IN VOLUNTARY CHILDLESSNESS: THE 
LIVED EXPERIENCES OF THREE WOMEN 

by 

ALISON MARY LINDSAY MORDELL 

B.A., Simon Fraser University, 1992, 

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF 

THE REQUIREMENTS FOR THE DEGREE OF 

MASTER OF ARTS 

in 

THE FACULTY OF GRADUATE STUDIES 

(Department of Counselling Psychology) 

We accept this thesis as conforming to the required standard. 

THE UNIVERSITY OF BRITISH COLUMBIA 

APRIL 1999 

© Alison Mary Lindsay Mordell, 1999
In presenting this thesis in partial fulfilment of the requirements for an advanced degree at the University of British Columbia, I agree that the Library shall make it freely available for reference and study. I further agree that permission for extensive copying of this thesis for scholarly purposes may be granted by the head of my department or by his or her representatives. It is understood that copying or publication of this thesis for financial gain shall not be allowed without my written permission.

Department of **Counselling Psychology**

The University of British Columbia  
Vancouver, Canada

Date **April 29, 1999**
ABSTRACT

Grief is a universal experience. The way people make sense of their world and process their grief is an individual process. For women experiencing involuntary childlessness, their grief involves multiple, significant, tangible losses, as well as intangible and symbolic losses.

A qualitative multiple case study design (using a phenomenological analysis) resulted in the exploration of the lived experiences of three women who were confronted with the grief of involuntary childlessness. The stories of their intense struggle and investment to reach their goal are shared, as well as the devastating and tragic losses they experienced. Part of the process of grieving their losses included healing transformation with the severing of hope, their reinvestment in living and the creation of new meaning in their lives.

In-depth interviews were audio taped. The co-researchers described their experiences from the onset of their hopes and plans for children, to their lives years later, where they have processed grief and reconstructed their sense of themselves, including their identification and role as mothers. A phenomenological analysis was conducted to uncover the thematic commonalities. The themes were validated by the co-researchers. The results were compared and contrasted with specific themes related to this study and specific themes identified in Claspell (1984) and Cochran & Claspell (1987).

This study builds on the existing body of research for involuntarily childless women, including their grieving and resolution processes. The findings in this study also add to the existing theoretical frameworks of grief and resolution such as "The Meaning of Grief: A dramaturgical approach to understanding emotion" by Cochran & Claspell (1987). These women's stories also provide greater understanding for therapists working with involuntarily childless individuals.
**TABLE OF CONTENTS**

Abstract ........................................ ii.
Table of Contents ................................ iii.
Acknowledgements ................................. v.
The Basis of my Assumptions .................... vii.

**CHAPTER I**

The Introduction .................................. 1
General Issues ..................................... 1

**CHAPTER II**

Existing Models of Grief ......................... 10
Kubler-Ross ........................................ 10
Parkes ............................................. 12
Cochran & Claspell ............................... 15
Application of the Models of Grief ............. 21

**CHAPTER III**

Involuntary Childlessness: Its Consequences and Outcomes ......................... 28
Childlessness and Infertility Research ...... 39
Summary ........................................... 57
Quantitative and Qualitative Research ...... 63
Case Studies ...................................... 66
Existential Phenomenology ..................... 69

**CHAPTER IV**

Methodology ...................................... 76
The Procedure ................................... 80
Co-Researchers ................................... 82
Criteria for Selection ................................. 83
Sampling Procedure ...................................... 83
The Interview Procedure ................................. 84
Analysis of Protocols ..................................... 86
Strength and Weakness of design ....................... 89
Summary .................................................... 93

CHAPTER V
Results ...................................................... 97
Description of Themes .................................... 100

CHAPTER VI
Discussion .................................................. 137
Comparison/Contrast ...................................... 141
Future Research .......................................... 154
Therapy Implications .................................... 157
Conclusions ................................................ 162

REFERENCES .............................................. 165
Appendices ............................................... 177
Bibliography .............................................. 241
ACKNOWLEDGMENTS

This thesis represents the journey of three extraordinary women, as well as a journey of my own. First, I must express my heartfelt thanks and appreciation to Anne, Barb and Cathy (their choice of names) for sharing their lived experiences. As I have always known, it is your stories that have created the compelling heartbeat of this document.

There are so many to thank in my academic community and with friends, colleagues and family. My profound gratitude and appreciation to my committee. Dr. Marv Westwood, Dr. Patricia Wilensky and Dr. John Freisen; all of whom gave me gifts of patience, guidance, and unending encouragement. It was with your help that I overcame some barriers that might have unravelled the completion of this research document.

Heartfelt thanks to my dear friends and colleagues in my peer counselling group. Your support, guidance, caring and sharing of your own experiences has been inspiring and deeply appreciated. Thank you Bruce, Clem, Heather, Karen, Lorna, Lawrence and Sandy. Thanks also to Claudia.

My thesis is the completion of years of work and is intrinsically interwoven with my academic and clinical training. I have received guidance and support from many of the graduate counselling psychology department staff, including Judith, Beth, Bill, Larry, Ishu, Norm, Richard,
Colleen and, of course, John, Marv and Patricia. Profound thanks to Penny, Naomi and Pat, who helped me discover some old and new threads of experience which have enriched my personal and professional life.

Thanks dear Mum. Your unending love and support meant so much. Dad, I know you would be proud.

I must acknowledge my computer wizard, Glen Taylor. He has rescued me and my thesis from peril as a result of too many computer and disc crashes.

Dear Don, I know the last few years have been difficult. Your steadfastness and wondrous gift, to fulfill another life dream of mine, renewed my vigour and purpose. I look forward to new opportunities to bring more joy, energy and passion into our lives that we share with our ‘girls’.
THE BASIS OF MY ASSUMPTIONS

I have had an interest in understanding both women’s and men’s experiences of involuntary childlessness and, in particular, the process of resolution for a long time. I discovered my infertility in 1985, when my husband and I began to act on our family plans. My efforts to become pregnant involved six years of extensive medical tests and surgeries, multiple miscarriages, financial pressures, social isolation and marital and family stress, among other stresses. My protracted quest to have a child was an acutely painful period in my life. I deferred my grief with each miscarriage so I could prepare for the next procedure.

My clinical depression emerged when my energy, investment and opportunities were blocked. I had to stop. My spouse wouldn’t tolerate any more efforts as our relationship became enveloped in inexorable stress. Hiding under my dark cloud of depression, I secretly held onto hope for a miracle, tenaciously grasping for fulfillment of my life dream.

I read copious books and journal articles throughout my quest in order to understand all medical options and processes that we might face. Although I read articles focusing on the need for counselling throughout infertility investigations, I didn’t seek support at first. At infertility clinics, I gave my support to others and learned something of the women’s and men’s experiences. A cycle of
hope and profound grief was a common theme for individuals trying to get pregnant over years. Many seemed trapped in the same tortuous and desperate struggle as my own. I could only begin to face the intensity of my grief when I was able to release, in large measure, my desperate and tenacious grasp on hope.

My traditional coping style is to go it alone. While undergoing in-vitro fertilization, I received little or no encouragement from friends. I was criticized for "going against nature" or "God's plan". Yet, to my mind, God and nature played no role. My determination and drive would get me pregnant and my loving care would maintain my pregnancy. When I was consumed by grief, I experienced complete isolation and lack of support from family and friends. I was admonished "to get on with my life" and "to stop being so emotional". My husband focused on his wounds and was either distant or angry. My one support, my Dad, was dying of A.L.S.. I did not share my pain with him. Instead I wanted my Dad to conserve every ounce of his energy and I gave him as much of my love and strength as I possibly could.

In 1988, I miscarried at 4 months, I lost my father and my job. I descended into a clinical depression and, briefly, moved closer to a disassociating and unreal world. After some months, I was able to resurrect my hope again.

Prior to graduate school, I began work as a grief counsellor with adults of all ages coping with the death of
a family member; usually a spouse. I sought answers to my questions about the needs of involuntarily childless people. Their childlessness also could be met in therapy. I realized I could never help this population until I processed my own experience of unrelenting hope and the grief that I was struggling to avoid.

My experiences of systemic experiential therapy, both in individual therapy and in a group context, led to significant growth and renewal. In individual therapy, experiencing myself in my '80's and 'looking at my younger emotionally tormented self' helped me shed some hope and, thus open a door to grief. I did not want to live all my life in such profound despair and knew I would if hope was maintained. It was hard to give up something I held so close to my heart.

Relinquishing hope showed me the pathway to my grief. Very tentatively, I began to walk along the path. A critical experience in my grief work, healing, and transformation occurred over a year later when I participated in an experiential systemic group setting: a group psychodrama. A significant change occurred in terms of my personal growth and movement towards health. In an experiential drama, I mourned and buried my unborn children, witnessed by a supportive, caring community. Being supported by this community while grieving gave me an extraordinary affirmation of my babies and my experience of profound
For the first time, the very secret integration of myself as a mother, was exposed for all to see. This community of peers, colleagues and mentors provided total validation, affirmation and support for my identification as a mother; no one could ever deny my motherhood and the love of my children again.

I had an opportunity to dispatch with vengeance the symbolic representation of physicians who had treated me so callously and coldly. Rage over these injustices, betrayals and rejections and my despair and overwhelming grief from so many losses had filled my well within. These tortuous and tormented experiences were expunged in this group process. My well was replenished with my mothering love for my babies, Kate and Ross, with the social affirmation of my losses and my integration of motherhood; all of which I will always treasure.

These shifts occurred, in part, because of my preparedness, my readiness and my personal work over a number of years. In the group psychodrama, I let my intuition guide me in this therapeutic group process, believing a healing door might open. The time was right. I took charge of my process; of setting the scene, the players and the action. I moved ahead into the drama, trusting the group leaders, this community of colleagues and friends, and the healing potential of the enactments.
My experience of grief is that, with healing transformation, grief gets carried as if in a tender embrace. This embrace is contained within, out of awareness until I choose to reflect upon my experience. As Claspell (1984) says, "grief fades into the backdrop of our experiences, our history, resident in the pre-reflecting level, until again we reflect upon it" (Claspell, p. 10).

Rather than prepare a paper based solely on my personal experience and assumptions, I chose to develop a deeper understanding of grieving processes based on other people's experiences. I recognized that infertility was an overwhelming and individual experience. Through personal referrals from friends and colleagues, I sought to locate people whose experiences did not necessarily follow my particular pathway. I sought women who tried to have children and experienced profound grief with their childlessness as well as some resolution.

In this multiple case study, using an existential phenomenological analysis, I showed my caring, regard, commitment and integrity to the co-researchers in order to 'be with' these women throughout my investigation. I used limited self-disclosure to demonstrate my membership in this community of involuntarily childless women: rather than expound on my past experiences and theoretical knowledge, a little self-disclosure helped to deepen and enrich my relationship and interview experience with these volunteers.
The criterion of Strauss & Corbin affirmed my understanding of what I had to bring to interviews. Included are "social sensitivity, the ability to maintain analytical distance, astute powers of observation and good interactional skills" (1990, p. 18). My clinical counselling training at U.B.C., my two practicums in the community, and my continued role as a therapist for a grief group helped prepare me for this important research interviewer role.
CHAPTER I
THE INTRODUCTION

General Issues.

There is a substantial amount of literature and research on grief related to the death of spouses, parents and children. During the last two decades, there has been an increased focus in both literature and research studies on the processes and losses relating to couples dealing with infertility (Menning, 1979, Shapiro, 1988, Daniluk, 1988, 1991 & 1996). There has been little research focusing on the resolution process when adults, including both heterosexual and homosexual women and men, must relinquish hope and face a life of involuntary childlessness (Daniluk, 1996). Equally, there has been little research supporting a therapeutic counselling model which would facilitate processing this complex grief and creating new meaning in one’s involuntary childless life. As Cochran & Claspell (1987) suggest, "meaning is implied everywhere, so it seems, but investigated scarcely at all" (p. 6).

Grief is a common experience with those facing involuntary childlessness. Working to overcome such a loss may mean facing enormous pain, but protracted pain doesn’t always lead to clinical symptoms or disorders. Individuals must eventually relinquish their struggle and investment to overcome barriers to having a child. Individuals must also grieve in order to move forward and develop a new construction of life (Schwartz, 1991). This grieving
process is often described in literature as analogous to growth.

"You shall be free indeed when your days are not without a care nor your nights without a want and a grief, but rather when these things girdle your life and yet you rise above them naked and unbound" (The Prophet).

Acceptance of the universality of the grieving process must not overlook or oversimplify an individual’s personal grieving process. Society, and our whole culture, can have profound external influence on individual mourning. Society and culture interact with our personal history, thereby affecting us internally (Lendrum & Syme, 1992). There are also significant cultural differences in response to grief. These differences include cultural beliefs, values and norms to guide individual and community responses to substantial loss (Rando, 1984).

"Give sorrow words. The grief that does not speak whispers the o’re fraught heart and bids it break" (Shakespeare-MacBeth).

In the Western world, social beliefs, values and norms can result in a more complicated mourning process for both individuals and couples. Confrontation of childlessness may result in a substantive struggle dealing with profoundly held hopes and dreams. One aspect of the struggle is the socially prescribed expectation of having children. "Women who cannot bear children are not fulfilled; men who cannot father children are not virile" (Menning, 1975, p. 456). Denial, dismissal and avoidance remain prevalent attitudes
in society’s response to loss (Daniluk, 1991, Littlewood, 1992). Community denial and self-imposed isolation while struggling with infertility can lead to pathological grief. "Repressing a major emotional onslaught like grief can wreak havoc with our emotional and physical health" (Tatelbaum, 1980, p. 50).

Rituals, including funerals and wakes, are important processes to honour the dead and foster healing. However, Western families frequently do not focus on the preparation and ceremony involved with saying good-bye to a loved one (Daniluk, 1991). These responsibilities fall into the hands of professionals, such as funeral directors or religious leaders. Modern rituals associated with death reflect current social norms which do not appear to provide support for those who are grieving (Savage, 1989, Littlewood, 1992).

For those whose hopes and/or efforts to have children are fruitless or shattered, the lack of any tangible object of loss often leads to a total lack of external understanding and support. Hopes and efforts are abstract or represent potential losses. Society, in general, has no rituals to honour these losses and no norms of behaviour to support the grieving. Western society imposes codes of appropriate loss and grief. There are no such codes for the multiple losses which can occur for the involuntarily childless. These losses can be completely overwhelming. "Infertility is like a death, a death for which there are
no rituals and little public acknowledgement" (Daniluk, 1991, p. 318). The impact of society and community dismissal can not only complicate grief, but also complicate the process of resolution and renewal. Far-reaching negative outcomes with previously established social networks can result. "Couples may experience intense conflict, isolation and enormous stresses in their relationship" (Berg & Wilson, 1990, p. 12). Any shift in significant relationships can lead to painful adjustments. Those close to an grieving adult may not understand the person's needs, while others may be too uncomfortable and ill at ease to give meaningful support to those struggling with the pain of involuntary childlessness.

Childless individuals who are found to have fertility problems face the potential for extensive medical intervention which can result in intense and prolonged trauma. These traumas are often experienced in the sterile setting of hospitals or labs, environments which do not have trained personnel present to help individuals with emotional needs as they undergo an array of intrusive and depersonalizing medical tests. Counselling intervention to provide information and prepare people for the strain and stresses is clearly lacking (Daniluk, 1996).

Non-productive adults may be perceived as medical "failures". Those who struggle in vain to have children may also deal with deep intrapersonal pain, exacerbated by this perception of failure and external stresses. They become
"infertile in a predominantly fertile world" (Shapiro, 1988, p. 1).

Expenditure of tremendous commitment, time, energy and finances may create an enormous drain on adults trying to have children. Private clinics charge between $1,000 and $6,000 for infertility treatment and drug costs are high. A wide range of personal resources may be overtaxed when the crisis of infertility and childlessness brings up unfinished family business. Painful unfinished key problems from an adult's past can be reawakened in an infertility crisis (Menning, 1980).

Attachment processes play a vital role in our lives (Bowlby, 1980). In addition to the attachments made to families, friends, spouse, etc., women involved with technological procedures to secure a pregnancy may experience a profound attachment to unborn children. For those going through extensive infertility treatments, a pregnancy and its progress is monitored on a day-by-day process commencing as early as a few days after conception. For some women, attachment can begin coincident with medical interventions such as artificial insemination, in-vitro or in-vivo fertilization. Any loss where a strong emotional attachment has been formed can trigger profound grief. The complexity of this grief may also damage other significant attachment relationships (Leick & Davidsen-Nielsen, 1991). In addition to marital and family stresses and disruptions with friends, there may be
negative consequences with colleagues and employment. Absenteeism or leaves to pursue medical options may be unsupported by employers or other employees.

The grief of childless individuals and couples may relate to the loss of a life goal, their heritage, their nurturing love; all of which may be personified in their unborn or imagined child. "One must say good-bye to a dream that may have felt like a right" (Clapp, 1985, p. 34). Adults experience loss of what might have been. This not only includes a significant intrapersonal loss in terms of unfulfilled potential, but also the finality of their own death without any children (Panuthos & Romeo, 1984).

Hope is a natural part of our existence, from the most banal hope to the most profound. It is "an essential part of everyone’s life" (Leick & Davidsen-Neilsen, 1991, p. 164). Hope is also one of the most difficult aspects of childlessness to relinquish. Cochran & Claspell identify a grieving person as one "who has lost something of great significance and is without hope of recovering it...what is ignited is a desire to recover the lost subject or object" (1987, p. 28). It is only by relinquishing prolonged hope and grieving that people can begin to foster new hope for what they may find in their future (Leick & Davidsen-Neilsen, 1991). Without hope and reinvestment in the future, healing cannot occur (Roberts, 1976).

Experiential therapy for individuals, couples and groups may provide not only tangible, meaningful support, but also the
opportunity to honour the breadth and depth of intangible losses. As well, opportunities for meaningful rituals to say good-bye to a dream, to a hope, and to an unborn child can occur. It is through systemic experiential therapeutic interventions that clients may be enabled to touch their deepest levels (Napier & Whitaker, 1978). Although love may never die, the burgeoning path of loss can be narrowed or diminished to a point where childless individuals and couples can regain new balance and new energy (Tatelbaum, 1980). Systemic experiential therapy may help individuals find necessary resources to restore a new kind of hope, as well as the energy and vitality required to re-invest in living. People can be enabled to find a new mastery and a new way of being in the world (Tatelbaum, 1980, Schwartz, 1991).

Experiential interventions are essential aspects of systemic family therapy. This therapeutic model to help individuals, couples and families is symbolic and experiential (Friesen, Grigg, & Newman, 1991). Many clients are enabled to work at a deeper experiential level through symbolic enactments and transformation. "Symbols are metaphors and possess meaning at multiple levels" (Friesen, et al., 1991, p. 4). Therapy is dynamic and involves the client’s intrapersonal systems in order to increase the intensity of the therapy experience. Symbolic expression can lead to creative avenues in which to process experiences. "Artwork and bodywork may be helpful as an avenue for expression" (Daniluk, 1991, p. 117). Flomenhaft and DiCori have found commonalties shared by experiential family therapy and psychodrama.
therapy with the focus on action, drama and the benefits of new insight (1992). Action and drama encourage movement towards transforming shifts. The more intense the experience for adults struggling with grief and resolution, the greater the sense of relief that follows (Leick & Davidsen-Nielsen, 1992).

An experiential therapy process, like group psychodrama, may facilitate a deep, healing and transformative shift. In a group context, other participants can provide a supportive, caring community, which may be missing in the person's social world. The frequent lack of community support and dissolving close social networks intensifies feelings of isolation when confronted with childlessness. In a group context, the combination of the therapist's or director's skill and the therapeutic influence of the group may enhance interpersonal rapport. "Each person looks to others for validation of feelings and attitudes and each person becomes a therapeutic agent to others" (Starr, 1979, p. 8). Dramatic enactments in group psychodrama draw people out of their isolation, their grief may become unblocked and healing transformation may begin (Carmin & Nordin, 1984). The symbolic expression, the enactment, the creativity and high drama, the deep emotional experience, the release and relief, the invaluable support of an individual's symbolic or representational interpersonal community, the restoration of new hope, energy and renewed commitment to a
rich, fulfilling life; all these may be possible through systems-oriented experiential therapy for individuals, couples, families and/or groups. We live in a "death-denying society" (Parkes & Weiss, 1983, p. 242). Experiential systemic therapy may provide clients with a therapeutic environment that may meaningfully fill a social void experienced day-to-day and may also provide the chance to acknowledge the death of a dream, of an unborn child within a meaningful, supportive context. With a collaborative and caring therapist, the client has permission and support to grieve as he or she needs to. The deeper the experiential work, the greater the sense of relief afterwards, as well as the potential for meaningful transformation (Cochran & Claspell, 1987, Leick & Davidsen-Neilsen, 1992, and Holmes, 1993).

"Grieve all that is lost to you. Grieve all potential that never thrived. So it is fair to cry, to weep and grieve. Come, cry here on my shoulder"
(S. Weed, 1992).
CHAPTER II

Existing Models of Grief

A number of models of grief and loss have been developed, providing a framework with which to understand the grieving process. However, the focus of research and literature is most often directed to losses of parents, spouses and siblings (Bowlby, 1980, Raphael, 1983).

The major studies of bereavement and loss have been predominantly based on adult experiences. A number of writers rely on such models in order to understand the complex experience of grief and loss. Most of the relevant literature draws upon at least one such model, as well as from theoretical frameworks including Freud (1917, "Mourning and Melancholia"), Jung (1939, "The Stages of Life: Man in Search of a Soul"), and Bowlby (1969, 1979 & 1980, "Attachment and Loss" 3 volumes).

These models of grief explore experiences of those facing imminent death, of losing a spouse as well as a large number of other losses both tangible and intangible.

Kubler-Ross' Stage Model

In 1969, Elizabeth Kubler-Ross presented a five-stage model of grief in facing one's own death. Although her model is not a contemporary one, her work provided a significant shift in the area of grief work examining intrapersonal processes. She argued that the terminally ill mourn their own death in ways mirroring those who
grieve a lost loved one. Grief is an event that must be endured. There are predictable sequences and the process takes time (Kubler-Ross, 1969).

**Denial** is a most common reaction to impending death. It also occurs at different periods of the dying process as the client cannot fully consider his or her impending death. This denial acts to protect people from the shock and enables them to collect themselves and begin to move towards the beginning of acceptance. Prolonged denial can create problems of avoidance and purposeless lives. "If you live your life in preparation for tomorrow, each today is lost" (Tatelbaum, 1980, p. 13). Kubler-Ross believed that facing your own death or the death of a loved one will lead to growth.

Following a period of possibly rigid denial, people embrace **isolation**. Isolation is a form of denial which enables clients to face their own death and still retain a strong measure of hope (Kubler-Ross, 1969).

