnosed as physically infertile.

6. REPORTED SYMPTOMS FOLLOWING IVF FAILURE: (Baram et al., 1988, 186)

	Women (n=47) (%)	Men (n=24) (%)
Sadness	85.0	62.5
Hopelessness	51.0	16.5
Feelings of Loss	42.5	29.0
Guilt/Self-blame	38.0	25.0
Feeling out of Control	34.0	04.0
Anxiety	25.5	15.5
Hypersomnia	21.0	04.0
Insomnia	15.0	04.0
Inability to Concentrate	19.0	06.0
Increased appetite	08.5	08.0
Decreased appetite	06.0	08.0
Memory Loss	06.0	00.0
Nightmares	10.5	00.0
Panic attacks	10.5	00.0
Suicidal ideation	13.0	00.0
Decreased Job Performance	15.0	04.0

7. AVERAGE STRESS LEVEL FOR STAGES OF INFERTILITY EVALUATION AND TREATMENT* (Baram et al., 1988, 187)

	Women (n=48)	Men (n=36)
Discovering an infertility problem	7.0	4.8
Undergoing infertility evaluation	5.6	4.1
Deciding to try IVF	3.9	3.7
Waiting to be accepted to IVF Program	4.4	4.0
Going through IVF	6.8	6.4
Waiting to see if IVF worked	8.1	7.4
Discovering that IVF did not work	8.5	7.0
Time since IVF completed	4.0	2.9

*Stress level evaluation: 1=least stressful, 10=most stressful

APPENDIX A

LITERATURE ON THE EXPERIENCE OF INFERTILITY AND COPING WITH INVOLUNTARY CHILDLESSNESS:

Anderson, K. "Infertility: The Silent Crisis" in Canada's Mental Health. 37(1), 1989. 9-12.

Batterman, R. "A Comprehensive Approach to Treating Infertility" in Health and Social Work. 10(1), 1985, 46-54.

Brand, H.J. "The Influence of Sex Differences on the Acceptance of Infertility" in Journal of Reproductive and Infant Psychology. 7, 1989. 129-131.

Butler, R. and S. Koraleski. "Infertility: A Crisis with no Resolution" in Journal of Mental Health Counselling. 12(2), 1990. 151-163.

Callan, V. and J. Hennessey. "Psychological Adjustment of Women Experiencing Infertility" in British Journal of Medical Psychology. 61, 1988. 137-140.

Callan, V. and J. Hennessey. "Psychological Adjustment to Infertility: A Unique Comparison of Two Groups of Infertile Women, Mothers and Women Childless by Choice" in Journal of Reproductive and Infant Psychology. 7, 1989, 105-112.

Callan, V. and J. Hennessey. "Strategies for Coping with Infertility" in British Journal of Medical Psychology. 62, 1989. 343-354.

Connolly, K.; R. Edelmann and I. Cooke. "Distress and Marital Problems Associated with Infertility" in Journal of Reproductive and Infant Psychology. 5, 1987. 49-57.

Conway, P. and D. Valentine. "Reproductive Losses and Grieving" in Journal of Social Work and Human Sexuality. 6(1), 1987, 43-64.

Cook, E.P. "Characteristics of the Biopsychosocial Crisis of Infertility" in Journal of Counselling and Development. 65, 1987, 465-470.

Covington, S. "Psychosocial Evaluation of the Infertile Couple: Implications for Social Work Practice" in Journal of Social Work and Human Sexuality. 6(1), 1987, 21-36.

Edelmann, R. and K. Connolly. "The Counselling Needs of Infertile Couples" in Journal of Reproductive and Infant Psychology. 5, 1987. 63-70.

Fleming, J. and K. Burry. "Coping with Infertility" in Journal of Social Work and Human Sexuality. 6(1), 1987. 37-41.

Fouad, N. and K. Kons Fahje. "An Exploratory Study of the Psychological Correlates of Infertility on Women" in Journal of Counseling and Development. 68, 1989. 97-101.

Frank, D. "Counseling the Infertile Couple" in Journal of Psychosocial Nursing. 22(5), 1984, 17-23.

Goodman, K. and B. Rothman. "Group Work in Infertility Treatment" in Social Work with Groups. 7(1), 1984. 79-97.

Greil, A.; T. Leitko and K. Porter. "Infertility: His and Hers" in Gender and Society. 2(2), 1988. 172-199.