The shift from denial and isolation to acceptance may take a tortuous path. When denial can no longer be maintained, **anger** results. People may strike out with resentment, bitterness and rage at the unfairness in their lives. These emotions may be directed at those closest to the individual, including family and caregivers. Those experiencing closeness may resent these attacks and may themselves become angry. In addition, meaningful social support may not be
accessible. Most people lack the social skills necessary to facilitate communication with the grieving person’s profound pain associated with loss (Kubler-Ross, 1985).

The third stage is **bargaining**. These bargains are often not shared with others and relate to negotiations to buy more time from the impending death (Littlewood, 1991). **Acceptance** is Kubler-Ross’ final stage. It is a stage almost absent of feeling. It is a period of disengagement from the caretakers and the world. Energy becomes lessened and a withdrawal occurs to enable the person to prepare for death.

There have been many criticisms of a stage model as a framework for grief processes. Cochran and Claspell viewed such a linear model as completely lacking the woven threads which are part of person’s tapestry (1987). In later years, Kubler-Ross did not frame these stages as linear. Rather she recognized that the stages for each individual can vary for different periods of time and that the stages may replace each other or exist at concurrent periods.

**Parke’s Phase Model**

In the 1970’s, Colin Parkes carried out a carefully controlled study monitoring the grief reactions of British widows over a year. He saw the widows five times during the study. It is from this study that he formulated a phase pattern of normal grief in the first year of loss. His research findings have been of
significant importance to a number of research studies and writers (Bowlby, 1980, Raphael, 1983). Grieving is defined as four phases:

**Numbness** is experienced shortly after a death and helps those grieving to disavow the reality of the death. This phase is usually very short. The defense against reality enables individuals to carry on as normal, deliberately avoiding thoughts of their loss. At the time, they may also experience a foreboding sense of impending trauma.

This phase is followed by a second phase, **pinning** or the "subjective and emotional component of the urge to search for the lost object" (Parkes, 1972, p. 40). Pining is heightened by the attempts of the bereaved person to search for and recover from her loss. Anger, frustration, and irritability are some of the feelings stemming from the futility of the yearning and search. Intense emotional affect including disbelief, tears and anxiety also are present. In this stage, people risk being overwhelmed by their loss as the defensive mechanisms recede. This anger tends to mark the first few months of grieving.

The third phase is of **disorganization and despair**. Though depression often punctuates periods of anger, as a year passes, depression increases in prominence. This phase moves towards relinquishing the quest for the loved one. Behaviour becomes more apathetic and aimless
with a disinterest in looking to the future and the meaning and purpose to life. Now, her husband, a life dream with a purpose and meaning is gone. Contacts with individuals or situations that place demands or pressures on the widow are avoided. It is here where the most problematic phase may occur: there is the risk of being stuck in depression. External circumstances have the potential to exacerbate and intensify a depression or can facilitate the start of a transforming positive shift. Parkes' perspective on external factors has long been substantiated in later literature and research (Lendrum & Style (1992), Littlewood, (1992), Anton (1996) and Daniluk (1996)).

In the third phase of reorganization/recovery, individuals slowly give up old ways of thinking and being. The attachment to the lost object is broken and new beginnings and attachments are slowly and tentatively made. Those who recover do not return to being the same people they once were. They must recognize the change that has occurred and "accept it, examine how basic assumptions about themselves and their world must change" (Parkes & Weiss, 1983, p. 155).

Like Kubler-Ross, Parkes' view of the grief or mourning process is analogous to growth. You cannot lessen or "stunt any phase connected with human growth (Kennedy, 1988, p. 250). Also like Kubler-Ross, Parkes believes the phases are universal.
Losses that are enormous in magnitude or complex in their implications can result in severe responses and problematic adjustments. Emotional acceptance may be problematic for many reasons, including "the complexity of feelings, the intensity of guilt and remorse, the difficulty of acknowledging and accepting feelings and behaviours that the mourner would like to disown" (Parkes & Weiss, 1983, p. 164). Parkes and Weiss (1983) report that, not only intellectual acceptance, but also emotional acceptance and the renewed model of self and the outer world are necessary. When people are bereft, their world may lose meaning, nothing may make much sense anymore and the individual’s emotional experience may be neither supported nor validated. These factors "compound the sense of loss" (Parkes & Stevenson-Hinde, 1982, p. 195).

Infertile individuals and couples who have struggled to have a child through medical intervention typically face acute pain and trauma if their efforts are in vain. Grief is often suppressed while individuals and couples retain hope. Once hope is relinquished and grief is unleashed, individuals often grieve intangible or tangible losses without any meaningful support.

Cochran & Claspell Model

The authors examine the specific emotional experience of grief. As well, the significance of existential experience in terms of meaning of emotion is
underscored as a pathway to understanding emotional manifestation. Stage and phase models of grieving or mourning a loss frequently circumscribe this process as having a start and a finish. This narrows down the relevant factors relating to the process to those which fit within this "bipolar dimension" (Cochran & Claspell, 1987, p. 37). This linear sequence is seen by the authors as having been more relaxed in recent years and developing a richer, more complex dramatic form (Cochran & Claspell, 1987).

Frequently, research and grief literature concentrate on the intensity of affect at a specific point in time of the mourning process. Cochran and Claspell (1987) see emotions on a continuum which vary in intensity throughout the period. The meaning of these emotional experiences is "organized into a dramatic structure, a story" (p. 14). The story is a narrative of how persons make the transition from the psychological "beginning" to the psychological "end" of grief.

In contrast to a specific stage or phase model of grief, this phenomenological investigation revealed thirty three themes of grief. They are part of a woven tapestry of meanings where the myriad of threads develop from personal accounts of individual experiences. These themes begin with the "sense of loss" (p. 63). The individual's profound attachment to what is lost may also crack the foundation upon which the person's very
existence is based. Throughout the description of these themes, the writings of C.S. Lewis (1976) are included to illustrate the meaning behind the titles.

"Her absence is like the sky, spread over everything. There is a sort of invisible blanket between the world and me. I find it hard to take in what anyone says. Or perhaps hard to want to take it in. I not only live each endless day in grief, but live each day thinking about living each day in grief. Still, there's no denying that, in some sense, I feel better" (C.S. Lewis, 1976).

According to Cochran & Claspell, the story of grief is one of transformation. It has a beginning, a middle and an end.

When loss occurs, the **Beginning of the Grief** story involves profound loss and emptiness. Initial shock can result in numbness of feelings and thoughts. If efforts are made to reach the emotions, the facade keeps shocked reactions above while turbulent emotions are fermenting below, out of reach. Once shock recedes, the volcanic eruption of emotions tears at the fabric of the person. Individuals may be left feeling weighted down, overwhelmed, depressed and full of despair and yearning for what has been lost. The loss pervades every aspect of life. Everywhere the person looks, the expansive loss fills each corner. Life may seem devoid of meaning and purpose.

The pervasive grasp of initial shock may now entrap the person in an empty life, a void. Such entrapment leads
to feelings of fear and anger over the unfairness and injustice of life, of a world in which loss is a pervasive theme. The anger that results lashes out in ways that were noted by Kubler-Ross (1969) and Parkes (1972).

The movement or growth in the beginning of grief is also analogous to Kubler-Ross's (1969) and Parkes' (1972) view. "The significance of beginning is what comes alive in a person" (Cochran & Claspell, 1987, p. 96). In the reactive struggle to such negative elements, the bereaved person can find strength and vitality.

Through the Middle of Grief process, there are many shifts or cyclical movements, including the most significant features of disorientation and orientation. Throughout the process, there is a struggle: to remain functional or to give in to the grief, to remain distant from others or to connect. The struggle between disorientation and reorientation not only deals with their interpersonal world, but also their intrapersonal world. Who are they if meaning is lost? The essence of the struggle is to build a wall between the loss and oneself. Outwardly, people's mask of normalcy may hide their inner struggle. "Inwardly they are still wretched" (Cochran & Claspell, 1987, p. 101). In relationships, the struggle is to pretend one is fully present, fully functioning and fully competent. However, the exhausting
effort to maintain such a facade may only exacerbate the intensity of the loss.

By giving into feelings of despair and experiencing the agonizing emptiness, glimmers of understanding begin to emerge and brief moments of relief can occur. Inevitably, a struggle ensues. Development of occasional ebbs soften what is unrelenting, intense pain. The ebb and flow of disorientation towards the external world begins, as well as an intense focus on what no longer exists. Experiencing meaningful support from others can diminish isolation and disorientation fleetingly. This experience of brief renewed orientation is critical.

However, too often, the grieving person struggles completely alone without meaningful supportive relationships, and protracted feelings of isolation and pain linger. It is in this depth of despair and agony of grief, where disorientation peaks and the individual often searches for a way out. This search provides a means of recreating new threads of meaning, which gradually replace the old, worn threads of disorientation (Cochran & Claspell, 1987). The path being weaved, however, may be uncertain or unclear. It will remain so until all the new threads of meaning are brought together and experienced. Not until the bereaved face their acute pain, can they search out and create new meaning. There is nothing clear cut about this process, nor can it be truly articulated. It means
creating meaning by gradually adding to one’s tapestry; piece by piece, thread by thread, from the experiences of feeling, understanding, insight, spiritual healing, and so forth.

From meaning-making comes a renewed hope and readiness to begin. This readiness means a willingness to be open and to experience real transformation. The quality of this transformation varies from individual to individual and from personal experience to personal experience. It may represent a giant step forward or a substantive all-encompassing shift. It may be openness to relationships, to change, to hope and to the realization that grief can be carried without the traumatic burden of despair.

The struggle throughout this process is cyclical. Cochran and Claspell consider the timing or stage of struggles to be irrelevant. It is the depth and breadth of the experience of struggling, and the interweaving and blending of features of the struggle that are significant. "They emerge as the essential parts of a whole" (Cochran & Claspell, 1987, p. 103).

The End of Grief is a period of consolidation. Uncertainties still linger, but faith in the essence of the person’s whole being fosters the active searching out and shaping of a new meaningful life. People learn to carry their grief; to learn from it, to use it in the work ahead, and, eventually, the grief ceases to be the
pivotal point about which everything else turns. Cochran & Claspell suggest the extreme features of the monumental struggle diminish and the extremes (distance and relationship) find a balance which is both harmonious and complementary.

One of the most profound reorientations which emerge includes a powerful conviction that life is precious, as are so many aspects of living. This willingness to begin to embrace and experience life so openly again may lead to some vulnerability. However, powerful inner assurance, conviction and strength renew the threads, which will grow and flourish in each person’s tapestry of life.

Consolidating the learning and applying the lesson to experiences ahead in life foster a purposeful desire to become a positive force; that is, to be good, to do good, to be of use to oneself and others. "It offers an inner calmness, strength and sense of wisdom (Cochran & Claspell, 1987, p. 109).

**Application of the Models**

To return to Kubler-Ross, her model frames death as an end point in the grieving process with a focus on dying patients versus the survivors of the loss. Her early primary focus was on the terminally ill. Kubler-Ross’s analogy of growth as resulting from the acceptance of the inevitability of death, of the loss, is similar to Parkes’ view of growth, as well as other
more current models (Leick & Davidsen-Neilsen, 1991). However, in this early model, growth is possible only in this final stage of acceptance. The advantage of Kubler-Ross’s model is that it provides a framework which is easily understood. As an initial introduction to the study of loss, this model can be applied without one having a deep theoretical background.

Kubler-Ross’s book was released in 1969. This was a time of turmoil and trauma to hundreds of thousands of American families, who had connections to those men and women being slaughtered in Vietnam. Her book may have provided some guidance to individuals and, perhaps, to a broader community in terms of understanding the grief processes they were enduring.

This model promotes universality versus any unique, individual grieving process and, as a result, fosters a simplistic understanding of the experience of grief. I question the concept of "failure" as being the lingering at any one stage for a protracted period of time or the lack of acceptance of impending death. Multiple miscarriages, terminal illness offset by remissions, a quest and passion towards life and a belief in the importance of struggling to overcome illness; these circumstances, among others, may testify to the unique perspective of many which can lead to varying outcomes.

My challenge is to Kubler-Ross’s early view of
normative healthy stages of grief. Kubler-Ross's contribution in developing her model of the grief process provides invaluable understanding. It not only provides an excellent teaching framework, but also fosters critical acceptance of loss as a significant factor in people's lives. Kubler-Ross created peaceful acceptance of her fate years ago, when she endured a series of debilitating strokes. Now, as she nears her end, she remains embraced in a sea of tranquility and complete acceptance.

"Here on the pulse of this new day you may have the grace to look up and out and into your sister's eyes, into your brother's face, your country, and say simply, very simply with hope Good morning".

(Angelou Maya, 1992).

Colin Parkes' framework is a medical model of grief (1972). His research was one of the very few rigidly controlled studies to examine normative reactions to grief in widows. He highlighted the significance of stress and the physiological and behavioural responses to stresses. He also examined the magnitude of psychological change resulting from sudden or unanticipated death. We live with assumptions about our world. When there is a substantial change without forewarning, the adjustment to change is very difficult. Parkes emphasized the approach/avoidance mechanism which exists in different emergent situations. This mechanism is analogous to the shifting struggle featured in the

Parkes sees bereavement as a psychosocial transition. In his model of grief, a vital task for the bereaved is to develop a new identity. This striving for intrapersonal and interpersonal growth is integral to the model of Kubler-Ross (1985) and Cochran & Claspell (1987). Parkes' medical perspective limits the period of healthy, normal grieving: much beyond a year was considered chronic or pathological grief. Grief had a beginning and an end for Parkes. This end point discounted the possibility of protracted grief due to recurring traumas such as miscarriages or unravelling health remissions. As well, it is possible to carry one's grief for the balance of life in a healthy way that no longer impedes growth and learning. "We need to stay aware of the reality that we continue to be a parent of our dead child until our own dying day" (Gersie, 1991, p. 143).

The importance of Parkes' introduction to the concept of the stresses with grief cannot be understated. It provides a profound shift from earlier perspectives of grief as strictly an internal process, to new considerations of the impact on the grieving individual from external forces.

Expanding on Parkes' work on identity development, Cochran and Claspell's theoretical model provides a holistic focus on the grief process, including the
profound potential impact from external forces, experiencing and coming to understand the loss, searching for and discovering new possibilities and then experiencing transformation towards a meaningful reinvestment and participation in life. Their theoretical model is presented as a narrative or story which is a powerful and intrinsic part of both individual and humanity’s culture.

In contrast to Kubler-Ross’ and Parkes’ focus on chronic grief, pathology, stages, specific populations, time periods, etc., Cochran & Claspell provide a more optimistic approach. They focus on the meaning people create in their lives; the experiences of trauma and devastating loss, as well as focusing on the renewal and participation in life. Grief, of course, is not limited to the dying or the survivors. Loss from a death and the process of grief is an essential ingredient in Cochran & Claspell’s theoretical model. Other life-impinging losses are considered.

The very non-specific, non-limiting and non-restrictive nature of this model invites a look at other losses. These include lost opportunities, loss of role, lost relationships, relocation losses, loss of a life dream, etc.. The universality of this framework suggests connections with the many losses we experience in our lives (Claspell, 1984). Our humanness, the breadth and depth of the structure of grief and
transformation and the 33 themes offer challenges to students of grief processes. This model needs to be learned, digested and then re-learned and taken in again and again.

Claspell’s 1984 doctoral thesis was a seminal, exhaustive, phenomenological study of grief. Thirty three themes were identified and the experiences of co-researchers were structured as a story with a beginning, middle and end. There was no specific linear process to the structure as each of these experiences could be revisited again and again. Cochran & Claspell’s model of grief (1987) evolved from this study. My reading of Claspell’s thesis and "The meaning of grief: A dramaturgical approach to understanding emotion" (Cochran & Claspell, 1987), provided me with direction in terms of research methodology for my own exploratory study.

Claspell’s research (1984), had no co-researchers who had experienced involuntary childlessness. She interviewed one woman whose daughter had been murdered three years earlier. Despite the tragedy of this loss, I believed there would be key differences between my co-researcher’s experiences and those in Claspell’s 1984 study. Women who could not become pregnant, for those who have miscarried; the losses and other experiences of involuntarily childless women historically were simply overlooked. Mainstream social values prevailed.
"Infertility is an invisible stigma, a deviation from the norm in a community in which fertility is prized" (Sandelhowski & Jones, 1986, p. 188). The relatively recent increase in literature and research on infertility may gradually bring greater understanding to the communities in which the involuntary childless live, and to society in general. Perhaps in time, these women and men will receive the compassion and support they deserve for their profound losses.
CHAPTER III

Involuntary Childlessness: Consequences and Outcomes

Infertility is on the increase. This is not the only reason for involuntary childlessness but it remains a major factor. Infertility is due to a number of medical, sociological and environmental factors. Various studies suggest 15% to 17% (or one in six married couples) are unable to have a child (Reed (1987), Menning (1988), Berg & Wilson (1991) and Daniluk (1996)). "One in three women who conceives is touched by a childbearing loss" (Savage, 1989, p. 2). Male fertility also appears to be diminishing as a result of estrogen substances in various products in the marketplace and other environmental factors. Opportunities for alternative methods of parenting such as adoption and surrogacy are fraught with difficulties, including constraining legislation and high costs which preclude many people from pursuing these alternatives. Lengthy career pursuits, the lack of an opposite sex partner, environmentally or genetically induced disablements and illness are additional factors.

Despite the technological advances of North American society, thousands of women lose their children through miscarriage, stillbirth and neonatal deaths. "Over one-third of all babies conceived will not survive" (Savage, 1989, p. 2). The specific subject of infertility has been garnering considerable media attention since the birth of Louise Brown, the first in-vitro baby born in
England approximately two decades ago. Much has been written about the new technological advances in medical treatment. Many practitioners of these new technologies to overcome infertility see infertility as an illness, the woman as a patient and pregnancy as a cure. This medical frame of reference "de-emphasizes the social and emotional dimensions and leaves women with a sense of being mere onlookers" (Stanworth, 1987, p. 17). Until recently, medicine frequently overlooked the possibility that the tragedy of infertility may not be solely a female problem. Physicians have become gradually aware that some males experience infertility. As result, in many cases, physicians routinely check both females and males for any medical barriers to pregnancy. Some women and men who hold onto this life dream of a child will never know why they could not have children. Daniluk (1996) suggests that women, without a medical label for their infertility, often reach a point of deciding to stop further treatment slowly and gradually. This contrasts with women who know why pregnancy isn't a certainty. "The women who received a definitive medical diagnosis gave up hope when treatment options failed" (Daniluk, 1996, p. 95).

Thanks to medical and/or pharmaceutical intervention, approximately 50% of infertile couples will achieve a successful pregnancy (Menning, 1988 & Daniluk, 1996). Daniluk points out that "researchers estimate that 18% of women who attempt to bear children experience difficulty
in conceiving or carrying a viable pregnancy to term" (1996, p. 82). Whether or not pregnancies occur, if women miscarry or if same sex couples wish to adopt, this quest for a child can place demands on every aspect of people's lives. "It overshadows daily living, which can affect the couple's relationship" (Reed, 1987, p. 57). For those trying to get pregnant, the very nature of the medical testing can generate intrapersonal and interactional stress. Individuals and couples undergoing diagnostic investigation may face a barrage of intrusive, painful and frightening tests. "Many women engage in a painful and protracted relationship with the medical profession" (Daniluk, 1996, p. 82). These patients often receive efficient yet depersonalized treatment. Poor communication, little or no acknowledgement of the psychological stress of infertility, and medical treatment can lead to extreme isolation as early as the preliminary diagnosis. The most frequent response to losses throughout the treatment process is depression. This struggle to get pregnant and endure so much pain and distress over a number of years is debilitating. "Many women drain much emotional and physical energy" (Daniluk, 1996, p. 82).

Counselling for anyone undergoing infertility interventions should begin at the initial stage of diagnosis, as most people do not understand the emotional and physical demands which lie ahead (Daniluk, 1988). Unfortunately, most individuals and couples are ill
prepared for the barrage of tests and treatments. The levels of pain in testing and the number of tests may be under-represented by health care professionals. It may also be a time of "psychological limbo" (Shapiro, 1989, p. 34) for those beginning the quest. On the one hand, they want to reach the end of potentially invasive, agonizing and stress-inducing tests and treatment. On the other hand, they may fervently hope that the next test will finally be met with success. "Motivation for a child can be a powerful social and emotional force. Adults may see this quest as a rite of passage or as role fulfillment (Menning, 1988, pp. 103-105). Having children may be seen as a normative progression in one’s life or as an expression of one’s identity as a woman and mother. Frequent lack of support and isolation add to the individual’s stress. Marital stress may also intensify between couples. "Many couples are rarely synchronized in terms of their commitment and involvement in infertility procedures and may often feel emotionally out of step" (Shapiro, 1989, p. 3). Psychological and physical stresses can result in a variety of marital dysfunctions, including sexual and intimacy disruptions and communication breakdowns (Daniluk, 1991). Women who face infertility "often present the most overt emotional distress, whereas infertile males may be more difficult to assess" (Daniluk, 1988, p. 317).

For many career-oriented single women, delayed
commitment to marriage and childbearing is a current social pattern. This delay may create problems. Because of age-related factors, attempts at conceiving at an older age may result in several difficulties, including decreased fertility, a higher risk of miscarriage, and health-related disorders for both mothers and children. Some people substitute their career for a new career of the relentless pursuit of pregnancy. This quest can supersede established careers and non-family goals. Educational or professional goals can be put aside for the "singular goal of conceiving a child" (Sandlowski & Pollard, 1986).

The levels of attachment people allow themselves to experience during treatment and the earliest stages of a pregnancy may influence their experience of loss. Women who lose a child suffer the most in terms of all areas of functioning (Cleiren, 1991). The loss of an unborn child, including early miscarriage, results in a "personal loss of soul" (Savage, 1989, p. 21). Natural parental projections, which are carried with the dream or hope for a child, are a normal part of attachment processes for both men and women. A loss means parental projections do not become realized. Research reveals the outcome of both perinatal and neonatal deaths can include substantial psychological disorders (Savage, 1989). While the intensity of distress results in increased risk in women for "depression, obsessive-compulsiveness and
psychoticism" (Daniluk, 1988, p. 988), not everyone absorbed by the intense, despairing struggle is psychologically disturbed. Some are just "heartsick" (Callan, 1987, p. 848).

The involuntarily childless may experience such profound desperation, commitment and investment in overcoming any barrier, that the attachment to an anticipated baby can be extremely intense. Some women show few signs of detaching from their hoped-for child or their life dream. "As long as there is hope that a pregnancy might occur, they were able to even avoid the pain of their childlessness" (Daniluk, 1996, p. 86). Those who cling tenaciously to hope are, at times, able to bury the pain of their monthly cycles, their miscarriage and simply focus intensely on hope for that next test or attempt. Those who have difficulty detaching often hold little or no hope for a meaningful life in the future (Cleiren, 1991). The lost hope, dream or unborn child is so often deeply integrated into part of the woman's identity that the future without a child seems bleak and empty. A loss of this kind leads to a "tremendous sense of a void and loneliness" (Clapp & Swenson, 1984, p. 428).