Lalos, A.; O. Lalos; L. Jacobsson and B. Von Schoultz. "Depression, Guilt and Isolation among Infertile Women and their Partners" in Journal of Obstetrics and Gynaecology. 5(3), 1986. 197-206.

Mahlstedt, P.P. "The Psychological Component of Infertility" in Fertility and Sterility. 43(3), 1985. 335-346.

Mahlstedt, P.P. and P. Townsend Johnson. "Support to Persons Experiencing Infertility: Family and Friends Can Help" in Journal of Social Work and Human Sexuality. 6(1), 1987. 65-71.

Matthews, A.M. and R. Matthews. "Beyond the Mechanics of Infertility: Perspectives on the Social Psychology of Infertility and Involuntary Childlessness" in Family Relations. 35, 1986, 470-487.

Matthews, R. and A. Martin Matthews. "Infertility and Involuntary Childlessness: the Transition to Nonparenthood" in Journal of Marriage and the Family. 48, 1986. 641-649.

McCormick, T. "Out of Control: One Aspect of Infertility" in Journal of Obstetric, Gynecologic and Neonatal Nursing. 9(4), 1980. 205-206.

McEwan, K.; C. Costello and P. Taylor. "Adjustment to Infertility" in Journal of Abnormal Psychology. 96(2), 1987. 108-116.

Menning, B.E. "Counseling the Infertile Couple" in Contemporary Ob/Gyn. 13, 1979. 101-108.

Menning, B.E. "The Emotional Needs of Infertile Couples" in Fertility and Sterility. 34(4), 1980. 313-319.

Miall, C.E. "The Stigma of Involuntary Childlessness" in Social Problems. 33(4), 1986. 268-282.

Olshansky, E.F. "Identity of Self as Infertile: An Example of Theory Generating Research" in Advances in Nursing Science. 9(2), 1987. 54-63.

Pfeffer, N. and A. Woollett. The Experience of Infertility. London: Virago Press. 1983.

Raval, H.; P. Slade; P. Buck and B.E. Lieberman. "The Impact of Infertility on Emotions and the Marital and Sexual Relationship" in Journal of Reproductive and Infant Psychology. 5, 1987. 221-234.

Sandelowski, M. "Sophie's Choice: A Metaphor for Infertility" in Health Care for Women International. 7(6), 1986. 439-453.

Sandelowski, M. "The Color Gray: Ambiguity and Infertility" in Image: Journal of Nursing Scholarship. 19(2), 1987. 70-74.

Sandelowski, M. "Without Child: The World of Infertile Women" in Health Care for Women International. 9(3), 1988. 147-161.

Sandelowski, M. and L.C. Jones. "Social Exchanges of Infertile Women" in Issues in Mental Health Nursing. 8(3), 1986. 173-189.

Sandelowski, M. and C. Pollick. "Women's Experiences of Infertility" in Image: Journal of Nursing Scholarship. 18(4), 1986. 140-144.

Valentine, D. "Psychological Impact of Infertility: Identifying Issues and Needs" in Social Work and Health Care. 11(4), 1986. 61-69.

Woollett, A. "Childlessness: Strategies for Coping with Infertility" in International Journal of Behavioral Development. 8, 1985. 473-482.

APPENDIX A CONTINUED

LITERATURE ON THE EXPERIENCE OF INFERTILITY TREATMENT:

Baram, D.; E. Tourtelot; E. Muechler and K. Huang. "Psychosocial Adjustment Following Unsuccessful In Vitro Fertilization" in Journal of Psychosomatic Obstetrics and Gynaecology. 9(3), 1988. 181-190.

Cook, R.; J. Parsons; B. Mason and S. Golombok. "Emotional, Marital and Sexual Functioning in Patients Embarking upon IVF and AID Treatment for Infertility" in Journal of Reproductive and Infant Psychology. 7, 1989. 87-93.

Daniels, K. "Psychosocial Factors for Couples Awaiting In Vitro Fertilization" in Social Work in Health Care. 14(2), 1989. 81-98.

Daniluk, J.; A. Leader and P. Taylor. "Psychological and Relationship Changes of Couples Undergoing an Infertility Investigation: Some Implications for Counsellors" in British Journal of Guidance and Counselling. 15(1), 1987. 29-36.

Dennerstein, L. and C. Morse. "A Review of Psychological and Social Aspects of In Vitro Fertilization" in Journal of Psychosomatic Obstetrics and Gynaecology. 9(3), 1988. 159-170.

Donnolly, K.; R. Edelmann and I. Cooke. "Distress and Marital Problems Associated with Infertility" in Journal of Reproductive and Infant Psychology. 5, 1987. 49-57.

Edelmann, R. and K. Connolly. "The Impact of Infertility and Infertility Investigations: Four Case Illustrations" in Journal of Reproductive and Infant Psychology. 7, 1989. 113-119.

Greenfield, D.; M. Diamond and A. DeCherney. "Grief Reactions Following In-Vitro Fertilization Treatment" in Journal of Psychosomatic Obstetrics and Gynaecology. 8(3), 1988. 169-174.

Hurwitz, N. "The Psychological Aspects of In-Vitro Fertilization" in Pre- and Peri-Natal Psychology. 4(1), 1989. 43-50.

Klein, R., Editor. Infertility: Women Speak Out about their Experiences of Reproductive Medicine. London: Pandora Press. 1989.

Leiblum, S. "Intimacy and the New Reproductive Options" in Women and Therapy: A Feminist Quarterly. 7(2/3), 1988. 131-143.

Sadler, A. and C. Syrop. "The Stress of Infertility: Recommendations for Assessment and Intervention" in Family Therapy Collections. 22, 1987. 1-17.

Shaw, P.; M. Johnston and R. Shaw. "Counselling Needs, Emotional and Relationship Problems in Couples Awaiting IVF" in Journal of Psychosomatic Obstetrics and Gynaecology. 9(3), 1988. 171-180.

BIBLIOGRAPHY

Albury, Rebecca. "Who Owns the Embryo?" in Test-Tube Women: What Future for Motherhood? London: Pandora Press. 1984. 54-67.

Anderson, K. "Infertility: The Silent Crisis" in Canada's Mental Health. 37(1), 1989. 9-12.

Arditti, R.; R. Klein and S. Minden. Test-Tube Women: What Future for Motherhood? London: Pandora Press. 1984.

Baram, D.; E. Tourtelot; E. Muechler; and K. Huang. "Psychosocial Adjustment Following Unsuccessful In Vitro Fertilization" in Journal of Psychosomatic Obstetrics and Gynaecology. 9(3), 1988. 181-190.

Brand, H.J. "The Influence of Sex Differences on the Acceptance of Infertility" in Journal of Reproductive and Infant Psychology. Vol.7, 1989. 129-131.

Brodribb, Somer. "Off the Pedestal and onto the Block? Motherhood, Reproductive Technologies and the Canadian State" in Canadian Journal of Women and the Law. 1, 1986. 407-423.

Canadian Abortion Rights Action League. Brief Presented to the Royal Commission on Reproductive Technologies. Halifax: CARAL. 1990.

Chodorow, Nancy. The Reproduction of Mothering: Psychoanalysis and the Sociology of Gender. Berkeley: University of California Press. 1978.

Cirasole, D. and J. Seager. "Women and Reproductive Technologies: A Partially Annotated Bibliography" in Women and Health. 13(1-2), 1987. 237-259.

Connolly, K.; R. Edelmann; and I. Cooke. "Distress and Marital Problems Associated with Infertility" in Journal of Reproductive and Infant Psychology. Vol. 5, 1987. 49-57.

Conseil du statut de la femme. Dilemmas. Quebec: Les Publications du Quebec. 1987.

Conway, P. and D. Valentine. "Reproductive Losses and Grieving" in Journal of Social Work and Human Sexuality. 6(1), 1987. 43-64.

Corea, Gena. "Egg Snatchers" in Test-Tube Women: What Future for Motherhood? Eds., R. Arditti; R. Klein and S. Minden. London: Pandora Press. 1984. 37-51.

Corea, Gena. The Mother Machine: Reproductive Technologies from Artificial Insemination to Artificial Wombs. New York: Harper and Row Publishers Inc. 1985.

Corea, Gena. "What the King Can Not See" in Embryos, Ethics, and Women's Rights. Eds., E.H. Baruch; A.F. D'Adamo, Jr. and J. Seager. New York: Harrington Park Press. 1988. 77-93.

Corea, Gena et al. Man-Made Women: How New Reproductive Technologies Affect Women. Edited Collection. Bloomington: Indiana University Press. 1987.

CRIAW/ICREF. Reproductive Technologies and Women: A Research Tool. Ottawa: CRIAW/ICREF. 1989.