Given society's lack of understanding or acknowledgement of this kind of loss, grieving individuals or couples are frequently left experiencing total isolation and distress. Changes may also occur with established domestic duties, work-related and day-to-day
activities, and the degree of socialization in their lives; all relate to people's dismay, dissatisfaction and possible depression. "Most feel emotionally impoverished and physically exhausted" (Daniluk, 1996, p. 86). Lacking a sense of control in their lives, their struggle is worsened by their inability to experience parenthood, and their inability to find alternative sources of satisfaction and fulfillment (Callan, 1987). Adding to the intensity of this struggle are the well-established issues of isolation, dismissal or rejection by their community. Woman may be "subject to stigmatization, negative comment and challenges to their self-esteem" (Callan, 1987, p. 848).

When men have to struggle with their own infertility or childlessness, frequently, their adjustment to loss appears less overt or explicit. They may internalize their loss in order to meet day-to-day functional demands. Partners may have to provide considerable support to a grieving spouse, thereby precluding the time to seek help or work on their own needs. One of the risks to such men is that delaying a grieving process can lead to slowly developing depression (Cleiren, 1991). Like the women, these men lack any meaningful societal support. Unlike most women, however, many men are socialized to be stoic and non-emotional. This socialization may result in denial of any loss, an intellectualization of grieving, as well as an avoidance of counselling help (Ogelthorpe, 1987).
Inevitably, individuals and couples must give up the pursuit of parenthood. This means relinquishing hope for the fulfillment of a life dream. The reasons may include financial and health considerations, no partner, marital pressures, vocational stress, increasing age, lack of resources, etc. People who relinquish their dream to have a child and try to deal with their loss are expected to participate fully in a normal life. When individuals and couples are struggling with their losses, social demands to get back on track come from many sources. The pressure often comes from their work place, their partner, their family and/or friends. These pressures and demands are usually premature and difficult for the involuntarily childless and, in particular, when their experience of loss is intense (Shapiro, 1989).

A key variable for couples in their ability to find resolution in their childless life lies in the quality of their partnership. "For couples who have not yet experienced a crisis with their relationship, they may be sorely prepared for as invasive and consuming an ordeal" (Daniluk, 1991, p. 318). A stable relationship or marriage is critical in surviving the traumatic experiences associated with infertility. However, research and literature show the difficulties and stresses couples often face (Berg & Wilson, 1991 & Daniluk, 1988, 1991). "Couples go through tremendous upheavals" (Daw, 1998, p. 13). Couples may face years of unsuccessful medical
procedures, multiple losses associated with overcoming infertility or other barriers resulting in involuntary childlessness. Couples who face protracted medical procedures often experience increased tension and interpersonal conflict as the years progress (Berg & Wilson, 1990). When couples find themselves without family or social support, they must rely on their own potentially fragile resources to come to terms with their childlessness. "Having to work so hard for what comes easily to others, scheduling sexual relations and investing time, money and energy can drain a relationship of spontaneity and significantly depress individuals" (Daw, 1998, p. 13).

For single men and women who must also relinquish any hope of having children, use of their own resources is critical, as they do not have the support of a partner going through the same experience. As a societal norm, "marriage is seen as central to family life, shaping the identities of men and women" (Chandler, 1991, p. 1). Single adults are not likely to be in a socially-sanctioned position to have children yet they may experience multiple losses over their inability to have a child. "The confrontations with the givens of existence are painful. Each person must face a sense of emptiness and meaninglessness in their life and emerge with a personal solution" (Leick & Davidsen-Neilsen, 1991, p. 23). Often those who cannot even consider having a child
may face daunting losses without a shred of support from others.

On the extreme edge of the social sanction continuum are female and male homosexuals and the physically or mentally disabled, whose expressed dreams and hopes for children are more than merely stigmatized. Disabled individuals are frequently dismissed as simply not having the same rights or desires as able bodied individuals. However, human beings regardless of their sexual orientation or physical states should have the opportunity to fulfill their hopes and dreams. Like heterosexuals, perhaps they want to fulfill a rite of passage, enjoy the caregiving of children, to express their own identity as a parent, to ensure genetic continuity and profound fulfillment, etc. There have been historical abhorrent practices of sterilization in institutional settings to individuals perfectly capable of caring for a child. Disabled men and women are also excluded from sharing their experiences about infertility or childlessness in both literature and research studies.

Homosexuals are frequently castigated by society as depraved, decadent, malevolent and intolerable or simply removed from the normative heterosexual social psyche (Pie, 1992 & Perchal & Brooke, 1994). Whereas meaningful support may be lacking for infertile heterosexual individuals or couples, society's traditional response to homosexuals has involved punitive legislation,
and overall societal degradation and rejection. They are also excluded from most, if not all, infertility literature or research.

Despite legal and legislative attempts to protect the rights of all individuals, the reality for non-heterosexuals is pervasive homophobia. "It's hard to avoid when the heterosexual lifestyle is hailed as the only acceptable choice" (Pie, 1992, p. 13). Perchal and Brooke confirm society's discrimination and rejection: "We are looked down on, attacked, ignored and rejected because of what is perceived as a deviant gender and sexual orientation" (1994, p. 8).

For individuals and couples who must face their childlessness, the experience of grief is unique to each person. Experiences may include numbness, disbelief, denial, anger, confusion, guilt, fear, depression, loneliness and isolation, rejection, etc.. Reactions vary according to a range of circumstances and experiences associated with the loss. Included are external and interpersonal factors, as well as "temperament, background, emotional and physical health, age, maturity of one's faith, and past losses" (Kuenning, 1984). Grief may also result in physical symptoms including fatigue, shortness of breath, headaches, digestive problems and appetite changes, insomnia or hypersomnia, disorganization regarding home or work activities, frequent restlessness, and numbness, etc. Other features include a preoccupation
and ongoing attachment to what was lost: self-blame, fury towards uncaring contemporaries, family members and cold, distant health professionals, guilt and inadequacy about not having done enough, etc. (Keunning, 1984).

A pervasive preoccupation with self-recrimination will only prolong and complicate the grieving process. "Psychologically, there remains a dark core, a sense of inadequacy that prevails, which accounts for the lifetime presence of shadow grief" (Savage, 1989, p. 60). Despite recognition and acceptance of the loss and a movement towards picking up the living threads, the dark core may remain immutable. "The pain, the crying, and the silences we experience are almost greater than we can endure" (Gersie, 1991, p. 149).

**Childlessness and Infertility Research**

Although research is expanding in the area of infertility, research on involuntary childlessness, regardless of cause, is limited in the area of resolution, where men and women must come to terms with their loss and childlessness. Many studies point to the need for providing information early on to give individuals and couples an understanding of the tests they may have to endure and the realistic appraisal of their chances. Daniluk confirms the need to prepare couples prior to treatment and also confirms the extensive literature and limited research which supports the need for early counselling intervention (1991 & 1996).
The following represents five infertility research studies and one childless study, which are reviewed.

(1) Sandelowski and Pollock's analysis of interview data revealed three predominant themes from the experiences of 48 purposefully sampled infertile women (1986). The prevalent theme of ambiguity included floundering with life goals and uncertainty about treatment and test safety, ambivalence towards physicians and "uncertainty about what in life is within human control" (p. 142).

The second theme of temporality was expressed by women projecting themselves into both the past and future while trying to overcome pressures of advancing age.

The third theme is otherness. Women felt isolation, separation and estrangement from spouses and fertile friends. These experiences are a common finding across research studies examining infertile women.

Site selections for this survey were at two infertility medical clinics; one private, and one public. The women (n= 48) were recruited for ethnographic interviews. The phenomenological approach in this research study provided a meaningful understanding of each woman's experiences living with infertility. Themes developed from the first interviews were validated by a second group (n = 28).

A second set of interviews with the primary group resulted from reformulated questions and foreshadowed
problems requiring further clarification and validation. Audio-taped transcriptions were analyzed employing Van Kaam's (1959) method of phenomenal analysis. The phenomenological-based research data from this field study was again validated through matching with the original sample and thereby enhancing internal validity. Selection effect was not a threat. Internal reliability was enhanced by the use of trained coders and two interviewers, who reviewed a random selection of tapes and transcripts before drawing conclusions about thematic patterns. The use of audio equipment and low inference descriptions also increased internal reliability. The 'outsider' interviewer role, the description of the social context and the means of data analysis increased external reliability. The interview format itself was not standardized.

Private clinic subjects received open-ended interviews for up to four hours, whereas the public clinic patients' interviews did not exceed 30 minutes. External validity was threatened by the small, select sample and the limited translatability of the divergent thematic expressions of the two S.E.S. (social economic status) groups. From the original sample of 48 women, 44 white upper S.E.S. subjects comprised the first group interviewed at the private clinic. After 22 "white" interviews, 28 "black" lower S.E.S. women from a public clinic were recruited to validate the initial analysis of the three themes, which were derived from the first
sample. Sandelowski & Pollock concluded that the lower level of thematic expression by this lower S.E.S. group is likely attributable to S.E.S. differences overall with this group, who are identified as disadvantaged. Further study is required to investigate if the difference in infertility experiences by women of divergent S.E.S. backgrounds is real or spurious.

Canadian infertility treatment is not as costly as in the U.S. but membership in the Canadian medical system has its price. Public hospitals have had lengthy waiting lists for infertility treatment. Private hospitals are costly. Drug costs can also be high. As a result, S.E.S. factors must be taken into account in any Canadian studies on infertile couples.

(2) In 1988, Daniluk’s Canadian longitudinal repeated-measures study examined the intrapersonal and interpersonal impact on 43 infertile couples. Variables included marital adjustment, sexual satisfaction, and psychological distress. Data was collected using six questionnaires, which spouses responded to independently over the course of eleven weeks.

The four standardized reliable measurement tests included Symptomatic Psychological Distress (SCL-90-R), the Relationship Change Scale (RCS), the Marital Adjustment Test (MAT) and the Index of Sexual Satisfaction (ISS). Analysis of the data was conducted with the BMPD computer program 4V MANOVA. The program is flexible and
able to handle more than one dependent measure over the four test situations at P <0.01. 4V MANOVA also tested simple main effects when significant interactions were tested between variables. Post-hoc testing (PIQ) used the Newman-Keuls method for testing differences between all possible pairs of means. Data results were automatically recorded.

This longitudinal developmental study found significant distress was experienced by couples during the early diagnostic stage (P <0.05). Women also exhibited higher levels of symptomatic psychological distress at the time of diagnosis than did men. Marital adjustment did not deteriorate. Significant differences between the sexes were observed with women reporting better accommodation to their partners than the men (P <0.05). On ratings of sexual satisfaction, all mean scores remained within the satisfied range; however, standard deviations suggest a wide variability between sexes in each of the three ISS categories (P <0.05).

Daniluk found a substantial majority of men and women indicated there was a need for counselling services. PIQ responses indicated 95.3% of the men and 97.5% of the women felt provision of such services would help meet the needs of the infertile couple.

The use of standardized tests increases external reliability given the thorough description of the data analysis strategy and conceptual framework in this study.
Reliability is also enhanced by the use of quantifiable measures and outcomes. Threats to this study relate to validity. The tests and experimenter-generated questionnaire do not allow for a breadth and depth of expression of lived experiences which can be drawn from phenomenological interviews. Attrition also threatens this study's internal validity. From the original sample of 63 couples, twelve couples voluntarily withdrew and seven were dropped because of the refusal of one spouse in the couple to participate.

The sampling procedure threatens external validity. The sample was drawn from a clinic. All the subjects volunteered. The results, therefore, can only be generalized to a similar, limited population. Threats are lessened by the multi-method tests and the longitudinal data collection period. Daniluk suggests further research is required to gain a more thorough understanding of sex differences for sexual satisfaction ratings (1988). The study did not reveal whether the experience of infertility impacted positively or negatively on marital relationships. Reasons for the differences on SCL-90-R scores are not known. Male and female subjects' high agreement on the need to provide counselling services do not reveal how many would actually use counselling services. Stanworth (1987) found men and women frequently recommend counselling. However, the majority of males do not pursue this option.
(3) In a subsequent report, Daniluk (1991) described the emotionally charged infertility experiences which have an impact on many aspects of a couple's marriage and quality of life together. These areas of difficulty include communication, sexual relationships, and physical as well as psychological withdrawal and isolation (Daniluk, 1991). Daniluk also found in this study that women undergoing infertility treatment, who are in profound distress, predominantly seek counselling support (1991). Gender differences in response to the infertility crisis may be attributed, in part, to males' socialization to stoicism and non-emotional responses.

For couples facing involuntary childlessness, the dynamic of the marriage relationship is of critical significance in the nature of the grieving process for these individuals. My own experience participating at a private clinic's infertility treatment program was similar to a number of fellow women patients. Our sexual patterns had shifted at the early stages of infertility investigations, given the pressures of following ovulation patterns. Sex was more frequently orchestrated rather than spontaneous. The five infertile women who shared my ward discussed how the sexual withdrawal by their husbands coincided with the commencement of infertility tests and schedules. They also reported increased tension with their male partners. Most had been undergoing protracted treatments over several years and identified several
differences in their sexual relationship, levels of intimacy and emotional distress. All the women recounted stories of their husbands' stoicism in general, and their frustration and anger over repeated sexual-on-a schedule regimes.

(4) A 1990 study by Ulbrich, Coyle & Llabre examined gender differences with couples who are involuntarily childless. The two variables were marital adjustment and dealing with involuntary childlessness. Ulbrich, Coyle & Llabre found stress associated with infertility undermined marital adjustment for both men and women in this study. Husbands adjusted better to involuntary childlessness if wives were employed and had high earnings, while wives' marital adjustment diminished with the length of the marriage. Infertility stress also undermined the women's ability to get necessary support.

This study employed qualitative techniques to collect data. Questionnaires were mailed to couples who had responded to newspaper ads or a letter delivered through the couple's M.D. (N = 103 couples). The Dyadic Adjustment Scale (DAS) measured couples' adjustment. Stress was assessed by an index of 21 Likert-like questions measuring infertility effects on self-esteem, guilt and sexuality. Statistical variability measures including means, standard deviations, correlations and t-values revealed significant gender differences. With perspectives on childlessness, women struggled more than men (P<.05), and were more
stressed than men (P<.05); however men rated the strength of the couple’s cohesion as higher than women (P<.05). Using multiple regression and correlation coefficients on marital adjustment, wives’ employment was positively associated with husbands’ marital satisfaction. The wives’ infertility stress was inversely related to all dimensions of marital adjustment except cohesion. The longer the couples were in treatment, the more wives believed the previous activities which couples shared had diminished. Marital duration was also inversely related to wives’ satisfaction.

This study showed that acceptance of a childless life has a strong relationship with problematic marital adjustment for men. Infertility stress, however, created problematic adjustment for both wives and their husbands. Most of the couples in this study were members of a support group for the involuntarily childless. The authors suggest, that while this may be helpful to the couple, it could also "foster a preoccupation with their infertility distress, especially for wives" (1990, p. 156).

This group membership for most subjects placed limits on generalizability of these results as many childless couples have no support network. Like Daniluk’s 1988 study, there were limited threats to reliability, given the use of an experimenter-generated questionnaire and the standardized DAS test. Threats to external validity
included selection effects. There was also no accounting for S.E.S. differences. Internal validity was weakened given the structure of this study, which precluded sharing and validation of lived meaning.

(5) A 1990 cross sectional study by Berg & Wilson (1990) examined gender differences on marital adjustment, sexual satisfaction and psychological functioning. A standardized questionnaire was given to 104 recruited infertile couples. These couples had no children and had been treated for infertility for at least one year. Couples were separated into three stages, based upon the length of time they had pursued treatment: year one, year two, and three years or more. Itemized questionnaires included the SCL-90-R, the MAT and an experimenter-questionnaire to assess sexual variables.

Analyses among subjects from the three stages revealed significant differences on the SCL-90-R (P<.0005) and sexual satisfaction (P = .03). Psychological strain entered into symptomatic range at the third stage (3+). An increased difficulty in adjustment was found with those recruited from a support group versus those recruited from medical schools.

Levels of hostility (P=0.4) and depression (p=0.6) were higher after at least three years of treatment of couples. MAT scores revealed that third stage couples had borderline adjustment scores with a significant difference in functioning across the three stages for women.
Couples agreed on an overall satisfaction with their sexual relationships. In contrast to the other stages, many men in stage three reported more dissatisfaction with their sexual performance and experienced loss of control over some sexual functions (P<.02). The Berg & Wilson sample, like the previous studies, predominantly represented a high S.E.S. class (the majority were college educated). Berg & Wilson identify this social group as typical of those who seek treatment.

This selection effect threatened external validity. Generalization was limited to the S.E.S. group represented in this study. The multi-method quantitative analysis enhanced reliability. Internal reliability was also enhanced by two investigators who coded all the data measurements. There was also low inference description. The principal threat was validity. There are limited explanations from the participants, as a result, the phenomenological reality of the participants' experience is incomplete.

Both Daniluk (1988) and Berg & Wilson (1990) used multi-method standardized tests which were sensitive enough to detect a difference. Significant differences were found with P levels predominantly at 0.05 and less at 0.01. Berg & Wilson reported that later stages of infertility treatment (three years and over) resulted in higher levels of tension, depressive symptoms, lessened

The process of struggling to achieve my life dream of having children took an increasing toll on my marriage over the six years of painful tests, surgery, repeated attempts and repeated miscarriages. As each attempt ended in miscarriage, my determination increased while my husband’s willingness to go through the ordeal of another in-vitro attempt diminished. That placed a great strain on every aspect of our marriage and added to the already-building emotional tensions that began when we both realized that having children was not going to be as straightforward as we had anticipated and planned. Stresses emerged relating to fidelity and divorce.

I was infertile. Would my husband seek someone else who was younger, healthier and not immersed in this traumatic emotional quest? Would he divorce me and find someone who could deliver babies? My anxiety about my husband’s possible reaction was symptomatic of a deepening depression. I eventually projected my fears and his cool stoicism and intolerance for my heightened emotionality resulted in intensifying, reactive anger towards him. Where was my partner’s support? "When a spouse reneges on his part of their marital bargain, she (the partner) experiences it as a terrible violation" (Scarfe, 1987, p. 239).

Shapiro confirms some infertile partners do fear
abandonment by their fertile partner. Others "continually test and provoke their mate" (1988, p. 9). My husband and I were at high risk for divorce, which is not uncommon among couples undergoing similar repeated experiences of intense loss and adjustment (Sanders, 1992).

In a 1986 phenomenological study of infertile women undergoing treatment, those interviewed expressed their difficulty with socializing in a world where most of their friends or co-workers had children. "They feel left out and trapped in social interactions where they are unable to contribute to typical female conversations" (Sandelowski & Jones, 1986, p. 175). Taking into account the potential for marital stresses, the need for social support increases, but is often not met. Some studies have estimated that as high a percentage as 90% of all couples have problems with their marital relationship within the first two years after losing a child (Sanders, 1992).

What of those individuals and couples who have tried but never been pregnant or have experienced invalidated pregnancy losses? When the options run out, how do these people resolve their grief, maintain their intimate relationships and rebuild their childless lives?

The above-cited research studies have examined infertility experience of couples commencing or undergoing infertility medical treatment. There is limited research examining the process of women, who are involuntarily childlessness, from their first hopes to the renewal and
reinvestment in their lives without a child. Not only must individuals and couples adjust to a childless future, but they must also frequently face intense intrapersonal and interpersonal crises. Too often, they must resolve these crises without family and social support, the lack of which may intensify and prolong their grieving process.

"Pain in the present is experienced as hurt. Pain in the past is remembered as anger. Pain in the future is perceived as anxiety" (D. Chopra, 1993, p. 186).

(6) A 1996 phenomenological exploration by Daniluk addresses the question: "How do infertile women come to terms with and make sense of their experiences of biological childlessness?" (1996, p. 81). Daniluk recruited 37 couples from across the country. This exploratory phenomenological study was conducted to learn how women resolved their infertility and reconstructed or renewed their investment in their future. Daniluk’s analysis followed the phenomenological protocol of Colaizzi (1978).

All the women had given up their quest for a child. The S.E.S. of this group was middle and upper-middle income women. As Berg & Wilson (1990) and Daniluk (1996) suggest, this S.E.S. level is representative of those most likely to seek treatment from fertility clinics.

The interviews were unstructured. Interviewers used empathy and open-ended questions "to create a conversational flow, and to elicit information-rich
in-depth descriptions" (1996, p. 84).

Two trained researchers and the research supervisor reached consensus in identifying themes. The themes were also validated by 10 randomly selected co-researchers. In the description of themes, the words of the co-researchers were used to enrich the essence of the themes. From the taped, transcribed and analyzed protocols, nine themes were identified:

Theme 1. **Sense of futility in continuing to pursue solutions.** Hope had a powerful hold on these women. It was only when hope was abandoned, that women could begin to recognize the futility in continuing and face their grief.

Theme 2. **Sense of physical, emotional & spiritual depletion.** Many of the women had pursued their quest for years and had expended their resources. It was hard to move forward until they had a chance to heal.

Theme 3. **Profound sense of loss & grief.** The losses these women endured began at the onset of their medical treatment when they knew their plans for a child wouldn’t unfold as hoped. The intense pain continued throughout medical interventions. As one co-researcher said, "there is something about childless that goes to the very core of your being" (1996, p.86).

Theme 4. **Sense of emptiness & missed experience.** The women reported on the emptiness, the void in their lives. Nothing seemed to be able to fill this void.

Theme 5. **Sense of marginalization & envy.** In a society which sanctions motherhood and parenting, these women felt forever excluded. The women’s friends and family continued to have children and the women were envious.

Theme 6. **Desire for closure.** The women wanted to put their experiences behind them. There was profound anger at their callous treatments by the medical profession. They also were confounded by the lack of a love object to have acknowledged and mourned. Society has no rituals for intangible losses.

Theme 7. **Sense of needing to redefine self.** Many of these women integrated into their identity their mothering capacity. A new definition was required. Due to their
preoccupation with their quest, it was difficult to focus on the future, to create new meaning. Some women pursued other parenting options.

Theme 8. **Need for acceptance & support from significant others.** Spousal support was critical for these women. The need for further support was problematic for some due to the pain of repeated sharing of their painful stories.

Theme 9. **Sense of relief of taking back their lives.** Hope was gone, they were released from the pain of medical intervention, there was a new opportunity to regain some control. The future was not clear, but the relief over leaving the agony behind was welcomed.

Daniluk acknowledges that there are clinics now that provide assistance to couples undergoing infertility investigation. The gap in services is identified for those women who remain involuntarily childless. "There are few people to whom the infertile women can turn for understanding and support" (1996, p. 96). Daniluk goes on to suggest that, as therapists, we can help the involuntarily childless to process and come to terms with their profound losses: with support for their grief, with information on alternative options to a biological child, with encouragement to begin reconstruction of their sense of themselves and with their renewal and reinvestment in the future (1996).