Daniels, K. "Psychosocial Factors for Couples Awaiting In Vitro Fertilization" in Social Work and Health Care. 14(2), 1989. 81-98.

Dennerstein, L. and C. Morse. "A Review of Psychological and Social Aspects of In Vitro Fertilisation" in Journal of Psychosomatic Obstetrics and Gynaecology. 9(3), 1988.
159-170.

Department of Obstetrics and Gynaecology. In Vitro Fertilization Program. (Patient Information Sheet) Vancouver: University of British Columbia. 1991.

Donchin, Anne. "The Growing Feminist Debate over the New Reproductive Technologies" in Hypatia. 4(3), 1989. 136-149.

Fine, Michelle and Adrienne Asch. "Who Owns the Womb? in The Women's Review of Books. 2(8), 1985. 8-10.

Franklin, Sarah and Maureen McNeil. "Reproductive Futures: Recent Literature and Current Feminist Debates on Reproductive Technologies" in Feminist Studies. 14(3). Fall, 1988. 545-560.

Gallagher, Janet. "Eggs, Embryos and Foetuses: Anxiety and the Law" in Reproductive Technologies: Gender Motherhood and Medicine. Ed., M. Stanworth. Minneapolis: University of Minnesota Press. 1987. 139-150.

Gerson, Deborah. "Infertility and the Construction of Desperation" in Socialist Review. 19(3), 1989. 45-64.

Gilligan, Carol. In a Different Voice: Psychological Theory and Women's Development. Cambridge: Harvard University Press. 1982.

Gordon, Linda. "Who is Frightened of Reproductive Freedom for Women and Why? Some Historical Answers" in Frontiers. 9(1), 1986. 23-26.

Greil, Arthur; Thomas Leitko and Karen Porter. "Infertility: His and Hers" in Gender and Society. 2(2), 1988. 172-199.

Hanmer, Jalna. "A Womb of One's Own" in Test-Tube Women: What Future for Motherhood? Eds., R. Arditti; R. Klein and S. Minden. London: Pandora Press. 1984. 438-447.

Hanmer, Jalna. "Transforming Consciousness: Women and the New Reproductive Technologies" in Man Made Women: How New Reproductive Technologies Affect Women. Eds., G. Corea et al. Indianapolis: Indiana University Press. 1987. 88-109.

Holmes, Helen B.; Betty B. Hoskins and Michael Gross. "Preface" in The Custom-Made Child? Women Centred Perspectives. Eds., H. Holmes; B. Hoskins and M. Gross. New Jersey: Human Press Inc. 1981. ix-xi.

Hornstein, Francie. "Children by Donor Insemination: A New Choice for Lesbians" in Test-Tube Women: What Future for Motherhood? Ed., R. Arditti et al. London: Pandora Press, 1984.

Hubbard, Ruth. "The Case Against In Vitro Fertilization and Implantation" in The Custom-Made Child? Women Centred Perspectives. Eds., H. Holmes; B. Hoskins and M. Gross. New Jersey: Human Press Inc. 1981. 259-262.

Humm, Maggie. "Motherhood has a History: Amenorrhoea and Autobiography" in Infertility: Women Speak Out about their Experiences of Reproductive Medicine. Ed., R. Klein. London: Pandora Press. 1984. 35-45.

Klein, Renate Duelli, Ed. Infertility: Women Speak Out about their Experiences of Reproductive Medicine. London: Pandora Press. 1984.

Klein, Renate Duelli. "What's 'New' About the 'New' Reproductive Technologies?" in Man Made Women: How New Reproductive Technologies Affect Women. Eds., G. Corea et al. Indianapolis: Indiana University Press. 1987. 64-73.

Lalos, Ann; Othon Lalos; Lars Jacobsson and Bo Von Schoultz. "Depression, Guilt and Isolation among Infertile Women and their Partners" in Journal of Obstetrics and Gynaecology. 5(3), 1986. 197-206.

Leiblum, S. "Intimacy and the New Reproductive Options" in Women and Therapy. 7(2/3), 1988. 131-143.

Lewis, Margaret. "Nowhere for Me to Be" in Infertility: Women Speak Out about their Experiences of Reproductive Medicine. Ed., R. Klein. London: Pandora Press. 1984. 19-27.

Lorber, Judith. "IVF and Gender Politics" in Embryos, Ethics, and Women's Rights. Eds., E.H. Baruch; A.F. D'Adamo, Jr. and J. Seager. New York: Harrington Park Press. 1988. 117-133.