This phenomenological approach provides meaningful understanding of the profound adjustment needed for these women to accept their biological childlessness after years of trying to have a child. It also speaks to these women's need for support from mental health practitioners and their community of friends and family.
The issues of validity and reliability are integral to the analysis of any qualitative study. It is not the purpose of phenomenological exploratory studies to generalize results to broader populations, nor are these 37 women representative of all infertile or involuntarily childless women. It is reliability that draws the most fire towards qualitative studies from quantitative researchers. With the apparent use of two outside research assistants and the rich description of the social context and lived experiences, using Colaizzi’s method of analysis enhanced external reliability (1978). Colaizzi’s analysis protocol provided clear methodological guidelines. The triangulation of various sources also strengthened reliability. In addition to extensive literature and research reviews which supported the present study, corroboration from more than one researcher and 10 co-researchers improved the strength of this design by checking for the consistency of what people and the common themes which emerged.

The use of audio equipment to transcribe verbatim protocols added to reliability. Reliability also relates to the consistency of the interviewer’s style, as well as consistency regarding data recording, analysis and interpretation. The recruited co-researchers were from several cities across the country. Two trained research assistants presumably conducted these in-depth interviews.

There exists the issue of interviewers bringing something
of themselves to the process, regardless of the bracketing that takes place (Van Manen, 1990). Reliability may be weakened assuming there are some differences in interviewing style. The issue of limited validation may have weakened both reliability and internal validity.

Internal validity was enhanced by an in-depth interview process where taped interviews were transcribed verbatim. Two researchers, their research supervisor and 10 randomly selected co-researchers from the pool of 37 women reviewed and validated the nine themes. Validity would be further enhanced if each co-researcher had an opportunity for a second validation interview and the chance to validate themes. It is also possible that the 10 randomly sampled women were solely from the Vancouver region, given the issue of travel costs. Random selection of co-researchers is supposed to ensure a representative sample. Again, internal validity would be much stronger with the validation by all co-researchers at different points of the protocol analysis.

External validity strength is a result of the in-depth rich descriptively transcribed and analyzed. The strength of external validity is lessened by the narrow S.E.S. population; for example, there were no apparent representatives from different cultures, same sex partners, disabled individuals and low income couples. As Sandelowski & Pollock (1986) demonstrated, lower S.E.S. couples also seek treatment. Two women in my study were
not representative of Daniluk's S.E.S. group of 37. It remains to be thoroughly explored if one S.E.S. Canadian group experience differs significantly from other S.E.S group experiences.

Summary

As is evident in the research studies listed above, Daniluk has made a huge contribution to developing greater awareness and sensitivity to the experiences of infertile women and couples (1984, 1988, 1991, & 1996).

The primary purpose of my study was to develop an in-depth understanding of the lived-experiences of involuntarily childless women; specifically, the focus was on women who will never have children versus the voluntarily childless, or women who have partial fulfillment of their hopes and expectations. It is important to note that involuntary childlessness is not the only issue of child-related losses for adults.

Individuals may have one child and may not be able to have a deeply hoped-for second child. Involuntarily childless individuals or couples may successfully adopt or foster a child or children. This is a path often fraught with great anxiety, distress and difficulty. Many women may have endured past miscarriages before having a child and carry the pain of earlier losses. Others may carry their pregnancy to term and have a stillborn infant or lose a child of any age in their lifetime. The magnitude of such tragedies are frequently intensified by societal
and community disregard.

This study's focus is on women who tried to have children and who will never have biological children nor children through fostering, adoption or other means. All three women in this study are in monogamous, long-term relationships. The lived meanings women make of their experiences has not been extensively researched, particularly in the area of how women come to term with their grief and rebuild their childless lives.

My goals to add to the body of knowledge surrounding infertility issues and grief research, as well as to review therapy guidelines, have been met in my research study. I have a clear understanding and acceptance of my own experience of involuntary childlessness. When I embarked on this study, I did not know the experiences of the three co-researchers.

The women or co-researchers included two heterosexuals and one homosexual. My focus on just three women was necessitated by the constraints of time and the joyful hopes of a group of three involuntarily childless women who decided to pursue adoption possibilities versus participate in my study. Two women also withdrew prior to the interviews. As well as excluding men, my study did not include women who hoped for children and never had the opportunity to become pregnant. A number of people approached me, once they learned of my study. I deeply regretted their exclusion as I sensed their
strong desire to have their stories told, however, they did not meet the criteria of my research study.

Daniluk's title "biologically infertile women" (1996), suggested to me that, while some women did not get pregnant or could not carry a pregnancy to full term, other women adopted or married into a family with children. In her phenomenological study, "some women were committed to pursuing parenting irrespective of whether they could have their own biological children" (1996, p. 90). This would preclude their membership with the involuntarily childless if they had a child by other means.

Daniluk also refers to the typical representation of middle and upper middle income individuals at treatment centres. This S.E.S. is a common feature in the above-noted studies excepting Sandelowski and Pollock (1986). Daniluk refers to Henshaw & Orr (1987), to support her argument. However, this report by the authors was focused specifically on fertility services in the United States. The three Vancouver women in my study had a mixed social and economic background. Two co-researchers had university educations. Only one fit the profile of middle to upper middle income. Two live in subsidized housing.

Specialized services are available in Canadian hospital fertility clinics. All three women had medical coverage although, for at least one person, coverage was not provided through work but through her own payments. Of
the three women one stopped her procedure, in part, due to extreme financial pressures. Ten artificial insemination treatments from a private source cost her thousands of dollars. Despite this cost, I don't believe we can fully equate the experiences of women being treated in hospitals and through public fertility clinics in Canada with the apparently higher cost of treatment at U.S. facilities. Sandelowski & Pollock (1986) found that the experience of infertility had a profound effect on the women studied, irrespective of their S.E.S.. However, they cite two studies which suggest that a low income reduces possible options for women. This study was also done in the United States.

The male partners of two women in my study apparently fertile. For men who are childless now, and who are fertile, age is not as important a factor as it is for all women. A former Prime Minister of Canada demonstrated that men in their 70's can still contribute to the reproduction process. At the same time, I recognize that both men and women have experienced substantial grief over their inability to have children, whether it is a result of their own situation or their partner’s. Further research into the experiences of involuntary childlessness for women and men is needed, regardless of sexual orientation, physical and mental health. Those involuntarily childless individuals who are disenfranchised in the literature, research studies and in their communities definitely
deserve a chance to be heard.

Anyone who has invested with great hope and expectation for a child and experiences profound loss is often cut off or misunderstood by mainstream societal standards. When one is denied the fulfillment of that dream, research can not only provide a substantive and relevant body of knowledge, but also provide validation and support for the experiences being interviewed. I will leave Webb (1994) to summarize one issue which supports my call for more research. Webb states "there is little research on the male experience of infertility, especially when the origin of infertility is exclusively male" (1994, p. 30). As governments increase the restrictive use of medical technologies to help the infertile, I believe the risks of isolation, stigmatization and disenfranchisement of all relevant populations may also increase.

The purposeful sampling of this multiple-case study, enabled me to benefit from information-rich interviews from which I learned a great deal about numerous experiences that were vital to answering the research question. Using a phenomenological interviewing process, I secured an in-depth exploration of salient issues, experiences, thoughts, feelings and meaning about the lives of these involuntarily childless women. The clear paucity of research relating to the grieving and transforming process in experiencing involuntary childlessness calls for further phenomenological research
explorations of the experiences of populations from diverse social and economic contexts, varied cultural communities, as well as those men and women who remain disenfranchised by society. They will provide information-rich data to existing research on grief and infertility. "Life world activities ... serve as the basis for theorizing" (Giorgi, 1979, p. 75).

This small group of co-researchers enabled me to focus on my research question without limiting the women's expression of experiences. This multiple case study used a phenomenological analysis (Colaizzi, 1978) in which 19 themes resulted. Some themes from my study were compared and contrasted with some of the 33 themes of grief in Claspell's research (1984) and in Cochran & Claspell's book (1987). The new information from my study makes a contribution to the existing theoretical model of Cochran and Claspell (1987).

One advantage to individual interviews is the reduction of a bias in terms of the direction an interview could take. Such biased redirections are more apt to occur in a dyad or couple interview. There would be greater difficulty in transcribing multiple conversations. As well, a dyad interview might lead to a shift in focus specifically to the couple versus the experience of each individual.

In 1984, E. Claspell completed her doctoral thesis using a qualitative methodology to understand the meaning
of grief from her co-researchers. As stated in her thesis, the value of her existential-phenomenological approach "is making explicit the meaning of a lived experience that many of us share, in such a way that incorporates the person in the context of his everyday interactions with the world" (p. 126).

Cochran & Claspell's (1987) theoretical model of grief is grounded in the structure and themes of people's experiences from Claspell's 1984 doctoral thesis. To understand the exhaustive nature of this seminal doctoral study, the philosophical and psychological tenets of Claspell's (1984) existential-phenomenological methodology is examined, following a general review of qualitative and quantitative research methods and case study methods.

Qualitative and Quantitative Research Methodology

Psychological research always begins with some problems or set of issues. These foreshadowed problems are the "main endowment of a scientific thinker" (Hammersley & Atkinson, 1992, p. 29). This scientific perspective is often equated with quantitative research where the problem is stated prior to data collection. This contrasts with qualitative analysis of the problem or issue. In qualitative research, "the statement of foreshadowed problems depends on prior knowledge of the events, the people to be interviewed or archival collection documents" (Schumacker & McMillan, 1993). The phenomena Claspell explored were the lived experiences of the process of
grief for eight adults (1984). Claspell entered into her research process with prior knowledge from a literature review and her personal experience. She was required to put any presuppositions aside and be open to the unfolding themes that emerged from her co-researchers' experiences.

Quantitative and qualitative researchers have exchanged volleys over the past few years. Criticisms of quantitative research have come from numerous qualitative researchers (Giorgi, 1975, Colaizzi, 1978, Romanysyn, 1978, Cochran, 1987 and Van Manen, 1990). Quantitative research "demands precision and exactitude and insists upon a de-emphasis of experience" (Colaizzi, 1978). In contrast, qualitative research delves deeply into lived experiences, and the resulting meaning is always reality-based. Quantitative research is considered "distancing, lacking in richness or a sense of reality" (Cochran, 1986, p. 27). This apparent lack of richness and the increased distance often relates to the relationship between the quantitative researcher or observer and the subjects. Quantitative research is removed from the important interactive experience (Giorgi, 1975).

The isolation of phenomena from the relevant context fuels qualitative arguments further. The focus of quantitative research is often on abstract variables, which are manipulated, and a causal, determined relationship is sought. Subjects are frequently randomized to two groups. The purpose of this research is
"characterized by its major intent: to investigate cause-and-effect relationships" (Merriman, 1988, p. 6). A quantitative approach to the lived experience of grief and infertility would insist on an operational definition and a systematic objectification of a causal factor or relationship. Such objectification does, in fact, eliminate biases, values and assumptions. However, operational definitions are descriptions of phenomena in terms of measures, observations and replications. Operational definitions reduce the experience of the individual in such a way that the meaning of experience is lost (Giorgi, 1975).

More fire is drawn from the existential phenomenological researchers over such objectification. "Psychology does not question the genesis of the becoming objective" (Romanyshyn, 1978, p. 45). Forrest adds the "objectivity in phenomenology means faithfulness to the phenomenon itself" (1989, p. 816). Traditional psychological research typically examines the objective behaviour of subjects without examining or understanding the origin or meaning of that behaviour (Giorgi, 1975, Colaizzi, 1978, Romanyshyn, 1978). If the meaning or origin of behaviour is a focus, that meaning is generally inferred by the researcher or observer.

Both Claspell and I considered that empirical scientific research was superficial and limiting in terms of understanding the lived experiences of grief and
resolution processes. There are, however, limits to both quantitative and qualitative research, as well as advantages to both research methods (Giorgi, 1975, Colaizzi, 1978 & Van Manen, 1990). The contributions of empirical research to the existing body of psychological research knowledge is immense, and will continue to make valuable additions to both psychological theory and general knowledge.

**Case Studies**

Qualitative research, using a case study approach, is frequently used to gain an in-depth, holistic, richly descriptive understanding of a phenomenon, such as a person or a process (Merriam, 1988). Most qualitative research, including case studies, take into account the foreshadowed problems from a review of the literature and research. Questions are raised and careful analysis of foreshadowed problems lead to the structure required to commence a research study. Thus the foreshadowed problem leads to the preliminary focus and a conceptual framework in which to pursue field research (Schumaker & McMillan, 1993).

Ethnographic field research incorporates in-depth interview techniques and/or observations, researcher journals and diaries, letters or anecdotal materials (Schumaker & McMillan, 1993) to gain information about the people, site and/or setting. Field work requires moving into the natural setting in order to observe the
behaviours of its indigenous people. This research approach is in common usage by anthropologists, whose work focuses on the culture of the social unit under study. Field studies' in-depth detailed descriptions of specific life experiences are presented within a specific cultural and social context (Hammersley & Atkinson, 1992).

Historical case studies involve an extensive, systematic investigation of historical archives, records, descriptions, institutional practices, oral histories, relics, etc. (Schumaker & McMillan, 1993). The analysis of historical material must also incorporate, into any timeline, the relevant context.

In survey research, both extensive interviews and a questionnaire are used. Survey research also requires skills and competencies on the part of the interviewer, which are articulated by Brenner (1985). "Rules exist for asking questions, dealing with answers, interacting with the respondent and for dealing with respondent problems" (p. 20). Survey research is deductive and investigative, and frequently the focus of studies is "extent, nature, and relationships among variables" (Merriam, 1988, p. 7). Qualitative case studies often use surveys; questionnaires may be distributed with the resulting responses as the data. This type of approach uses investigator-generated questions to delineate the experience of subjects. The breadth and depth of lived experience are limited by the imagination and understanding of the investigator. Case
study surveys, however, are an expedient way of gathering information and are frequently used in educational settings.

In contrast, my case study research is descriptive and inductive in nature. It is "neither guided by established or hypothesized generalizations nor motivated by a desire to formulate generalized hypotheses" (Merriam, 1988, p. 27). The selection of a holistic, descriptive case study design was determined by the nature of the material I chose to study. My questions came from my own experience, from talking to other women, as well as from an extensive search of the body of research focused on grief and infertility. "Anchored in real-life situations, the case study results in a rich, holistic account of a phenomenon" (Merriam, 1988, p. 32).

Claspell's decision to proceed with a study of grief using a qualitative existential phenomenological method was based on the expectation that rich description would provide the most meaningful structural and thematic results for her study. "Lived experience is the starting point and end point of phenomenological research" (Van Manen, 1990, p. 36). The participants or co-researchers shared their lived-through quality of experience. Claspell's research objective was met in part through her intuitive understanding of the essence of the co-researchers' expression and the meaning of their phenomenological structures. Again, both Claspell's study
and this study do not dismiss all empirical research. A rational, organized and systematic approach to research provides a clear understanding of changes occurring between relationships or variables in an exacting, precise and clearly defined way. In the context of both studies, further scientific study to tap into differences versus commonalties between subjects or to test existing counselling interventions would contribute to the existing research on grief and infertility.

**Existential Phenomenology**

In assuming an existential phenomenological approach, Claspell clearly indicated the assumptions of her research approach. From an existential phenomenological perspective, foreshadowed problems have a different conceptualization, while continuing to provide a preliminary focus. How we begin this process depends on the researcher’s view of the research objectives before commencing.

Neither Claspell nor I presumed to know all the questions requiring answers. We did not know the lived experiences of our respective co-researchers. We had no preconceptions of how they integrated loss into their lives and how they began the creation of new meaning and reinvestment in living. Any preliminary considerations were based on personal assumptions and knowledge of the literature and personal experience. Are integration, creation of new meaning, reinvestment, etc. part of the
essence of these co-researchers' experiences? Claspell and I could not know until the co-researchers shared their experience through a rich, detailed description. Van Manen (1990) believes good description reveals the essence of experience captured in the lived experience, that this description enables us to "grasp the nature and significance of this experience in a hitherto unseen way" (p. 39). Researcher's lived experience and assumptions may in no way reflect the lived experiences of the co-researchers in a phenomenological research study.

This approach falls under the realm of humanistic psychology. "The world is essentially human and that human existence is intelligible only in terms of an engagement with it" (Cooper, 1990). Claspell's assumption with her approach is that individuals are constantly interacting with their world, and are neither passive nor controlled by external factors. "People have situational freedom of making choices within a situation which the world presents to them" (Claspell, 1984, p. 59).

Phenomenological research requires the researcher to recognize not only the experiences of the co-researcher's, but also his or her own experience through the process. Drawing from existential philosophy, phenomenologists are concerned with the phenomenological experiences of individuals and how individuals live out those experiences. Existentialism's focus is in understanding our essential being, and how that manifests
itself in our complex and concrete world. "Our consciousness, as the trafficker in meanings, animates and constitutes the world as it is encountered" (Cooper, 1990, p. 46). We are always free to create our own interpretations of what we experience. The phenomenological researcher tries to approach the life experiences of co-researchers with as few preconceptions as possible. He/she researches the data of consciousness and "attempts to explicate and elucidate the processes whereby the phenomena that he/she sees make their appearance to and within consciousness" (Vanderberg, 1971, p. 30).

The existential phenomenological movement stemmed from Heidegger's "cross fertilization of the problems and substance of existentialism obtained from Kierkegaard and Neitzsche with the method of phenomenology derived with modification from Husserl" (Vanderberg, 1979, p. 21). The goal of research is to describe the essential structure and meaning of the phenomenon under exploration.

My examination of both existentialism and phenomenology helped me to grasp the meaning of this cross fertilization. Martin Heidegger recognized the significant existential philosophical question related to human existence in the natural world and the "meaning of Being" (Owne, 1994, p. 349).

Existentialism emphasizes the "living immediacy of experience as the individual lives it" (Monte, 1987, p.
345). Individuals engage in complex processes: changing, striving, working towards self-fulfillment; and are fully aware of their own striving. From an existential perspective, individuals also engage in a world with whom they can choose to interact. They can also disengage themselves from the external schemes and processes in which they have been engaged. "Far from losing themselves in this operation, they appropriate their own most Being" (Cooper, 1990, p. 161).

Two of the earlier existential philosophers, Keirkegaard and Neitzsche, were influenced by the quick and vast technological and mechanistic changes of their time which appeared to negate humankind. Kierkegaard perceived humankind as experiencing alienation from the world and, in particular, their God. Human beings were not always self-sufficient and independent; our authenticity was always in relationship to God. (Grene, 1976). This alienation results in existential anxiety. It is "in reaction to the perception of freedom and choice" (Owen, 1994, p. 347).

Neitzsche's concept of universal plight for humankind incorporated society's preoccupation and passion for technology and mechanical development based on knowledge. "This special knowledge has, as its sole aim, the triumph over the experience of suffering and the absurdity of life in the face of death" (Colaizzi, 1975, p. 23). Neitzsche believed humans have to seek out who they are, which also
means taking human nature's path (Owen, 1994).

Heidegger's conceptualization did not raise the individual's struggle and search for freedom to such a universal principal. Each individual alone has to seek his or her own freedom, and will inevitably experience alienation. To Heidegger, we create our own world and choose the meaning of each situation that we are part of. Heidegger considered our choosing of meaning as "being in the world" (Heidegger in Edwards, 1982, p. 134). At a later stage in his life, Heidegger placed a great emphasis on technology leading to a greater alienation for humankind (Cooper, 1990). It is the concept of alienation which is a major thread throughout existential philosophy.

Phenomenology was developed by Edmond Husserl (1959-1936). Husserl was neither anti-science nor anti-technology. He tried to base thought or cognitions within our conscious processes (Vanderberg, 1971). As a science, "phenomenology strives for intersubjectivity and general structures" (Kruger, 1983, p. 17). Husserl investigated conscious experience in order to obtain reality-based knowledge; he also introduced the concept of consciousness as "intentionality" (Kruger, 1978). Humans engage in conscious, intentional acts to relate to their world.

Existential phenomenology attempts to describe the phenomena within the context of human existence. Existential phenomenological methods of interviewing are
appropriate for examination of meanings and experiences, particularly when little information is available. These interviews result in revealing the lived experience of each individual. The meanings attached to these experiences are realized through an in-depth focus on each individual's subjective experience, feelings, intrapersonal and interpersonal views. By remaining in touch with a person's truth through new exploration and communication, the role as researcher is very different from a researcher who objectifies some aspect or phenomenon of that person. Phenomenology attempts to describe the "subjective experience and does not hypothesize or impose itself onto other's understanding" (Owen, 1994, p. 263). Researchers must put aside any biases and assumptions. Phenomenological researchers must "suspend or bracket the 'natural attitude' which includes our habitual modes of thought, our scientific and prescientific biases and sedimented ways of attending to phenomena" (Kruger, 1978, p. 21).

As existential phenomenological research is based on cooperation and collaboration rather than control or manipulation, the term "subjects" seems inappropriate (Colaizzi, 1978). Subjects are called "co-researchers". It is essential that the relationship between researcher and co-researchers is based on fundamental counselling guidelines; that is, warmth, trust, respect, an unconditional regard and an equal footing. However, the
roles of therapist and researcher are not to be confused. "All human research, particularly psychological research, is a mode of existential therapy not meaning that therapy should usurp research" (Colaizzi, 1978, p. 69).

Claspell concludes that by investigating the lived experiences of grief phenomenologically, and exploring the description and essential structure of their shared experiences, only then can one understand, in a profoundly personal and holistic way, their meaning of grief (1984).

There is universality of the grieving process. Every human experiences a loss of one kind or another: it is a natural process. What becomes burdensome and problematic is when the natural flow of grief, resulting from a loss, becomes blocked by an unrelenting struggle between hope and devastation. Once the barriers are broken, individuals are free to experience their grief, to live through the experience and to begin to search and eventually discover new meaning and new wisdom in their lives.

"All women search for meaning in their lives; all need to know who they are beyond the roles they play. By exploring your deepest needs, longings, and hurts, by confronting your beliefs about yourself and about life, you embark on an inward spiritual journey. You learn to value yourself, to feel whole" (Linda Huntingdon, 1992, p. 17).
CHAPTER IV

Methodology

My underlying research question explored the lived experience of grief for involuntarily childless women. A rich, thematic, descriptive portrait of the experiences of involuntarily childless individuals was best achieved through an existential phenomenological research method. My hope was that the thematic findings from my multiple case study, using a phenomenological analysis, would provide both meaningful understanding and insightful information for researchers and therapists alike. I hoped to add new information to the existing body of research on infertility. I also hoped to make an important contribution to an existing theoretical model of grief by comparing and contrasting the thematic results of my study with that of Cochran & Claspell (1987).

My research question began with my own experiences. I was also witness to the grief of many women from many cultures as they struggled with their tragic losses at all stages of infertility testing, surgery and their recurring, agonizing outcomes. The question of resolution also emerged from my own experience. After experiencing three miscarriages and being immersed in a profound and prolonged period of grief, I began to climb out of my black hole. I clung tenaciously to threads of survival from my tapestry, which had been fortified by earlier family losses. I struggled in isolation up a slippery slope. I read copious
books and articles on grief, infertility and childlessness. The writing of my story, in various contexts, was part of my healing. The extraordinary support from two therapists and a transforming group process with many peers of my graduate class as well as some close friends created significant healing shifts.