Mahlstedt, P. "The Psychological Component of Infertility." in Fertility and Sterility. 43(3), 1985. 335-346.

McCormack, Thelma. "Public Policies and Reproductive Technologies: A feminist Critique" in Canadian Public Policy. 14(4), 1988. 361-375.

McCormack, Thelma. "When is Biology Destiny?" in The Future of Human Reproduction. Ed., C. Overall. Toronto: The Women's Press. 1989. 80-94.

McCormack, Thelma. "Ethics and Human Reproduction: The Bias of Bioethics" in Moral Expertise: Studies in Practical and Professional Ethics. Ed., L. Macniven. London: Routledge. 1990. 144-160.

McEwan, K.; C. Costello and P. Taylor. "Adjustment to Infertility" in Journal of Abnormal Psychology. 96(2), 1987. 108-116.

Menning, Barbara. "In Defense of In-Vitro Fertilization" in The Custom-Made Child? Women Centred Perspectives. Eds, H. Holmes; B. Hoskins and M. Gross. New Jersey: Human Press Inc. 1981. 263-267.

Menzies, Heather. "Rethinking Abortion: Comprehending the Abortion Issue in Women's Own Words" in Canadian Forum. October, 1991. 13-18.

Miall, Charlene E. "The Stigma of Involuntary Childlessness" in Social Problems. 33(4), 1986, 268-282.

Moss, Kathryn. "New Reproductive Technologies: Concerns of Feminists and Researchers" in Affilia. 3(4), 1988. 38-50.

Murphy, Julie. "Egg Farming and Women's Future" in Test-Tube Women: What Future for Motherhood? Ed., R. Arditti et al. London: Pandora Press. 1984. 68-75.

NAC: National Action Committee on the Status of Women. The New Reproductive Technologies: A Technological Handmaid's Tale. A Brief Presented to the Royal Commission on New Reproductive Technologies. Toronto: NAC, National Office. 1990.

Notman, M. "Feminine Development: Changes in Psychoanalytic Theory" in The Woman Patient: Concept of Femininity and the Life Cycle. Eds., C. Nadelson and M. Notman. New York: Plenum Press. 1982. 3-29.

Nsiah-Jefferson, Laurie. "Reproductive Technology: Perspectives and Implications for Low-Income Women and Women of Colour" in Healing Technology: Feminist Perspectives. Eds., K. Strother Ratcliff; M. Marx Ferree; G. Mellow; B. Drygulski Wright; G. Price; K. Yanoshik and M. Freston. Ann Arbor: The University of Michigan Press. 1989. 93-118.

Oakley, Ann. "Feminism, Motherhood and Medicine - Who Cares?" in What is Feminism. Ed., J. Mitchell and A. Oakley. Oxford: Basil Blackwell. 1986. 127-150.

Overall, Christine. "Reproductive Ethics: Feminist and Non-Feminist Approaches" in Canadian Journal of Women and the Law. 1, 1986. 271-278.

Overall, Christine. Ethics and Human Reproduction: A Feminist Analysis. Winchester, MA: Allen and Unwin Inc. 1987.

Overall, Christine. "Access to In Vitro Fertilization: Costs, Care and Consent" in Dialogue. 3, 1991. 383-397.

Pappert, Ann. "A Voice for Infertile Women" in Infertility: Women Speak Out about their Experiences of Reproductive Medicine. Ed., R. Klein. London: Pandora Press. 1984. 198-206.

Petchesky, Rosalind Pollack. Abortion and Woman's Choice: the State, Sexuality, and Reproductive Freedom. New York: Longman Inc. 1984.

Petchesky, Rosalind Pollack. "Foetal Images: The Power of Visual Culture in the Politics of Reproduction" in Reproductive Technologies: Gender Motherhood and Medicine. Ed., M. Stanworth. Minneapolis: University of Minnesota Press. 1987. 57-80.

Pfeffer, Naomi. "Artificial Insemination, In-vitro Fertilization and the Stigma of Infertility" in Reproductive Technologies: Gender Motherhood and Medicine. Ed., M. Stanworth. Minneapolis: University of Minnesota Press. 1987. 81-97.

Pfeffer, Naomi and Anne Woollett. The Experience of Infertility. London: Virago Press. 1983.

Poff, Deborah C. "Reproductive Technology and Social Policy in Canada" in The Future of Human Reproduction. Ed., C. Overall. Toronto: The Women's Press, 1989. 216-225.

Rapp, Rayna. "Moral Pioneers: Women, Men and Fetuses on a Frontier of Reproductive Technology" in Embryos, Ethics and Women's Rights. Eds., E.H. Baruch; A.F. D'Adamo, Jr. and J. Seager. New York: Harrington Park Press. 1988. 101-116.

Raval, H.; P. Slade; P. Buck; and B. Lieberman. "The Impact of Infertility on Emotions and the Marital and Sexual Relationship" in Journal of Reproductive and Infant Psychology. Vol. 5, 1987. 221-234.

Raymond, Janice. "Feminist Ethics, Ecology and Vision" in Test-Tube Women: What Future for Motherhood? Eds., R. Arditti; R. Klein and S. Minden. London: Pandora Press. 1984. 426-437.

Raymond, Janice. "Reproductive Technologies, Radical Feminism, and Socialist Liberalism" in Reproductive and Genetic Engineering. 2(2), 1989. 133-142.

Rose, Hilary. "Victorian Values in the Test-Tube: The Politics of Reproductive Science" in Reproductive Technologies: Gender, Motherhood and Medicine. Ed., M. Stanworth. Minneapolis: University of Minnesota Press, 1987. 151-173.

Rothman, Barbara Katz. "The Meanings of Choice in Reproductive Technology" in Test-Tube Women: What Future for Motherho :d? Eds., R. Arditti; R. Klein and S. Minden. London: Pandora Press. 1984. 23-33.

Rothman, Barbara Katz. "Reproduction" in Analyzing Gender: A Handbook of Social Science Research. Eds., B. Hess and M.M Ferree. California: Sage Publications. 1987. 154-170.

Rowbotham, Sheila. "To Be or Not to Be: The Dilemma's of Mothering" in Feminist Review. 31, 1989. 82-93.

Rowland, Robyn. "Reproductive Technologies: The Final Solution to the Woman Question?" in Test-Tube Women: What Future for Motherhood? Eds., R. Arditti; R. Klein and S. Minden. London: Pandora Press. 1984. 356-369.

Rowland, Robyn. "Motherhood, Patriarchal Power, Alienation and the Issue of 'Choice' in Sex Preselection" in Man Made Women: How New Reproductive Technologies Affect Women. Eds., G. Corea et al. Indianapolis: Indiana University Press. 1987a. 74-87.

Rowland, Robyn. "Technology and Motherhood: Reproductive Choice Reconsidered" in Signs. 12(3), 1987b. 512-528.

Sandelowski, Margarete. "Sophie's Choice: A Metaphor for Infertility" in Health Care for Women International. 7(6), 1986. 439-453.

Sandelowski, Margarete. "Fault Lines: Infertility and Imperiled Sisterhood" in Feminist Studies. 16(1), 1990. 33-51.

Shaw, P.; M. Johnston and R. Shaw. "Counselling Needs, Emotional and Relationship Problems in Couples Awaiting IVF" in Journal of Psychosomatic Obstetrics and Gynaecology. 9(3), 1988. 171-180.

Sherwin, Susan. "Feminist Ethics and In Vitro Fertilization" in Canadian Journal of Philosophy. 13, 1987. 265-284.

Silverman, Phyllis. Helping Women Cope with Grief. Berverley Hills: Sage. 1981.

Solomon, Alice. "Integrating Infertility Crisis Counselling into Feminist Practice" in Reproductive and Genetic Engineering. 1(1), 1988. 41-49.

St. Peter, Christine. "Feminist Discourse, Infertility and Reproductive Technologies" in NWSA Journal. 1(3), 1989. 353-367.

Stanworth, Michelle. "Reproductive Technologies and the Deconstruction of Motherhood" in Reproductive Technologies: Gender Motherhood and Medicine. Ed., M. Stanworth. Minneapolis: University of Minnesota Press. 1987. 10-35.

Valentine, Deborah. "Psychological Impact of Infertility: Identifying Issues and Needs" in Social Work in Health Care. 11(4), 1986. 61-69.

Zipper, Juliette and Selma Sevenhuijsen. "Surrogacy and Feminist Notions of Motherhood" in Infertility: Women Speak Out about their Experiences of Reproductive Medicine. Ed., R. Klein. London: Pandora Press. 1984. 118-138.