Having the privilege of exploring the lived experiences of other involuntary childless women has given me a deepened understanding: of their investment, of their immense grief and struggle to make sense of this loss, of the extraordinary process of their emergence from the darkness and void to the creation of new meaning and personal transformation. "Lived experience is the starting point and end point of phenomenological research." (Van Manen, 1990, p. 36) Their stories are the essential and compelling part to this research.

I recognized my own preconceived assumptions about involuntary childlessness and my potential for bias. "What we implicitly view as the final meaning or value of our research will influence how we approach an investigated topic." (Colaizzi, 1978, p. 55) Like Claspell, I had to bracket or suspend any assumptions and beliefs I had. Only by bracketing my assumptions or creating an epoche (Patton, 1990) could I provide clear, unbiased interviews and the subsequent analytical processes. The only assumption that a phenomenological interview should begin with is "that the perspective of others is meaningful" (Patton, 1990, p. 187).
The three co-researchers gave me detailed descriptions touching upon their most profound experiences. With each description, it was essential that I live with the taped recordings and written transcripts for a period of time in order to pick up any subtle intonations that I could have missed during the interviews. This time was also necessary before I could begin to select the most meaningful statements and to consider creating chronological narratives. "Primitive dramas might emerge from hearing a story. Whatever the source, a person acquires a multitude of them. As yet, there is no necessary organization." (Cochran, 1986, p. 157) Any conclusions I drew from these stories were always validated by each co-researcher.

Claspell’s 1984 Doctoral research provided the basis for Cochran’s & Claspell’s book "The Meaning of Grief: A Dramaturgical Approach to Understanding Emotion" (1987). My findings contribute to both grief process theory, infertility research and counselling frameworks. This was an exploratory and descriptive multiple case study using an existential phenomenological research framework. I followed the guidelines of phenomenological analysis by Colaizzi (1978) the case study guidelines by Patton (1990) and Yin (1994).

I proceeded because of the paucity of meaningful research in the area of grief for the involuntarily childless including the process of resolution of that loss. "Absence of detailed knowledge of a phenomenon or process represents a
useful starting point for research." (Hammersley & Atkinson, 1992, p. 30)

As an existential-phenomenological researcher in this multiple case study, I did not seek causal relationships, explanations, rules or laws. Rules or explanations for the phenomenon of lived experience must be eliminated (Claspell, 1984). This method enabled me to understand the essence and structure of each co-researcher's experience, a fundamental requirement for any phenomenological researcher (Colaizzi, 1979) and (Patton, 1990). The relationship between this research interviewer and the co-researcher was based on the fundamentals of a counselling relationship including safety, trust, caring, respect and collaboration. As well, each co-researcher was made fully aware of the purpose of the interview and the thesis, as well as the process of methodology. R. Yin (1994) outlines the basic list of interview skills for conducting a case study:

"A person should not be trapped by his or her own preconceptions.

A person must have a grasp of the issues being studied, even if in an exploratory mode.

A person should be unbiased by preconceived notions, including those derived from theory."

(Yin, 1994, p. 56)

These research interview guidelines can be reframed into phenomenological terms. A knowledge base of relevant theory and research was essential for this study, as well as the bracketing or suspension of any personal or theoretical
preconceptions. Any concerns about interviewer bias or misconceptions were eliminated by the review and validation of the three co-researchers of the original transcripts. The co-researchers also validated the "meaning clusters", the themes and the chronological narratives. Validation by each co-researcher's story, at every stage of the research process, is essential as these stories can vary with each telling. "The vissitudes of memory, participant desire to represent the self in a certain light, the hidden demands of the interview process can all hinder accurate recounting and interpretation." (Feuchtwanger, 1994, p. 66) The interview and validation processes broadened the horizons and depths of each story.

A goal in case study analysis is to "compare the chronology with some explanatory theory" (Yin, 1994, p. 116); accordingly, the emerging themes from my research were compared and contrasted with some of Cochran & Claspell's themes. There was also a brief comparison and contrast with the essential structure of my study with Claspell (1984) and Cochran & Claspell (1987). More comprehensive and exhaustive research studies to compare or contrast with Cochran & Claspell's theoretical model of grief or the conclusions of a significant infertility study will have to be pursued by another researcher.

The Procedure
1. Identify the co-researchers (those who experienced the phenomenon, met the criteria and could provide a rich,
in-depth description of their experiences).

2. Letter of Introduction and Subject Consent Form to the co-researchers.

3. Co-researcher screening telephone interviews.

4. Phenomenological interviews to elicit in-depth accounts of co-researcher's experiences of involuntary childlessness.

5. Brief note taking to track later questions for clarification and notation of non-verbal expressions.

6. Verbatim tape recordings are transcribed.

7. Immersion with each interview, by listening to the audio tape and rereading the transcript twice and in part several times.

8. Validation of the original transcripts by the co-researchers in a second interview with note taking on my part to record changes, clarifications, or new experiences to add to the original transcripts.

9. Extracting the meaning statements from each transcript.

10. Creation of individual "meaning clusters" and validation of same by co-researchers.

11. Identification of individual themes and validation of same by the co-researchers.

12. Conducting a comparison across all themes to determine the common threads shared by all.

13. Creating the essences of each common theme and validation of same by the co-researchers.

14. Creation of a chronological narrative for each co-researcher and validation of their individual
narrative by each co-researchers.

15. Commencing a multiple case research study using a modified phenomenological analysis.

16. Review of portions of the research document with two committee advisors prior to completion of the study.

Co-Researchers

My research included interviewing adult women who have been confronted by their childless future, who have struggled with this experience and have also experienced some resolution or transformation. My intent was not to generalize my research findings to all women, but rather to develop construction of meaning from the expressions of experience of these co-researchers. I have identified and selected common themes that characterize some of the essence of experience of co-researchers for comparison and contrast with other research and a theoretical model of grief.

Two woman was referred through a third party and the third woman volunteered after learning of my research proposal. All of the women were childless and had no expectation of having children.

In contrast to the doctoral existential phenomenological research of E. Claspell (1984), who interviewed co-researchers until saturation or redundancy of themes occurred (Giorgi, 1975), I had to limit the number of co-researchers to three women. Yin describes a multiple case study as both "compelling and robust" (1994, p. 45). My decision to limit the study to women only versus couples was
based on the research methodology selected. It would likely have been difficult to separate the unique relationship with each couple from individual experiences.

Issues of gender differences may have been difficult to separate as well. My focus was on the lived experience of individual women who met my specific criteria. I cannot deny the importance of the experience of other people who are involuntarily childless for reasons other than infertility. The depth of potential research in this area demands exploration beyond the scope of my research study.

Criteria for Selection
The criteria for selection include:
1. The co-researchers had planned and hoped for children, were involuntarily childless, struggled with the loss, and have resolved their grief to some degree. These women believe they will never have children.
2. The co-researchers could articulate their experiences.
3. The co-researchers accepted the taping and transcription of their phenomenological descriptions.

Each woman met the above-noted criteria.

Sampling Procedure
The method of sampling is informal yet purposeful. Purposeful sampling is regarded as a key difference between qualitative versus quantitative inquiries (Patton, 1990). While multiple sources of data may be tested to determine causal relationships between variables in quantitative studies, in qualitative studies such purposeful sampling
assumes the provision of an in-depth, rich description. In contrast to large sample sizes in quantitative research, smaller sample sizes in qualitative research necessitates provision of this kind of description to gain a great deal of information. "One can learn about issues of central importance to the purpose of the research." (Patton, 1990, p. 169)

**The interview procedure**

My researcher interviewer role was as an observer/participant. More than simply a passive observer, I participated in the research interview. I was not the expert or leader. My role as an interviewer was to prevent "warping or biasing by imbalanced excesses" (Cochran, 1984, p. 27). My interviewing style was a combination of neutrality, empathy, support and encouragement, as well as non-directive guidance back to the research question. I approached the interviews with as few preconceptions as possible. I maintained repeated self-reflection to acknowledge any of my assumptions or biases and was able to bracket them.

Each woman interested in the study was contacted by telephone as a screening to ensure the criteria were being met. Each person received further information about the study, including methods to ensure confidentiality. Any questions about the study by participants were answered by the investigator. Once each co-researcher was identified as appropriate for the study, a mutually agreed-upon time was
arranged for each first interview. At the choice of the co-researchers, each interview was at the participants' home or home office. Each co-researcher was interviewed face-to-face two times. There was also telephone contact and brief personal contact when delivering documents for validation.

The first interview involved establishing a rapport with the co-researcher, briefly reviewing the purpose of the study, reviewing and obtaining two copies of an ethical consent form (see Appendix "F"). I briefly obtained some demographic information and engaged in a brief relaxed preamble. This preliminary stage of the interview process was necessary in order to foster the kind of relationship between myself and my co-researchers that was needed to facilitate expression of experiences. This rapport building continued throughout the interview process. There was also little structure. I provided an opening statement to enable each co-researcher to focus on the phenomenon. When the co-researchers moved away from the research question or when I needed clarification, I asked some questions during the interviews:
1. Could you possibly go back to your experiences with your husband and share a little bit more about your relationship?
2. You have talked about lack of support in a number of areas. Can you share any experiences you have had with your family?
3. Could you please clarify for me the time frames of the
experience you just described?

4. Is there anything else you would like to add?

The co-researchers told their own story. This process was facilitated by my ongoing attentive listening and support. My counselling skills demonstrated my genuine respect, caring, and acceptance throughout the interviews. This was key, as interviews have the potential to open up painful experiences (Patton, 1990). I did not assume the role of therapist at any point during the interviews.

**Analysis of Protocols**

Each interview was tape recorded. The first interview lasted approximately 2 1/2 hours. When co-researchers experienced strong emotional responses in sharing their experiences, I turned off the tape and sat with them quietly until the moment passed. Each interview tape was transcribed and the transcriptions were returned to each respective co-researcher to ensure there had been no omissions.

A week or two after delivering the transcripts, a second interview occurred. During the time between the delivery of the transcript and my follow up interview, the co-researchers had an opportunity to review their verbatim transcript and consider any new issues that emerged from that process. As well, I used the time to immerse myself listening again to tapes and rereading transcripts. This enabled me to formulate some questions and clarifications.
In the second interview, some experiences were explored in greater depth; further elaboration and clarification was also provided by the co-researchers. Written notes were taken during this second interview. In each case, the interview notes were typed and appended to each relevant original transcript. The second interview took between 1 and 2 hours.

Transcripts provided me with the "meaning statements" as the first part of my analysis. I extracted the statements from the transcripts and recorded verbatim individual "meaning statements" on 4" x 6" index cards, noting the code name of each co-researcher and the sequence number of each excerpt. The cards were also colour coded to represent each one of the co-researchers. I returned to the original transcripts and meaning cards numerous times to clarify or elaborate on particular points throughout the analysis. "It is important to keep returning to the original recordings to assess the adequacy of an interpretation." (Mishler, 1986, p. 48)

From these "meaning statements", I formed the "meaning clusters". These were delivered to the co-researchers for validation. From those individual clusters came the individual themes, which I had validated by each respective co-researcher. When the common "themes" emerged, I provided each co-researcher with a copy to review. I explained why all their experiences could be included in the common themes since some experiences were unique to an individual or to
more than one co-researcher. However, the appended chronological narratives ensured readers have a portrait of their individual stories (see Appendix "A", "B" & "C").

The chronological narratives were forwarded to each co-researcher and approved for inclusion as part of the appendices. These narratives were an important part of the document. It was one way that I could provide a chronological frame to the myriad of threads in each person’s story. I felt this was necessary because of the many digressions and tangents during the interviews. At times, the threads of continuity were lacking in the recordings and subsequent verbatim transcripts. During each interview, the flow shifted in direction and focus many times.

"Stories seem to be the natural way to recount experience." (Robinson & Hawpe, 1986, p. 112) However, "Experience does not automatically assume narrative form." (ibid, p. 111) The language of each co-researcher was woven throughout each of their respective narratives.

The sequence of analysis was done for the first co-researcher up to the point of "meaning clusters", before I began my second interview. The first two interviews had their analysis complete to their individual themes before the third interview occurred. Patton suggested in case studies that all the available data or descriptive protocols should be analyzed before comparisons/contrasts with other cases (1990). This is also supported in the analytical protocol of Colaizzi (1978) although saturation
themes was not a goal.

Each co-researcher acknowledged that their experiences were represented by this investigator in a clear, expansive, and accurate way. Each co-researcher will receive a copy of the completed and approved thesis.

These transcripts or protocols were analyzed based on the model of Paul Colaizzi (1973 & 1978).

1. Each transcript is read to acquire a sense of the whole.
2. Significant co-researcher statements and phrases pertaining to the grief process of the involuntarily childless women are extracted from each transcript.
3. Meanings are formulated from these significant statements.
4. Formulated meanings are organized into themes.
5. Themes evolve into theme clusters. Theme categories will result.
6. Results are integrated into a thorough description of the phenomenon.
7. The essential structure of the phenomenon is formulated.
8. Validation is sought from co-researchers to compare descriptive results with their experience as lived. (Colaizzi, 1973, 1978)

Strength and weakness of the proposed design

Credibility issues that are addressed in this study have been set forth by Patton (1990). Guba & Lincoln (1989) concluded that a naturalistic inquiry is the key to credibility:

1. "Techniques for gathering high quality data that is carefully analyzed with attention to the issues of validity, reliability and triangulation.
2. The credibility of the researcher, who needs training, experience, etc.
3. A philosophical belief in the phenomenological paradigm, appreciating naturalistic inquiry, quantitative methods and holistic thinking."
   (Patton, 1990, p. 451)

Validity requires showing a clear representation in the
conclusions I reached to the truth and meaning as shared by the co-researchers. Internal validity of this study is extremely vigorous. The phenomenological interview process provided a rich in-depth sharing of experience. At every stage of the analytic process, the co-researchers were able to review and validate each progressive part of the analysis. The rich description lends credibility to validity.

The small sample size of three cannot possibly be generalized to match other involuntarily childless women. Nonetheless, these three women, though small in number, contribute significantly as ambassadors from the world of the involuntary childless. This study possibly "provides a starting point for revealing universal meaning" (Claspell, 1984, p. 79) of involuntary childlessness.

Triangulation is another part of this research process, which supports reliability and adds further credibility to the study. While triangulation is predominantly used in quantitative studies, the triangulation sources in this research included the validation of the findings over time by co-researchers, by my supervising coordinator and another committee member, and with an extensive review of the literature and research studies on both grief and infertility. Reliability was also strengthened by the consistency of the one researcher's interviewing style, the method of taping, analysis and interpretation. As well, the structure and context of the women's experiences was truthfully described. My analysis only digressed from the
analysis protocol outlined by Colaizzi (1978), when the number of women I could interview precluded interviewing to redundancy or saturation.

A powerful S.E.S. difference was revealed in this study where costs to one co-researcher became insurmountable. As Sandelowski and Pollock suggest, people from all levels of social and economic strata pursue medical services to overcome problems related to fertility and options are restricted to lower income women (1986).

The weakness in a phenomenological study of this kind is also a strength; having one interviewer means consistency and increased credibility. Maintaining consistency from different interviewers over a number of studies cannot be guaranteed simply because of the very nature of the interactional and collaborative relationship researchers establish with co-researchers. As well, the stories shared by the co-researchers use their choice of words, meaning, and flavour of that day’s telling. The strong internal validity of this study ensured that their experiences over time were represented truthfully and credibly. However, it cannot be assumed that with every subsequent study, looking at this particular lived experience, the results will be the same.

As an exploratory study with such a small sample, it was only intended to provide new information to add to existing studies or a theoretical model. Patton (1990) reviewed the critical importance of meaningful discovery, topical and
politically sensitive issues emerging and the possibility of affecting some change in relevant systems (1990). The resounding relevance, meaningful discovery and political, social and community challenges from this study strongly enhance its credibility. Patton also considers trustworthiness as a foundational criteria for a study (1990). The level of trustworthiness and truth in what has been represented in this study supports internal reliability, "which is a precondition for validity" (Guba & Lincoln, 1989, p. 233).

No research design can specify the exact cause from observed data. In an existential phenomenological interview process, the co-researchers revealed their own experiences and enabled me to draw the thematic categories from the essence of these women's experiences. The nature of the participant/interviewer relationship enabled each co-researcher to uncover and reveal her own truth and experience. For Colaizzi (1978) the researcher relationship must be "dialogically conversant with subjects, and takes place only among persons on equal levels, without the divisiveness of social or professional stratification" (p. 69). As a trained counsellor and skilled interviewer this does enhance reliability in the context of the interview and also answers the second issues of credibility: the qualities/experience of the interviewer.

There were no quantitative studies reviewed as part of this study. Controls, like those used in lab experiments,
lessen threats to external reliability, however, the lack of internal validity and the purpose behind collecting and analyzing the phenomenal experience of individuals restricts the usefulness of controlled experimentation. "Manipulation of phenomena distorts participants natural occurrence." (LeCompte & Preissle, 1993, p. 332)

My own experience of infertility could have threatened external reliability. I had to be vigilant in being fully aware of personal suppositions that could have coloured this process. Reliability, as indicated earlier, depends on the ability of later researchers to replicate or reconstruct the original analytic strategies. The subjective quality of the co-researcher’s descriptions, and my creative and intuitive meaning making of those experiences preclude exact reconstruction of the original analysis.

An existential phenomenological approach seeks to understand the structure of the person’s story and personal meaning through descriptive methods (Cochran & Claspell, 1987). This philosophical and research-oriented issue answered the third question of credibility. This study stayed true to both the method and my belief in the importance of phenomenological research inquiry to understand the lived experiences of people and the meaning they make of their lives.

**Summary**

Based on my examination of the literature, my past exposure and extensive dialogues with childless couples and
individuals from a variety of cultural, social, and economic backgrounds, I strongly believe that the experience of this involuntarily childless process requires more research investigation. I learned from my interactions with men and women at infertility clinics in England, Canada and the U.S.A. that involuntarily childlessness had a significant impact on the meaning many people made of their lives. Many of the women held their life dream as an essential part of themselves and they reported feeling derailed from a path in life that they believed was their right.

My research question sought to gain new understanding of the meaning the three women made of their experiences. Their stories are shared with honesty, truth and integrity; again strengthening and supporting the credibility of this study.

Interviews from an existential phenomenological perspective enabled my co-researchers and I to travel through their tapestry of experience in depth. Given the lack of information of this complex experience, these co-researchers' descriptions and the subsequent analysis provides an increased understanding of human experience for both future researchers and interested therapists.

Both the criteria and the purposeful sampling procedure ensured that the women had the capacity and willingness to share their experiences in a compelling and rich portrait. Site selection for the interviews was extremely important. (LeCompte & Preissle, 1993). Location was vital
to my research and was at the complete discretion of the
participants. The selection of the environment by
co-researchers created a natural setting which enhanced
safety, security, and confidentiality.

One interviewing goal was to lessen the influence of
I had to say. My principal role was to gently create a non
intrusive space where these women could share their stories.
I needed to "facilitate the open expression of the
informant's perspective on the world" (Hammersley &
to attentively listen only to these women's words and to
share their experiences. It was my privilege to receive the
gifts from their stories.

One goal of this qualitative research was to "guide and
enrich other investigations" (Smith, 1991, p. 7). I also
hoped to make recommendations for counselling or therapy for
those individuals who must contend with a permanently
childless future. My faith in meeting those goals grew over
time. I hope these women's stories reach out and touch
people's minds and hearts. I also hope to effect some
positive changes in attitude, tolerance and compassion in
community and institution settings, such as mental health
centres and hospitals.

Further qualitative and quantitative research will help
to examine in further detail the experiences of involuntarily
women and men. Qualitative analysis of individuals or
groups can provide a rich basis from which to reformulate
more research questions or problems. As the studies in this research show, quasi-experimental designed research can also make an important contribution to this area of investigation.

Nonetheless, existential phenomenological research "claims a more reliable and accurate basis for building an a-causal, non-reductionistic, non-reifying philosophical psychological understanding of human nature (Owen, 1994, p. 262). Phenomenological analysis offers three psychological tenets: "Discovery and articulation of the protopsychological as it represents itself in the life world; discovery of the process of scientific constitution of data; and scientific conceptualization in terms of generalization rather than formalization." (Giorgi, 1979, p. 76 - 77)

"We seek to live our own story that unifies our existence, to be the central character of a drama that endures over one's life." (Cochran, 1986, p. 4) These courageous women openly shared the meaning they created from their personal lived experiences. This existential phenomenological research study reveals the rich and meaningful conceptualization of their stories; their drama.
CHAPTER V

Results

This section presents the themes shared by the co-researcher, which were validated by all three. Each theme has a description as well as phrases and sentences from each co-researcher to enrich and deepen the essence of these women's lived experiences. There were many themes that emerged which were not shared by each co-researcher. Appended to this document are three chronological narratives. These ensure each woman's lived experience is told within a chronological structure, which is more easily followed versus the original transcripts.

This study's methodology of analysis commenced with an existential phenomenological interview. The analysis of the protocols followed a particular phenomenological structure; that of Colaizzi (1978). However, this case study format, which was determined by the small number of co-researchers, precluded continuing with interviews until saturation or redundancy was achieved.

This multiple case study was an exploratory study which provided new meaningful lived experiences of three involuntarily childless women. This research was intended to provide new information to both therapists and researchers. The body of qualitative research in this area is limited. "There is little known about how infertile women come to terms with their experience of involuntary
childlessness." (J. Daniluk, 1996. p. 81) There has been little research on women who are fertile and involuntarily childless, and who have shared the full range of their experience which led to the acceptance of their involuntary childlessness. These women's stories are profoundly compelling. Each of the women endured extremely painful and traumatic medical interventions. They experienced the exhilarating heights of unspeakable joy and wonder with the fulfillment of their greatest hope and dream before plummeting to tremendous depths of shock and devastation which was exacerbated by the acute social isolation they endured. "Women felt abandoned by and alienated from their fertile social networks because they could not achieve what most women achieved." (Sandelowski & Jones, 1986, p. 186)

All were trapped on an emotional roller coaster created out of their hope, and with the knowledge they had been pregnant before. Their hope held a tenacious grip. "As long as these women believed there was a possibility of success, they felt hooked into the system." (Daniluk, 1996, p. 85)

The decision to stop medical intervention did not necessarily end the thread of hope for all the women. For one co-researcher, a decade of emotional chaos and despair and the acute tension with her partner were factors in her decision to stop.

One woman could not face the emotional risks of multiple fetus losses from using fertility drugs. As well, most of her money was gone; medical interventions had
proved too costly. Her hope was later rekindled with adoption options; however, this hope was overcome by fears of reentering a threatening, homophobic and oppressive system. Another woman held onto her ever-thinning thread of hope until the onset of menopause brought hope to an absolute end more than 10 years later.

These women’s grief extended over years and did not begin with an obvious point: their miscarriages. While Claspell suggests "there seems to be an evident point where grief begins" (1984, p. 9), these women experienced multiple losses prior to and after their miscarriages. Loss and grief resulted from isolation and, in one case, from external hate and complete rejection. In two cases, pregnancy was a result of needles, drugs or other unnatural and traumatic means.

Three lives were lost. There was no tangible life to mourn for one woman. One lost her fetus to a cold lab technician and another buried her fetus privately. Threads of personal identity unravelled. Depression enveloped each woman. Grief was a marker in one case, however, this loss began 15 years before this woman tried to get pregnant. Grief was trapped in a complex dance with hope throughout these women’s very long journeys. A difficult struggle out of the blackness, finding a voice, time, new insights, therapy: some helped each woman move beyond her greatest pain to start the slow process of healing and restoration. This in turn gradually lead to reinvestment and creating
new meaning in their lives.

"The deeper that sorrow carves
into your being, the more joy you
contain" (Gibran, 1961, p. 29)

Description of Themes

THEME 1 EXPECTATIONS AND INVESTMENT IN A DREAM

Two of the women had plans and expectations for years about having a family. Having children was an inevitable, natural passage in their lives (Ulbrich, Coyle, Llabic, 1990). Traditional Western society supported and continues to support this framework of life. These two women had no doubts about the certainty that they would have children. In contrast, another woman had to painfully bury any hopes and dreams of children until later in her life. Nonetheless, at that later time, her hopes and desires were as profoundly felt as those of the two women who were certain of their passage through pregnancy and parenting. Having children, loving and nurturing children, raising children; these were some of the hopes and dreams that these women sought to fulfill as part of their own identity and their future.

Cathy hoped for two children, and early in life she had wanted a daughter and was going to name her after her best friend. "I had a clear expectation she would have red hair." Prior to getting pregnant, Anne and her partner talked about the world they would create for their child. "We would make the child feel special, feel chosen... we
hoped for a boy and picked out boy's names."

Barb had fantasies about many experiences shared with her husband. Barb also knew she would get pregnant. "I believed God would give me a baby" and she thought about what her pregnancy would be like. "I saw myself going in and out of maternity shops, imagined how my husband would treat me, imagined myself as a mother, walking to the beach with my husband and baby. I would share the romance of his touch to my stomach. What a perfect, beautiful thing that God makes between a man and a wife that really love each other."

Once she became pregnant, Cathy was very clear about her expectations. "I wanted a girl and had that planned out." When Anne was pregnant, she became immersed in the joy and wonder of this miracle, which she had been denied for over a decade. "We would look at a book on the different phases of gestation. We would look and say 'there it is'. We thought it was so beautiful and so remarkable." In contrast to Cathy, who didn't keenly anticipate the actual pregnancy and delivery, Anne wanted to fully experience her miraculous journey. "I really wanted to experience the pregnancy and birth. I wanted to have offspring".

Once she was pregnant, Barb wanted to savour "the romantic idea of how I would share the wonderful news with my husband". She thought about the romance between her husband and the changes she would experience. "I want to
look like this when I’m pregnant. How big will I get? What will it be like to breastfeed? That’s really precious in life."

Each of the women had a clear expectation and plan about how they would parent or mother their child. This role was one they planned for and assumed immediately upon learning they were pregnant.

Cathy was certain about the needs of her hoped-for children: "I understand the importance of self esteem for the children." Barb had a clear vision of herself as a mother: "I dreamt so many times how I would mother my child." Anne knew many aspects of her life would change and she looked forward to parenting: "Parenting opened all kinds of options, like adopting or being with someone who already is a parent." They had all been influenced in part by their own early childhood and family experiences.

For all three women, their investment incorporated tenacious qualities as their quest became more difficult. Anne took on all the research that needed to be done in order to get when she wanted and she pursued her A.I. treatment despite great physical pain at her first treatment. Barb was absolutely terrified of physical pain and yet she drove on, taking test after test to achieve her dream. Cathy’s grip on hope was unrelenting, even when realizing that the odds were against her. She held onto that hope until her body became incapable of producing a child.
THEME 2 ECSTATIC FULFILLMENT OF A DREAM

Each of the women in this study had to deal with traumatic pain, at the very least, in order to achieve pregnancy. They invested so much of themselves in their hopes and dreams for family. The apparent fulfillment of their profoundly held hope went beyond exhilaration and joy. "I could not think of words to express the wonder, the wonder and never felt more connected to myself in life" said Anne. Barb’s exhilaration and thrill was woven within the fabric of her Christianity. "I was on cloud 9. My partner and I had this wonderful gift to share together. What a perfect, beautiful thing God has made between a man and a wife." Cathy counted the days, determining when her baby would be born. "I was so very excited." Not only were these women pregnant and their dream of a child fulfilled, but they also experienced affirmation of their role and identity as mothers, which they continue to express with nurturing and love.

THEME 3 PROFOUND DEVASTATION

Each of the women miscarried. This was a crushing, traumatic, agonizing loss. These women were so profoundly invested in and connected to their beloved fetus that they had not anticipated nor were prepared for a loss of such magnitude.

Cathy experienced terrible nausea, bleeding began and, while at home alone, she miscarried and her fetus slipped
into the toilet. As directed by her G.P., she drove herself to the hospital to deliver the fetus, in a container, to a lab. The hospital’s response added to her despair. Her fetus was of no interest to the lab, but the technician took the jar away. Cathy went home alone, and uncertain of what happened to her fetus. "The entire experience was traumatic."

When Barb began to bleed at work, she was utterly devastated. "With a sinking feeling in my heart, I realized there may be a possibility that my life dream might not be a certainty."

Anne had endured an ultrasound and was told by a lab technician that her fetus had no heartbeat. Terrified, she went to her G.P., who was dismissive. "I miscarried within 24 hours, I felt the fetus slipping out of my body and it fell into the toilet. I cried and cried."

The brutal and traumatic unravelling of their intensely treasured and nurtured dream and the apparent disintegration of their loving and nurturing role and identity as mothers eventually contributed to one co-researcher reaching the brink of suicide. Depression was experienced by all the women.

**THEME 4 VIOLATION AND TRAUMA**

All three women in this study experienced callous, cold treatment and outright rejection by physicians and other health professionals. When struggling to overcome barriers
and recover from the devastation of miscarriage, the medical system and some of its personnel treated these women appallingly.

While Cathy was in hospital after miscarrying, "none of the medical professionals at the hospital were saying anything. I was terrified." Cathy had investigative surgery and, as she was coming out of the anesthetic, she was told by her specialist that nothing was preventing her from getting pregnant. When she asked him about the next procedure, he suggested to her that she get a new hobby. "I was absolutely shattered and felt like I was thrown out of the medical system."

Barb said her physician had been dishonest about the extent of physical pain she would have to endure. "I was aghast by her deceit and stunned by her attitude." Barb also said her doctor became increasingly cold with each perceived failure to find an answer. "At the end, my doctor became cold as ice."

Anne's experience of newly found hope that she could have a child was met with clear, resounding rejection. She was told no doctor in B.C. would perform artificial insemination for lesbians. Her G.P. suggested that she lie. "I would have to go to a new G.P., say hello, say that I am a 35 year old female, that I am single, heterosexual and want a kid. I'd have to lie and provide needy reasons versus good ones."

The rejection of these physicians was shattering to
the women and completely unconscionable. Two of the women were treated like failures by their physicians and felt thrown out of the medical system by these doctors. The third woman experienced rejection from virtually most of the medical community in Vancouver.

Each of the woman had to endure times of extreme physical and psychological pain while undergoing the myriad of medical interventions used to investigate their infertility, or to enhance chances of pregnancy. The experience of extreme pain generated post traumatic stress with one woman.

When Cathy had her first artificial insemination, "my specialist jabbed me painfully. I started bleeding from the puncture and it was extremely painful. These evaluative tests were agonizing and traumatic."

While undergoing an ultrasound in the presence of technicians, Anne said "you have to take an implement, shove it up inside of you and you are supposed to manipulate it in front of them. It was demeaning." During her A.I. procedure, Anne's doctor went in past the cervix without an anesthetic or freezing. "I was terrified. Medical tests were invasive and horrifying. I had to tolerate mechanical, heartless, cold medical procedures. It was definitely intrusive and abrupt. I felt violated so much."

During a preliminary test, Barb had a biopsy. "I saw the bottle which held the sample...it was filled with my
blood and a piece of white meat. I had never been afraid of pain until that test and it was the physically most painful experience of my life. It was like a ransacking: emotionally, physically. Emotionally, it was like a rape. I was never afraid of pain until then. I became more fearful of having a baby because I thought if having a baby is worse than this, then I don’t know if I’ll survive."

All of the women were traumatized by acute pain and experienced violations from intrusive tests and coldly rejecting medical personnel who treated the women like machines, as if on factory belt.

THEME 5 THE EXPERIENCE OF ISOLATION

There are two distinct threads that emerge from this theme. All the women experienced isolation from their families, their communities, and their friends. Given society’s few guidelines to deal with grief and, having normative expectations that children are ‘inevitable’, all the women experienced acute isolation. Lack of support extended into thoughtless or negative feedback, outright rejection, and in one case, blatant homophobia.

For Anne, "part of my pain was that there was nothing human in the (sperm) catalogue. We couldn’t share this with anyone, we didn’t know anyone who had to do this." Anne’s experience of lack of support also included condemnations and rejection. "My homosexual community gave me no support. When my partner and I told friends about our hopes, we were
told our child would be hated at school. Our heterosexual community thought of us as freaks. I was either crazy, selfish, completely anti-nature, anti-society, anti-world, anti-everything." Anne and her partner's families were horrified. "They thought we were freaks or they were unbelievably quiet. They did absolutely nothing and our sense was that our families were relieved." Anne's best friend sent her a card with a message that marginalized her hopes due to age. "It hurt me deeply and suggested I was too old to have a child. No one would acknowledge our loss." There was a sense of isolation, even with her loving partner. "There was no love, no touching, no union, no joy of baby making."

Cathy shared her anguish and solitude during her tragic miscarriage and, later, undergoing a D & C procedure without any support. "There was acute pain from isolation when I went to the hospital after my miscarriage. I had driven myself, I was in the hospital bed by myself, I was alone in my anguish and was very vulnerable. I felt so miserable and alone." Cathy also received lots of negative feedback from male friends who told her having kids wasn't what it was cracked up to be. "Another friend told me I shouldn't be doing this at all in my mid to late 30's. I was 38 when I miscarried and one friend was surprised that at my age, I even wanted children. In my 40's, I found people continued to be insensitive and came at me with comments that were very upsetting." When Cathy told her
mother that she had miscarried, the response to her daughter was hurtful. "To my mother, it was more embarrassing to have to tell the relatives that her daughter wasn’t pregnant after all. She was not supportive."

Barb found herself as the only person in her community who wasn’t having children. "I believed I was the only one who had this problem. I didn’t know where to go and knew no one who had this problem. I watched everyone else conceive and watched everyone else grow. I felt left out all of the time and was painfully isolated." Barb had previously enjoyed an excellent relationship with her colleagues. "My nursing colleagues knew I wanted a baby and didn’t understand my pain. I had absolutely no support. My work mates didn’t share their joys and I wasn’t invited to any showers. I felt left out all the time because they isolated me."

External isolation was pervasive in each of these women’s experiences. As well, all the women coped with their pain and anguish by isolating themselves to some extent. This was an established coping style for two women and, for the third, was unique to the profound stresses and fears which emerged.

Barb said "I didn’t acknowledge my loss to anyone and I didn’t want to burden my husband. My parents and brother had no idea of my struggle as I did not share my experiences." Barb also withdrew from her partner and his
pain. "I couldn't face him opening up. I didn't want to explore it because I couldn't cope. I turned the other way because I was so hurt." Barb also isolated herself from her social community. "I didn't feel the freedom to talk to anybody because people really didn't understand, no one could relate to me as I was the only one who had this problem. I had never heard of infertility and I was weird. I was afraid if I told someone, I was afraid they would think I was a freak."

Through her miscarriage and medical tests, Cathy kept her experiences to herself. "I didn't discuss anything with my work mates and I didn't reach out for support. Even when feelings were pretty raw I kept my feelings hidden. I also kept my problem with infertility quiet and I didn't want to discuss this with anyone."

Anne knew she would miscarry later one night. Her partner asked to be awoken when it happened. Anne didn't call her when she miscarried. "I sought solitude. I wanted to be alone with my pain. I didn't want to talk to anyone. I withdrew into my grief and didn't ask anyone for things. I was alone, as alone as when I was sitting on the toilet miscarrying, and that is the way I wanted it to be." Anne identified this pattern in another context. "I have this lovely ability to say that I am just fine and I can handle it and I'm fine and can do this by myself. I didn't want to call on my friends, but withdrew to lick my wounds."

Not only were the women isolated from their community
and family, but part of their self isolation stemmed from
the belief that they were strictly alone in their community
trying to overcome profound losses and grief. The
isolation they experienced intensified their grief.

**THEME 6 ACUTE PARTNER STRESS**

Each woman experienced periods of extreme stress in
their relationship with their partners. Partners were
either not involved in the process and seemed distant and
unfeeling or were overwhelmed themselves by their own
losses.

"I had distance and indifference from him, he was
not there for me", said Cathy. "I was shocked and
extremely upset by his response. He showed up three minutes
before I was to have a D & C and without any understanding
or support." She added, "I didn’t know if I wanted to
continue on with the marriage."

Barb’s partner withdrew into his own pain. "My
husband was unable to support me as he was totally
devastated as well. My marriage faltered. I was worried he
might leave me and find someone who could give him a baby."

Anne’s partner was also devastated and emotionally
drained; tensions and arguments increased. "How long can we
battle, knowing it is tearing the flesh from our bones and
jeopardizing our 12 year long relationship? It was
extremely hard on our relationship."

Despite the fact that separation or divorce can be
an outcome for those who cannot have children, or who have lost children, these women and their partners were able to keep essential threads in their relationships alive so they could rebuild.

**THEME 7 PROFOUND SHOCK**

All co-researchers experienced extreme emotional shock. The initial response to the enormity of what their loss meant at the time of miscarriage, and at other stages of medical interventions, lead to a intense, overwhelming shock that placed an icy grip on each individual. For a time, they were frozen with the impact or moved like shadows of their real selves.

For Barb, "I was at work when I started bleeding. My period began and I was devastated and shocked. I was on fertility pills and they were going to work and yet I was bleeding." Barb’s realization that the fertility pills might not work had an immediate impact: "I was paralyzed. I was in crisis. This horrible black thing just came upon me. I felt like I had a dozen bricks on my back. This horrible, gripping paralysis suddenly gripped me. I’m lost, I’m not coherent. I shifted into automatic, feeling like a robot. I didn’t know what to do, whether to eat, sleep, drink, what to say, what to do. The numbness and pain was intense, a shock because it came so suddenly."

After her bleeding continued despite her bed rest, Anne had an ultrasound. Her worst fears were realized. "I
sat in the waiting room and was in shock. I didn’t cry. I wasn’t doing anything. The technicians had told me nothing, but they had told me everything. I couldn’t move, I had no energy, I wasn’t wanting to move."

Cathy had tried artificial inseminations and later had an exploratory laparascopy. The blatantly patronizing and rejecting statement by her surgeon, when she was most vulnerable, was traumatic. "I was in shock, I was stunned by his remark. I had nothing I could say and I was at another dead end."

For two of the women, the coldness and rejection of their physician had an immediate reaction of shock. For all, their miscarriages created immediate disbelief. This couldn’t be happening, and yet it was, in a sudden and devastating way.

**THEME 8  THE ROLLER COASTER OF HOPE AND DEVASTATION**

Another compelling thread of these women’s journeys was their entrapment on an emotional roller coaster. For one co-researcher, the ride finished after a few years. For the others, the ride continued for over a decade. This roller coaster involved a complete emotional, mental and physical investment; it had to work as each month passed. Any descent into despair, when the inevitable menstrual cycle began, had to be contained for next month as the next attempt lay ahead. Hope and investment had to be resurrected every time.
The roller coaster started for Cathy with sex-on-a-schedule where she was to remain in bed after sex with her legs pointed up. "I hoped, month to month. I absolutely dreaded the period that would arrive each month like clockwork. It was absolutely dismay every month and it was very depressing. By age 43, I knew I wasn’t likely to get pregnant, but I still held onto hope each month." Cathy’s hope and desire struggled to overcome her consistent, clockwork, monthly cycle. "Even though I got cramps, I would think it’s not happening, it’s not happening, it’s not going to happen this time. I would make up a little story for myself that it wouldn’t happen." This was Cathy’s focus; hope as the cycle started, hope and a positive outlook until she actually bled. "My hidden hopes were there each month until symptoms of menopause began in my late 40’s."

Barb was also on sex-on-a-schedule. "I believed it would work, I would get pregnant, it had to work." Barb tried everything to increase her chances. "I kept renewing my hope by talking to myself and saying it will happen, it will happen and I put energy into my quest. I tried everything in the book. There was nothing that I didn’t try. I tried people’s suggestions to drink Robitussin so I did that. They told me to stand on my head, which I did. I did every old wives’ tale, I did everything." Every month when her due date came up, "I got anxious, tense and full of anticipation and hope. I repeatedly hoped it was
probably this month." Barb added "Monthly due dates became an emotional roller coaster of building anticipation and hope, so much hope, followed by increasing devastation." Like Cathy, Barb was trapped on that roller coaster for years.

Anne and her partner would go in for artificial insemination treatments and, after two inseminations, they would return home with hope and anticipation. "We would go home and wait, wait, wait. Then I would get my period and we would cry every month. Emotions crashed down each and every time we tried. We tried and tried again. We had to build up our energy, our hopes and go on. We were involved in an intense ritual." They used all of their resources to generate more hope. "After each A.I. procedure, we would light candles, put the silver out, we would count the days, I would stop drinking coffee. If we ritualized this and we somehow invested completely positive thoughts and lit candles and did a lot of ceremonial things each time. I wore a coral necklace because it was supposed to increase fertility. Every month, after each A.I. procedure, our emotions would go up the roller coaster, hope, hope, hope, hope and then come crashing down. It was an insane desperate whirlwind because I knew I could get pregnant. I didn’t conceive, didn’t conceive, didn’t conceive."

The determined attempts to rebuild hope and the confrontation of their despair and devastation recycled
through their lives taking an exacting toll on the women. They had all been pregnant before. This had to work and so it was month after month, year after year.

THEME 9  RAW PAIN AND DEPRESSION.

For each woman, there was a time of overwhelming pain and despair. The losses they experienced over years of trying had driven them to complete exhaustion, profound suffering and devastation. These losses went beyond their miscarriages. They had lost their community and family support and were treated as failures by a medical system which withheld the respect and compassion these women deserved. They were repeatedly faced with the possibility that their life dream and identity as a mother might be crushed and lost forever.

For Anne, her losses and depression spanned decades. In her 20's, she realized she must never have children. "I could not have a child because of the political and judicial fear. It was agony. If I had a child with a man, I would lose my child. The world was against me. I could not bear to have a child taken away because of political and society bigotry against lesbians." At 23 years of age, Anne was despairing and alone. "One morning at 4 am, I was sitting alone, I was unhappy and depressed, and realized that I must never have a child. This was my first unbearable loss." Almost fifteen years later, following her miscarriage and the aftermath of her treatment at the
hospital, Anne was overwhelmed. "I didn’t have the energy to fight for six months after my miscarriage. I was standing still, not wanting or able to move. I was standing in front of the door for a few months, in front of this door with my head down. Emotionally, I just didn’t move."

When her fertility pills were not working and years of her emotional roller coaster continued, Barb’s strength and energy ebbed away. "I was paralyzed by my depression. I left the house a mess and didn’t care. Every task seemed huge and I could not cope with daily living. I was living in a shell." Barb experienced profound hopelessness and despair. "I was in a boiling pit. With my depression, I felt like the world was going to end. I really did. I have no reason for living. I was hopeless and life was meaningless." Barb’s way of coping with depression was to escape. "My only coping mechanism was getting into fantasy worlds or reading fairy tales. I didn’t care about anything anymore." Barb’s loss of hope was the blackest time. "The light at the end of the tunnel is off, I am finished and I’m groping in the darkness not knowing where to go ever. That’s the bottom."

Cathy said, "I had really little energy for anything. There were just too many steps and I felt physically and mentally stretched to the end." The ongoing losses were cumulatively weighing her down. "I was exhausted with everything and couldn’t single out what was wearing me down. I just had really little energy for anything. There
were too many things and I felt physically and mentally stretched to the end. I remember looking at the staircase and being too tired to climb up the stairs at the end of the day."

All of these women were weighed down by the enormity of their losses. This was their longest, darkest period. Each of the women descended into periods of profound depression and despair. For one woman, the intensity of experiences brought her to a place of total blackness and thoughts of suicide. Life had lost its meaning for a time.

**THEME 10 SELF BLAME**

Every one of the co-researchers experienced self blame for not achieving their longed for hopes and dream. Often this blame was intertwined with a sense of having failed others.

Barb blamed herself for creating the devastation for her husband and for not producing grandchildren for her parents. "I blame myself because I failed my husband, my parents. I failed my husband as his wife and had let him down. I felt that my husband should have married someone else and he would have been happier. Barb took on more self blame and shame. I started to associate our sex with my failure." In terms of decision-making, Barb’s self blame emerged in the present. In selecting her fertility specialist, "I didn’t care if she was warm or not, which I think was a huge mistake on my part."
Like Barb, self blame emerges in Cathy’s present context. "If I hadn’t been negligent, things might have turned out different. I should have been more knowledgeable. I was quite oblivious and should have clued in. I have to take credit for not being up on it myself. I wasn’t that careful with the medical people I chose. I consider myself stupid and heavily deficient. I also thought I had been pretty selfish in my marriage."

Anne had experienced from others a great deal of rejection, vilification and revulsion. At a point during her protracted struggle to get pregnant, Anne internalized this intense, long-term rejection: self-doubt and self-castigation emerged. "I thought probably it wasn’t a good thing for us to have kids anyway. Maybe God knew what He was doing. We absorbed some of that negativity and hatred. Maybe it wasn’t right for us to have a child. Maybe we were not good enough parents. Who did we think we were?"

Throughout her 2 1/2 years of artificial insemination attempts, Anne continued to ask herself what she was doing wrong. "There was a lot of self-blame. Not only was I to blame for the miscarriage, but also obviously I had done something wrong, like drink a Coca Cola at the wrong moment. I must have. I must have done something wrong. With my new tries for pregnancy, I must have done something wrong." Once again, Anne’s self blame was also intensified by the enmity from others. "I wasn’t sure I was being a horrible person by deciding to stop. I asked if I was being
selfish. I thought maybe I should have sold my car, sold all of my furniture, gone to work at McDonald's to get enough money, get two jobs. I believed I was pretty horrible basically."

The most salient aspect of this thread of self blame is that it still resonates, particularly for two of the women. The social isolation that was endured likely intensified every woman’s experience of self blame.

THEME 11 MULTIPLE LOSSES

The losses each of these women experienced had many levels including lost hopes, dreams, their miscarriages, lost community, lost roles and loss of an intrinsic part of their inner self. These women’s experiences of loss and grief shattered their understanding of who they were. Their personal identity was shaken to the core.

Cathy reflected about the age of her lost child in the present. "It would have been a teenager now and, while it might have been a challenge. I think it is one I could handle. I certainly know I am missing one of life’s valuable experiences - having children to mother. It was to have been a natural process. How my life would go. It was my idea of who I was." Barb experienced losses around motherhood and her sense of herself. "I lost my chance to mother my child as I had hoped and dreamed of. I lost the chance to feel like a real woman. I had no pregnancy and my mothering person had no experience. I lost out on what it
would be like to find out I am pregnant and know what it is like to feel a baby kick, to experience all the anticipation, wanting to look pregnant, having your husband put his hand on my stomach and feel the baby. I lost my role as a woman. Pregnancy and childbirth are major reasons for being a woman. I will never have that and I don’t think that I will ever get over that loss."

Anne also had profound losses. "I had lost my child. I had lost a life. I had loss and had lost. Spiritually, physically, politically. I had lost. There is a duality or two components of my loss - the loss of my personal dream and my sense of myself, of what I should be. My loss of being a parent and wanting to bear a child and loss of a person in my life, loss of whatever opportunity there was to nurture and love. The fact I will never have a genetic link to other human beings, my DNA is not in the universe."

These women’s investment in their unborn and wondrous "little one" was closely integrated with their sense of themselves as women, mothers, parents; the loss by miscarrying their fetuses was a powerful thread which was interwoven with their role as they defined it and their sense of themselves. Although a healing process was underway, each recognized their key losses were enduring and would likely colour other experiences in their lives.

**THEME 12 ANGER**

This theme, experienced by all, most often was
directed towards others for their biases, shortcomings, or unacceptable attitudes and behaviours. As has already been revealed, some anger was directed to the self for perceived failures or feelings of self-blame.

Barb hated the advice she got. "I was tired and fed up with all the advise as I struggled to get pregnant again." She received lots of advice from her church community. "People would pat me on the back and advise me to pray and smile. They frustrated any healing process through the years of trying." An important transformation for Barb occurred when she found some energy and a source towards which she could direct her fury. "I was really angry and resentful towards God for His lack of understanding and support. I could yell at God: 'You know You’re supposed to be so loving, so just, so kind and so good’. I had God to yell at..the only one to yell at."

Anne didn't get advice. She was confronted not only by lack of support, but also direct prejudice. "I was angry at the injustice, the loneliness and the assumptions made by people. I was angry after my doctor suggested I lie saying I was heterosexual in order to get a medical procedure." She deeply resented the apparent need to portray herself as something other than who she was in order to get medical service. "I was going to make myself into a neurotic lonely spinster in order to be pitied enough that..oh well, let’s make her a whole woman. I was also angry at the insensitivity and callous behaviours of
health personnel when I got pregnant. To all the people in the world over and over again during the seven years...it was 'fuck them'. I was enraged when I had to give up. I was forced to pay large sums of money for treatment and was left with using my last $700 and taking artificial hormones." Anne also fought with her partner. "We had lots of fights. There was an element of being angry with the other person as though she was responsible for getting me pregnant or because she couldn't do anything about it. I was angry at my partner for blaming me because I couldn't get pregnant". Anne remains angry. "I just couldn't roll over again next month as I don't sleep beside a sperm bank every night. I still get hot thinking about the system."

Cathy had reason to be angry with her first physician and specialist. "My previous G.P. was dreadful, an idiot. His testing was idiotic. He was a shaky old man. My specialist and every aspect of dealing with him and his office was an ordeal. The receptionists from hell made it difficult. He was always too busy and not available." Like Anne, Cathy's anger is still experienced. "I get hot thinking about that medical experience."

Like self-blame, this is an experience which resonates in the present day context. These women are still angry after many years have passed. Their rejection and callous mistreatment by medical personnel, the acuity of their isolation or unwelcome interventions; The intensity of their anger may have somewhat dissipated over the years.
However, their anger which emerged in the interviews suggests that some medical personnel, among others, are not forgotten nor forgiven.

**THEME 13 RELINQUISHING HOPE**

A key transition for all three women was in relinquishing their long held hopes and dreams. This process, whether immediate or gradual, sometimes opened the door to face the magnitude of their loss and grief. It was a means to take control of a process where each of the women experienced a lack of control for long periods in their lives. However, control was not always a factor. Hope simply had to be given up as risks were too high.

In Barb’s case, she had been trapped on a roller coaster of hope and devastation. Each monthly devastation added more weight to her shoulders as she slid ever deeper into depression and suicidality. She needed to eliminate hope to save herself. "I was on an emotional roller coaster of hope and devastation for years and experienced profound deep depression and hopelessness." Her agony had driven her to a point where she believed "I’ll never get over this. I’m not going to be able to live." Barb reached for control. "I decided I had to give up hope. I had to take myself off the roller coaster." She decided to eliminate any possibility of having children by taking birth control pills. "I absolutely needed to stop thinking about getting
pregnant. I coped the very best way I knew. It provided me with a much needed cure. By using birth control, after ten years of my agonizing struggle, I decided this was conducive to my mental health. My mental health meant giving up all hope."

Anne was forced into her decision to give up hope from external pressures, including financial losses, increased medical risks, etc. "It was finished...the testing which had been 2 1/2 years of trying all together, including my miscarriage." Anne’s doctor had suggested she consider taking fertility pills, but the risk of a multiple pregnancy and the higher risk of miscarriage stopped Anne in her tracks. "I didn’t want to take fertility pills and lose five babies. I couldn’t bear the agony of having science interfere even more and, if anything happened, I couldn’t handle it emotionally. I just couldn’t. It was like a door shut for me and what I was left with was standing outside that door. I wasn’t going to turn the handle or try to open it, but I was also not wanting to turn around and walk away from it." Anne and her partner reached a decision without an obvious starting point. Gradually, they came to a realization. "We had no more hope left. I don’t literally remember saying out loud that we would not try again. There was a deeper understanding between my partner and I."

Cathy’s elimination of hope did not come to a sudden end, but gradually subsided over many years. A major challenge
to her giving up hope had been Cathy’s ability to get pregnant once. "The medical system told me there was nothing wrong with either of us, so why not hope? My hope was gradually eroded over a decade." After experiencing rejection from her specialist and a clinic in England, "I felt as though I had been thrown out of the medical system and hope was eroded. My new doctor could not find a reason why I could not get pregnant but the doctor didn’t offer a whole lot of hope. After years of sex-on-a-schedule, I was another year older and I started to think, ‘there isn’t going to be a pregnancy’." Nonetheless, she still held onto some hope. Several years later Cathy had a conversation with a friend that created more lessening of hope. "My friend asked me why I would want a child at 46 years of age. I thought she was probably right." Cathy held on a faint thread of hope until she encountered pre-menopausal symptoms.

The meaning these women created for their children and themselves was so profound that the power of that meaning lingered. They could not give up, would not give up. Each had been pregnant and they held onto their belief they would get pregnant again. Hope was built by their profound investment in their life dream and the energy from their purposeful drive. Although this energy and investment endured for years, each eventually brought their hope to an end in ways that were unique to each of them. Nonetheless, for each woman, relinquishing hope closed the door once and
for all, and new doors had to open.

THEME 14 PARTNER SUPPORT

Despite the distancing, indifference, anger or overwhelming despair that each partner experienced, eventually, every partner played an important supportive role.

For Anne, her partner's support was there at the start. After her miscarriage "I woke my partner and we lay together and cried and cried and cried. She took care of me, taking me to the hospital, protecting me in hospital. I know my partner postponed her own grief to care for me. We love and respect each other."

Cathy's partner's support emerged when she finally expressed her profound despair and great unhappiness with him. "He doesn't let problems sit and he is a good communicator. He didn't want to let things get out of hand and made me talk about my feelings. He said he was profoundly sorry when he realized how devastating my experience had been." Shortly thereafter, when Cathy was overwhelmed by multiple family losses, she was able to share her experiences with her husband. "He was very supportive during all of that time. He kept things going on the home front and was supportive."

Barb's husband had not been able to understand Barb's deep depression. However, eventually he read notes from her diary. "He identified with my experience and slowly we
began to open up and increase our sharing about our agony and pain together." Barb has learned to be open about her feelings and so has her husband; she recognized that her innocence and naivety about marriage were not based on the real life demands of marriage. Her marriage works now because they both work at it. "My marriage now is a real life marriage with my husband. We provide meaningful support to the other. We work through problems and issues, although it requires hard work, commitment, responsibility and faithfulness."

The tension with their partners intensified the women’s sense of isolation and rejection. The rebuilding of their relationships led to a substantial increase of support when further stresses or losses occurred. In one case, a partner’s support was there for one woman at the start of her experiences versus at later stages in her grief processes. Each woman recognized the value and meaning in their committed partner relationships and eventually invested in positive reconnecting and partnership renewal.

**THEME 15 NEW INSIGHTS.**

Having experienced grief over a lengthy period of time, all the woman gradually gained a new understanding about grief and their own grieving process.

Anne said "I feel fully involved in the journey. I know the process of grieving isn’t finished completely. Now I understand and accept my grief. I carry it with me."
Looking ahead, I anticipate something again. I know grief has more things to show me. I expect my losses will influence and colour my understanding of losses to come. The process of grieving is not finished completely because it is only eight years. I know what is needed."

Barb learned that "when grief is held, or contained, it can resurface. My grief seems like an open box. I could take it out, deal with it, and then close the box. Then I would be free to get it out another time. I learned that burying painful experiences alive means it just keeps coming. I have learned you must face the pain and deal with it. I recognize I will have to face some pieces of grief, perhaps for the rest of my life. I am open to this experience."

Cathy believes you can always see what is wrong in your life, but you can be blind to what is good. "My grief experience helped me to get back in touch with and develop new meaning in my life. I see my experiences in stages from the beginning, through the middle to an end and the ending enables me to draw on my experiences."

All three women were able to reflect and develop insights and create new meaning of their experiences. This came out of their gradual healing process and fostered a greater understanding and acceptance of grief.

**THEME 16 RENEWED STRENGTH**

All of these women are strong. In the midst of their
despair, loss of control and monumental struggles, their sense of self drifted or disappeared at times. All seemed to lose the certainty, appreciation and sense of their own strength. This was particularly evident with their self blame and sense of having failed. One indicator of their renewed inner strength was being able to be with others who have children or who have lost children. It was also an indicator of their healing and resolution.

Anne can listen and be with other women who have lost children. "I can be there with them but it doesn't become my pain." She also clearly identifies herself as having experienced motherhood. "I can say freely to people who ask, I lost a child." Anne also was able to confront one of her family members who had been against Anne’s attempts to get pregnant. "I hauled out a painting I had done. It is a water colour. I used to call my child Finnigan, so the water colour is called ‘Finnigan Returns’. I said this is the one I did for the child that I lost and put in front of my sister's face. I felt really good and really strong." As well, Anne knows she has gained the strength to move on. "Now I can close the door, knowing that I have access to it. It is not locked. I have turned the handle and walked on. Not walking away from it but walked on."

Cathy loves other people’s children. "I no longer yearn for them. I really enjoy my friend’s children who are teenagers and I laugh and say those same teenagers are driving their parents insane". Her life is focused on her
present experiences and her future.

Strengths emerged in the women's acceptance of their loss. "The experience of loss is precious" says Anne. "I would not be human if I hadn't had the experience of loss, as much as she had the experience of gain." Cathy said "My experiences gave me strength." As for Barb, she has found strength in realizing her purpose in suffering. "My suffering was not in vain. It has increased my compassion, empathy and love and sensitivity. My suffering was not in vain. It has great blessings. I realized God's plan and purposes go so much deeper than whatever I hoped, expected or dreamed. By the pain, I grow so much closer to Him."

The emergence of their strength fostered greater insight, understanding and acceptance of their experiences. The acceptance and integration of these experiences again showed the forward looking reinvestment in their lives.

THEME 17 A NEW MOTHERING ROLE

Each of the women devotes some of their loving and nurturing in other people, in different roles, or with pets. In this way, their identification with themselves as mothers was not completely lost as they had believed earlier on. Their investment and nurturing of new love objects (people and pets), continues providing great comfort and fulfillment to these women.

Cathy considers her pets as members of her own family and she mothers them. "They are important, more so than
with people who have children and pets. Dogs are a constant in our lives. We lost a pet last year and were devastated. "The arrival of a new dog brought them profound joy.

Through a vicarious experience in a therapeutic group psychodrama, Anne rediscovered her motherhood. She was deeply moved in witnessing someone else's grief as a mother of two dead unborn children. "It filled me with the experience of how much I had loved my child, how good the experience was even if it had been for 2/12 months of being a mother. I had a relationship as a mother with my child. It was an internal relationship and I could grieve the child." Anne found her mothering moved into a new realm. "I have a need to nurture, and my dog is the dearest little creature in my life." I am mothering him with all of my mothering abilities. He needs nurturing, he needs my care, he is completely dependant on me and I give full expression to it." Anne knows her nurturing, mothering side is part of her. "It is larger than it has even been. At my eulogy, they will say 'that she was briefly a mother'. I hope I will have been a mother a hundred other ways to people and to other creatures."

For Barb, her work provides great fulfillment. "I love mothering people and some people love to be mothered. The people that come here (to her ministry) love to be mothered. I feel so good to be of use to other human beings."

For all of the women, mothering had been an intrinsic
and explicit part of their identity. For a time, it seemed part of their 'self' was shattered. Each has created new meaning for their mothering identity and role and has given it full expression in a variety of fulfilling ways.

THEME 18 RENEWAL OF THE SELF/INVESTMENT IN THE FUTURE

The tenacious grip of hope ended and these women's experiences of grief from the magnitude of losses occurred. Gradually, over time, a new focus and a new energy emerged. This renewal of energy and investment was directed towards personal development in the area of fulfilling careers, relationships and/or creative expression. It was a powerful move towards clarifying and consolidating their own identities and having a focus on the future.

Cathy's focus was on her marriage and her career. "I am not sure that I began to rebuild from the year when I decided I had to move on. I decided basically to invest more in my friendships and also with my family. I also worked on improving my relationship with my partner." Career wise, Cathy developed clear plans. "I put more effort into it than I had for the last few years. I decided to look at it with fresh eyes and realized I was very happy. I enjoy my work, like my patients and want to do the best job I can. I look at courses that I can take that would be interesting to me and help me with my skills."

Barb invested a great deal in understanding the reason for her loss and how it was weaved into her
Christianity and commitment to serving God. "His purposes for me were so much deeper than I had realized. My pain and suffering in the black boiling pit had purpose. Life has its downfalls and it is a good thing for Christians to go through really rough times. I am a potential model to others regarding faith. I know I will minister to other people to get through their hard times, through their pain and feelings of hopelessness. It's a time for deepening, growing, learning and ministering. I can look back now and really be thankful that I didn't have children because the result is that many other people have been blessed by it that never would have been. Instead of having the benefit just for myself, it has now benefitted tons of people and the benefits are ever more further reaching that I even understood because I speak publicly and people ask me to share."

Anne reawakened her artistic expression which had been blocked. "My artistic expression, of being able to express myself in the way that I commonly express other aspects of my life, told me I was not immersed in my grief." Anne used the mediums of art and writing to express herself. "I wrote a poem for my child and I keep it in my journal. Now I can write about it in a short story...not completely autobiographical, but I could write, putting images of bearing children, still births, etc. in short stories". Anne also painted: "Finnigan Returns" was one such painting.
Drawing upon their own resources, these women created new meaning in their future lives, focusing on reconstruction, reinvestment, and renewal.

**SUMMARY**

All of the women in this research study experienced hopes and dreams, which became intertwined with their deeply held sense of self. They experienced the wonder and unspeakable joy of pregnancy. They experienced multiple losses over a prolonged period of time and the grief of those losses was often intertwined with unrelenting hope, however faint. They have experienced considerable healing and integration of their losses. They carry their loss within and can look ahead with renewed energy and investment in varying aspects of their lives.

The themes which the co-researchers share in common reflect the voyages they undertook. However, these themes are not universal nor are they intended to galvanize challenges to existing theories or models. Out of these existential and phenomenologically-based interviews comes the richness and depth of a phenomenon, as it relates to these women. Through their own vivid descriptions and recollections, this researcher was enabled, as I hope other researchers and therapists will be, to gain a profoundly deeper understanding of the meaningful process each of these women has lived through. This process, as Daniluk suggests, represents a journey of these involuntarily childless women's lives (1996).
Each co-researcher dealt with the relinquishing of hope differently. That elimination of hope was integral to the realization of their childless future, and gradually opened the door to a better understanding of their own process. Each woman moved through grief, despair and depression uniquely. Two women experienced Epiphanies - profoundly meaningful realizations and transformations in their lives. For another, it was the emerging support of her partner, time and her biological clock which facilitated healing. Only one woman sought therapy - once with disastrous results and, later, finding the courage to risk asking for help again. This experience facilitated her healing process.

To illustrate part of a woman's journey in this process, I have quoted from a metaphor described by a co-researcher who so exquisitely revealed her own revelation:

"My struggle is that of the butterfly in it's cocoon. In order for the butterfly to survive, it needs to struggle in the cocoon, to strengthen its muscles in order to survive and fly. Letting it out of the cocoon with a helping hand would weaken the creature and it would die. God never opened the cocoon. He gave me the opportunity to develop the strength to survive."
CHAPTER VI

Discussion

Grief is often described as a universal phenomenon: we all die. We all experience losses of one kind or another: loss of family, of friends, of a job, relocation losses, loss of pets, of dreams, hopes or expectations, etc. As a result, grief has received extensive focus, both in literature and the sciences. In the past, grief was traditionally circumscribed by models of stages and phases (Kubler-Ross, 1969 and Parkes, 1971). Specific feelings were delineated and the positioning and placement of such feelings were outlined. "Many if not most current theories of emotion focus almost exclusively upon emotion at a time" (Cochran & Claspell, 1987 p. 13).

In examining Claspell's doctoral research (1984), I discovered a thread of duality in grieving. This experience was shared with a co-researcher in my study. Claspell reflected that "in grief, a person loses something meaningful, but also finds something through the experience. There exists a struggle against grief, but the griever develops an appreciation for the experience." (1984, p. 117) For one woman in my study, the understanding and adjustment to her loss and pain was eased by the clear understanding of having had something to mourn. "My experience is a complete experience. I understood and felt to the bottom of my soul, the fullness of 'having' in opposition to the fullness of losing." Claspell's doctoral

I was keenly aware of the necessity of bracketing, or separating myself from my own experiences, preconceptions, or assumptions about the experiences of these women. I was able to put aside my own experience and could sit with my co-researchers, which allowed me to be fully present and attentive, with no distractions or pressing issues of my own. This enabled me to be "more open and sensitive to an aspect of a phenomenon" (Cochran & Claspell, 1987, p. 40).

Each of the three women met the criteria of my study; they had tried to get pregnant, experienced grief, and relinquished their hopes for a future with a child. They also experienced some resolution. Medical intervention was not a criterion. Pregnancy and miscarriage were not mandated. Nonetheless, medical involvement and pregnancy followed by miscarriage were experienced by all co-researchers.

Sharing their lived experiences in the interviews at times, emotionally distressing for all three women.
Some threads of experience from past events resonated for these women during their interviews. "There is a past and a future in present experience." (Cochran, 1986, p. 182) Self-blame and anger were among such meaningful experiences. Anger was directed towards callous mistreatment, extreme isolation and various systems from the past and brought into the present. These shifts from past to present are reflected in my analysis.

In the first interview, the co-researcher had never before shared her experiences in such detail. The topic seemed so expansive that she was not clear where to begin or what area to cover. I did not direct her based on my own agenda, but reviewed the research question again and ensured every question was open ended. As a result, the threads from the first interview wove in places and times I had not anticipated; her experiences of newlywed hopes and plans and early childhood fantasies. I had counselling skills and understood the need to listen actively, to seek clarification, and eventually, to guide the direction with questions "without leading the person" (Cochran & Claspell 1987, p. 42). I established a caring collaborative relationship with each co-researcher, all of whom spoke with absolute clarity.

My research methodology was based on Colaizzi's research model (1973 & 1978) and I was able to integrate the experiences of the co-researchers in a description of the phenomenon (Cochran & Claspell, 1987). However, I had to
limit this research to a multiple case study. I was unable to find a sufficient number of co-researchers to examine the phenomenon until redundancy or saturation of the themes occurred.

Colaizzi's methodology also required revealing the fundamental structure of these women's lived experiences (1973). The chronological narratives, taken from the original transcripts and meaning clusters, provided such a structure. We followed the early threads of childhood and young adulthood to the magical wonder of their pregnancies, weaving through the complex turbulence of grief, trauma, violation, devastation and depression. We sailed through tumultuous hopes and dreams and crashing devastation over and over again; we watched as the threads of life were almost completely submerged before rising from the depths to weave new threads of hope, renewal and reinvestment.

There were many beginnings, a middle and, in one case, a very slow ending. Though perhaps not quite as Yin (1984) intended, there was structure and substance to these stories. The end was resolution, but with it came a beginning, a new way of looking at grief and carrying grief. The thread to that treasured part of self, the memories, the experiences; these were never broken or cut by the women. "It is an ending now as I can draw on my experiences. I recognize I will have to face some pieces of grief, perhaps for the rest of my life. I am open to this experience."

The data in this study was not intended to be
generalizable to the population of infertile women. The results and narratives provided a rich descriptive process, which explored the meaning-making these three women made of their experiences. This research provides opportunities for further research questions and raises important therapy issues.

**Comparison and Contrast**

I restricted my comparison and contrast to some aspects of the structure as reported in Claspell’s research (1984), to specific contrasting or comparative themes from my study with certain themes from Claspell (1984) and Cochran & Claspell (1987). There were indeed similarities in these women’s process of grief to many themes which are identified in Claspell’s research. From a structural standpoint, Cochran and Claspell support the view that grief is not a linear process, but rather a circular one, where experiences or themes may appear at different times and at varying intensities and duration (1987). The outcomes in this research concur with this finding.

Grief runs hand in hand with some kind of loss: in the case of my study, multiple losses. Claspell suggested that "to make sense of the meaningful loss, the person engages in a life review, which fills out the context of the loss and eventually recognizes a personal investment which made the loss so immense." (Claspell, 1984, p. 112) For the women in my study, grief penetrated their lives due to multiple losses over a protracted period of time. Any life reviews
took years to begin.

In one case, an "unbearable loss" was painfully suppressed and buried for over a decade. At that time, the struggle of this woman, who was embroiled in an impossible marriage and the emerging awareness of her homosexuality, precluded reviewing her loss and making sense of it; the social climate was too threatening. Investment in hopes and dreams for a family had its first beginnings for one woman in childhood. All the co-researchers were fully aware of the depth of their investment and the role they intended to fulfill prior to their miscarriages.

Each co-researcher distanced themselves from their grief in order to try again and again and again. "Distance helps one to cope, to manage one's experience," (Cochran & Claspell, 1987, p. 70) Cochran & Claspell's theme DISTANCING ONESELF FROM THE LOSS appeared to be a coping stance, which helped people avoid the onslaught of grief from their loss. It also appeared to be a common stance when individuals were either forced to carry on with their every day lives or generate extra work in order to be distracted. "I tried to put it out of my mind basically. (During the medical tests) I didn't brood, I was just getting on with it."

One woman sought counselling assistance to process her grief rather than distance herself from it and ran into a wall of judgement and dismissal from her therapist. It was only after that experience that she distanced herself from her grief as the others had.
For years, this coping stance was used not only to bury or defer grief, but also to free up physical, mental and emotional investment in hope for another pregnancy. Month after month, grief was buried so hope could live. The desperation and drive which fueled these three women's repeated coping stance differed from the "stop gap measure that prolongs grieving" (Cochran & Claspell, 1987, p. 71).

The struggle was pervasive for one woman for at least two years; there was no gap or break from its intensity. She found no release from her struggle following her miscarriage. At every waking moment, she lived to resurrect and maintain hope while suppressing her experiences of grief. This thread of grief which was woven throughout years of this woman's life, was never allowed to consume her while hope remained. Claspell suggested that the weight of the struggle is "alleviated by moments of release" (1984, p. 112). The very essence of the struggle for all three women precluded any possibility of release. Their investment was so intensely focused so long as hope lay ahead in the next month. One woman moved ahead with a resounding conviction that her pregnancy was inevitable due to God's plan for her and her husband. There was no release until she was catapulted into a pit of depression. Another woman's struggle intensified after her miscarriage due to acute marital stress and the terminal illness of her mother; her extreme stress was overwhelmed when she lost two family members. She found enforced release brought on by
overwhelming exhaustion and emotional depletion.

Each woman experienced a pivotal moment when change had to occur, as Claspell suggested in her description of the essential structure of grief (1984). For one, risks of multiple births and severe financial difficulties brought her quest to an end. Through her anger at God, one woman discovered a flicker of light in her personal darkness, which helped her take the first step out of her depression and suicidality. "God was the only one I could yell at and it was my first shift to lighten the weight of the dark, heavy cloak within." She also took a definitive step of eliminating hope after more than a decade of struggling.

One women’s hope was tenacious if not continually vigourous. A conversation with a friend had jarred her enough so that she began to question factors around her age, her marriage, and her quest. Nonetheless, she quietly held onto hope each month until, premenopausal in her late 40’s, her body gave her clear signals. This one woman’s experience seems to contrast with the experiences in Daniluk (1996).

"The women reported a strong need to bring closure to the dream; however, they struggled with how to do this." (p. 89) My co-researcher’s hope seemed to glide to a peaceful end while she concurrently made investments in her new goals for the future.

Grief was a thread weaving through the tapestry of two co-researchers for more than ten years. This contrasted with grief as a 'beginning' in Cochran & Claspell (1987). "The
burden of grief is this raw, intense yearning for what is not there, leaving the world empty and leaving oneself with a sense of inner mutilation." Cochran & Claspell, 1987, p. 95).

Some time after her miscarriage, one woman was told by her doctor that there was no more to be done, that something was wrong in the mix between herself and her husband. The co-researcher walked out of the office and immediately plummeted into a black pit of overwhelming, intense pain and despair. Rawness and yearning enveloped her. However, this was not before this co-researcher and the others were caught in an excruciatingly painful and prolonged dance of devastation and grief with intense hope. Grief was potent but so was each woman’s hope; hope fostered by profound personal investment, which was a powerful thread weaving through the agony of these women’s emotional roller coaster.

The theme of the ROLLER COASTER OF HOPE AND DEVASTATION did not emerge in Claspell’s 1984 research. After the initial shock, devastation and grief ensued with loss experiences being buried, month after month, year after year, while these women held tenaciously onto their hope and investment. The hopeful ‘ups’ and agonizing ‘downs’ might also be found with cancer survivors after several remissions, or with close family members witnessing such an experience.

Hope, a universal phenomenon, remained a powerful thread based on natural expectations, dreams, past
pregnancies, these women's profound investment in their lost child, and their investment in their role as mothers. For two co-researchers, this investment endured for more than a decade.

The theme of VIOLATION AND TRAUMA did not appear in Cochran and Claspell (1987). Acute pain, trauma and violation was experienced by all of the women prior to their pregnancies as well as after their miscarriages. There were times when the medical treatment these women received was unconscionable. They had to contend with cold, callous attitudes, gross incompetence and acute physical pain. The violation these women experienced reached deeply into their souls. Enduring fear of pain and further violation predominated. "Emotionally, it was like a rape. I was never afraid of pain until then." One woman was sufficiently traumatized so that her terror of pain remains to this day.

In Cochran & Claspell (1987), the theme of FEELING OF BEING SINGLED OUT FOR THIS EXPERIENCE included self-blame. "People felt singled out, search to make the loss meaningful. Is the loss a punishment, a responsibility, a preparation. People wonder and search." (p. 76) Self-blame and feeling singled out were experienced by the women in my study. However, the magnitude of self-blame eclipsed the experiences described by Claspell (1984). One woman absorbed years of hatred and rejection and turned it onto herself with intense self-blame. All the women felt they had failed their partners and failed as women by not having a
child. The theme of self-blame strongly resonated over a decade for two co-researchers after their miscarriages. They believed they were responsible for the miscarriage, for not having a child: they were stupid and negligent for not researching problems about fertility, etc.. Self blame continued to resonate in the interviews.

The theme, DISCOVERING MEANING IN GRIEVING (CULTIVATION OF HOPE), Cochran & Claspell, 1987, revealed hope as it pertains to the future. Hope for new meanings and a new way of looking at grief pertain to this theme.

HOPE for the co-researchers in my study has already been established as something unique to their lived experiences. In Claspell's research someone or something was lost and a process of grief began (1984). Each woman in my study experienced multiple traumatic and tragic losses. Hope and the investment in that hope was the fuel which kept these women going. It generated drive and direction, which necessitated using all these women's energies, as well as the suppression of grief. Grief would only undermine their energy and drive.

After years of holding onto hope, the relinquishing of hope was a key transition for these co-researchers. It opened many doors to movement, to change, and also to grief. In contrast to the finding in Daniluk (1996), only one co-researcher relinquished hope due to the "strong need to bring closure to their dream of having a biological child." (p. 89). For one, the fear of multiple pregnancy losses and
financial ruin were key. For another, running into the wall of premenopausal symptoms brought more than a decade of hope to an end, only after a "last hurrah" by her hormones at 48 years of age. The thread of hope had very gradually weakened over the years but was never cast off until after this last hormonal surge.

The creation of A NEW MOTHERING ROLE did not emerge in Claspell’s research (1984). One of her co-researchers tragically lost a young adult child. The three women in my study had careers and, for two, the investment in their role at work eventually generated new meaning and a future focus.

All three women had an extraordinary investment in their unborn child and in their role as a mother and parent. Each sought fulfillment of that role in other love objects and people. Two of the women chose to mother their dogs, to integrate these pets into their families. One woman has disadvantaged individuals in her Ministry where she fulfills her role. "People come here to be mothered, I love mothering people, it makes me feel so fulfilled." Another has a pet and mothers and nurtures this dog "in every sense of the word". These new investments provide the women with extraordinary fulfillment of their need and capacity to love and nurture life.

In Daniluk’s 1996 study, it was not clear who among the co-researchers came to accept their childless lives versus those who sought alternative options. It is also not clear who in the study got pregnant and miscarried or never got
pregnant. These experiences would have generated some differences, thus their exclusion in the nine themes shared by all co-researchers in Daniluk’s study (1996).

In my study, one woman buried her fetus, created her own ritual and had something tangible to mourn, to call her own. Another had an apparent chemical miscarriage early on and grieved the lack of a tangible object to mourn. These were sufficient differences to preclude these experiences in my study’s themes. However, they are included in the narratives, which adds more description and drama to their stories.

Resolution suggests coming to terms with loss and moving forward to new opportunities, having gone through a process of personal renewal and redirection. Cochran & Claspell suggest various shifts in meaning as people work through their grief and begin to move in new directions (1987). "One shifts from anger to appreciation, from entrapment to freedom, from helplessness to self-reliance and hopefulness, from anguish to well being, from indecisiveness to decisiveness and from identity diffusion to a restoration of identity among other things" (Cochran & Claspell, 1987, p. 108-109). In Daniluk’s final theme (1996), the women experienced profound relief in having the medical interventions and their quest for motherhood laid to rest. "There was a clear sense that while the future was still uncertain, it was hard to imagine it being worse than the fertility trap." (Daniluk, 1996, p. 92)
My understanding of these women's processes is that the shift towards decisiveness and establishment of clear goals towards the future was not yet within their grasp. Regaining personal control was a meaningful shift from past experiences. Their progress towards resolution seems incomplete, which contrasts with the experiences of the women in my study. Each woman made a significant investment in alternate love objects in order to fulfill their mothering instincts, capacity and role; all of which remained integrated within their identity. Their individual goals differed, but each woman found new energy and had greater clarity about her future. All the women focused on aspects of themselves that they sought to strengthen and enhance; creativity, spirituality, professional career development, partner relationship enhancement, reassessment of friendships, etc.

"Your joy is your sorrow unmasked and the self same well from which your laughter rises was oftentimes filled with your tears."

(Gibran, 1960)

SOCIAL ISOLATION was a powerful theme in the lives of the three women, in copious research studies, and in literature. Claspell identified two themes, SENSE OF STRAIN IN RELATIONS WITH OTHERS and ISOLATION AND LONELINESS (1984). In their relations with others, Claspell's co-researchers experienced exclusion, unhelpful advice, dismissal from others, as well as an expectation to "get back on track" quickly. They also witnessed apparent
ignorance and discomfort on the part of family and friends. These experiences were very similar to the social isolation experienced by co-researchers in my study.

One woman's experience of social isolation was coloured and shaped by the heinous hate, castigation, disgust and bigotry in her medical community, social community, family and other systems.

Apart from external isolation, the three women isolated themselves as an established coping stance, as a wish to keep parts of their lives private, or as a result of their belief that no one could possibly understand their losses since no one else had to go through this experience. "One withdraws from others and they withdraw as well" (Cochran & Claspell, 1987, p. 75). Each of the woman believed they were the only ones going through this particular agonizing experience. "There was no one we could share this with."

Another aspect of their isolation was the discord and acute tension with their partners, which occurred at different times in each of their relationships. For two women, there were periods of intense anger towards their partners. In terms of their partners' reactions, two were overwhelmed by their own grief while one seemed to be completely unaware of the traumatizing experiences unfolding in his wife's life.

The research also illustrated the lack of ritual that exists for losses of this magnitude. Funerals and memorial services are the conventional way to say good bye to the
dead in Western society. Intangible losses have no rituals. One woman had the chance to bury her fetus in a park. One lost her fetus to a lab technician in a hospital. Another miscarried without any trace of an tangible object to mourn. As each woman reported, the isolation they experienced only intensified their grief and made their healing more difficult.

Despite an explosion of publicity around infertility and new medical technology to help couples, research to explore the lived experiences of the involuntarily childless has not been extensive. Yet North American women and men face increasing levels of infertility and involuntary childlessness. "The American Society for Reproductive Medicine (ASRM) defines infertility as a disease of the reproductive system that impairs the body’s ability to perform the basic function of reproduction" (Daw, 1998). Of the 15% of couples facing infertility in Canada (Terry Bullick, 1997), "85 to 90 percent of cases are treated with conventional therapies such as drug treatment or surgery of reproductive organs." (Daw, 1998, p. 13) The women in this study were not infertile. They became pregnant. Nonetheless, they are seen as infertile by the scientific and medical community as they could not sustain a pregnancy nor get pregnant again, despite medical intervention.

In contrast to those individuals and couples who chose to be childless, the experience of these women included having a clear assumption that having children fulfilled
their deepest desires and was intrinsic to their sense of self. They wanted to parent. This ability to have children is seen as a rite of passage in many cultures and remains a part of traditional or mainstream Western society.

Yearning for the experience of pregnancy was shared by two co-researchers. The need to bond with a child, to nurture and love a child as a loving parent; these were all desired and achieved by the women in this study. Tragically, their experiences of mothering were agonizingly and traumatically cut short by miscarriages.

Colaizzi (1978) promotes a descriptive method, a study of phenomena from an existential phenomenological viewpoint. Interviews require open-ended questions, a mainly unstructured interview, suspension of researcher experiences, and use of counselling skills and a collaborative relationship to elicit a broad and in-depth description of the phenomena or lived experience (Daniluk, 1996).

Although I transcribed "today's edition, today's story", the experience of sharing these stories in a supportive, caring and respectful context gave two co-researchers their first opportunity to share their stories. They were no longer isolated. I sat with each woman and contained their stories gently and carefully without losing the collaborative relationship nor losing my sense of the research question. "As we interview others about their experience of a certain phenomenon, it is imperative to stay close to experience as
lived." (Van Manen, 1990, p. 67) While the interviews stirred up feelings, each reported some later relief or further processing from the experience. These descriptions and the thematic essences of the phenomena lay down the groundwork for raising new questions in research about the involuntarily childless, as well as for therapeutic approaches.

**Future Research**

Traditional empirical research methods cannot reveal the profound meaning individuals make of their experiences. This was true for these involuntarily childless women in my exploratory research study. Some non existential phenomenological studies have found data that is salient material for both therapists and researchers. Berg & Wilson (1991) tapped into the psychological functioning of couples at different stages of treatment. Daniluk (1988) examined the outcome on sexual relationships and other dynamics in marital relationships.

The question of why to study meaning in the first place is answered. "Such a study might illuminates areas of great practical importance, there is a gaping hole in the study of emotion, an investigation of meaning might directly extend one group of theories and to try to make sense of emotions." (Cochran & Claspell, 1987, p. 8) Cochran and Claspell intended to provide a test case for an emotion: grief. "The intent is to both show its meaning as lived but also to illustrate a way that other emotions can be
investigated." (Cochran & Claspell, 1987, p.9). This study supports Cochran & Claspell’s method of exploration of lived experiences and, most recently, Daniluk’s 1996 phenomenological study. It is not clear if the interviews with the 37 couples in Daniluk’s study were conducted separately with each partner. If this is not the case, there is a risk that the interview may have been biased in terms of direction, simply by the pull or influence of one member of the dyad (Feuchtwanger, 1994).

My study adds new information about the experiences of involuntarily childless women. The results were from an exploration of profoundly moving lived experiences of three woman who were able to articulate, with so many colours and textures of threads, the tapestry of their deepest hopes and dreams, their many losses and tremendous struggles, their grief and devastation, their pain, their trauma, their renewal and reinvestment in living and life. Groundwork is laid down for greater understanding of the meaning of involuntary childlessness.

One woman’s story highlighted the extraordinary circumstances that she had to endure as a lesbian throughout her life and, in particular, in her quest for a child. Lesbians and gays have been blatantly overlooked in terms of their experiences of childlessness. The Canadian Charter of Rights and Freedoms and the B.C. Human Rights Code guarantees that gays, lesbians and bisexuals are treated as equals in society. The reality of their experiences often
represents the antithesis of these so-called guarantees.

Apart from a lack of research, some lesbian and gay men may suppress any hopes and dreams due to the fear of social vilification, condemnation and threats. "The Royal Commission on Health and its ensuing document, The Seaton Report, did not identify these communities (lesbians, gays, bisexuals and transgendered persons) as a community of interest for health planning." (Perchal & Brook, 1994, p. 2) Gays have been marginalized or rejected by the medical community. "The medical community in general still considers homosexuality as deviant." (Perchal & Brook, 1994, p. 15)

The pursuit of medical help to have a chance to have a child can be fraught with difficulties and outright rejection as one co-researcher discovered. There is little research on the experiences of women and men who have remained single and childless with profound regrets, or on women and men whose ability to have children has been compromised by disabilities. There is also little research on involuntarily childless women and men from different cultures.

Existential phenomenological research in these areas could not only provide the academic and therapeutic community with ground-breaking understanding, but also will serve another critical function: the provision of absolute respect and support for these co-researchers. More research is called for.
Therapy Implications

Therapists in an individual, couple, family or group context are obliged to provide, at the very least, unconditional respect, regard and empathy. Therapists facilitate expression, engender trust and create the contained space in which a client can share his or her most private parts of self, and, as a result can effect transformation or change.

My belief in the necessity of therapy, and in particular, an experiential systemic individual, couple, family or group therapy was challenged. One of the co-researchers sought individual as well as a group therapeutic experience. Two other women found healing through their own efforts, while another woman was trapped in a dark pit. "Each person must face existential isolation, a sense of emptiness and meaninglessness in their life and emerge with a personal solution." (Leick and Davidsen-Nielsen, 1991, p. 23). Cochran & Claspell (1987) share this view. After being trapped and enveloped in dark despair, anger eventually surged from the profound injustice this woman witnessed. Her cry of injustice and rage towards God was her first step towards healing. Another woman healed over time, using her own resources in order to understand and accept the inevitability of her biological clock and the end of her dream.

My belief in the ability of accredited, trained therapists to provide a helpful model of therapy was shaken,
but not because two co-researchers found their own healing path. Both said they would have benefitted from counselling at earlier stages of their process and with support from their families and community.

My chief concerns stem from the experiences of one woman, whose early attempt to get counselling to help her process some of her grief resulted in judgement and criticism from her feminist therapist about inappropriate sharing. Her attempts to get pregnant took place almost a decade ago, yet the climate of hate, bigotry and threatening homophobia still persist not only in today’s society, but also in the world of therapists.

Such negative social attitudes continue to be embedded in the value and belief system of some therapists. I have witnessed homophobia in mental health settings. Another example was in the June/July issue of "Family Therapy News", which contained an article supporting the inclusion of homosexuals into the Church family. "Love the Sinner but Hate the Sin? Gays and Lesbians in the Church Family" (J. Long, 1998). I was shocked and angered by two responses in "Letters to the Editor" which followed in the subsequent August/September 1998 issue of the same journal. Comments from these two letters include:

"I felt the article was trying to sway readers to accept homosexuality. The Bible has always taught us that homosexuality is a sin. Sin is sin and wrong is wrong. Approving homosexuality is sin.

The author ignores data that indicates that choice plays an important role in the sexual orientation of some people."
The most telling and fundamental weakness in this essay is the author's uncritical acceptance of the premise that gay is good in spite of evidence that homosexuality is either a functional neurosis or a biological flaw or both. God did not create homosexuality, murder, adultery, rape, incest, etc. With free will, we choose evil."

(Family Therapy News, p. 27)

Family Therapy News is published by the American Association of Marriage and Family Therapists. My understanding is that it is sent to accredited members of the AMFT. These experiences affirm the fact that, apart from pervasive community homophobia, there are therapists who clearly consider homosexuality to be morally repugnant and evil. Client beware.

I held some hope that lesbians or gays will overcome the homophobia present in families, communities, government, and other institutions, but recent news has shaken this hope. The proposed changes to Alberta's laws, which would have increased the rights of same-sex parents, was recently rolled back by Ralph Klein to reflect the more restrictive recommendations from the Catholic Diocese and Bishop Henry.

In an article in the March 15, 1999 issue of Maclean's magazine, Bishop Henry wrote "sexual relations must occur within a marriage between a man and a woman and that homosexual behaviour is therefore morally unacceptable." (p.45). Henry also suggested the courts should guard against any more legitimizing of the homosexual lifestyle by avoiding any support for spousal or adoption benefits for homosexual couples (1999).

As a result, Klein amended his original proposal to
limit full and equal rights to gays and lesbians in Alberta. These legislative proposals may be overturned by the Federal Government. In a recent issue of the Globe and Mail, it was reported the Finance Minister is making recommendations to change the tax act to reflect the Supreme Court ruling barring any discrimination against lesbian or gay couples (McCarthy, 1999). However, McCarthy also reported of the likely "opposition from the Reform Party and other conservative groups that object to the recognition of gay couples as common-law spouses" (McCarthy, 1999, p.1 & 5).

As we approach the next millennium, I have lost some hope that our society will develop much greater tolerance and acceptance for those whose sexual orientation, skin colour, values and spiritual beliefs differ from some so-called societal mainstream norms.

There is, at the very least, a need for counselling services to reach out to women and men who approach physicians for help in order to have a child. These people deserve information about the processes and procedures they may have to face, including potential traumatic and violating interventions. They deserve to hear the truth about their chances. The needs of distressed individuals and couples have been identified in various research studies including (Berg & Wilson (1990), Daniluk, (1988 & 1996) and in my own research. "Most childless women display no evidence of their disappointment and sadness as they go about their daily lives. Their loss is silent and hidden."
(Anton, 1992, p. 2) For some, keeping their loss to themselves and getting on with their lives, without counselling support, is their chosen path. In fact, in Daniluk's study (1988), while many of participants in her study suggested the need for counselling support, only "58% of the male participants and 72.1% of the female participants reported they personally would have availed themselves to such services had the opportunity been provided" (p. 969).

I support Daniluk in the importance of providing services at the earliest stages of medical intervention (1988). I also support Anton (1992) who outlines the need for individual or group therapy. Anton and I have processed our grief, and come to terms with our involuntary childlessness. We are both therapists, and Anton suggests that such therapists can "serve as beacons for those who haven't progressed as far" (p. 180).

Based on my personal experiences and discussions with others who have experienced multiple losses and profound grief with their involuntary childlessness, I suggest that an experiential systemic approach may provide some help, to those who have experienced intangible or invalidated losses such as early miscarriages, with the opportunity to create and integrate symbolic expression of their losses. The distress that envelops couples could benefit from a similar therapeutic approach to enable partners to find new ways of being in relationship; "to
enable their relationship together to flourish again."
(Appleton, 1990, p. 847) Individual, couple or group therapy should be made available. Certainly, in a group setting, some may find much needed community support versus the social void with which childless people must cope. Therapy may also facilitate a shift leading to the channeling of new energy towards reconstruction of the 'self' and renewal and reinvestment in the future.

Daniluk recommends that "as mental health practitioners, it is important to assist infertile women who remain unable to bear a child in coming to terms with their biological childlessness and reconstructing their lives. We have a responsibility." (1996, p. 97). I hope all therapists can learn greater tolerance and acceptance in order to meet that responsibility. I am committed to providing genuine respect, acceptance and unconditional regard for anyone who enters into a therapy process with me. Another important responsibility of a therapist includes self examination. "It is imperative that therapists examine their own thoughts, beliefs and feelings so that they can be more aware of biases." (J. Long, 1988, p. 12).

Conclusions

A metaphor of these women's long process slipped into my consciousness very recently on a walk along the ocean front. Each sacred vessel which I had carried was transported to a river making a long and incredible journey to the sea. There were times the river seemed to glide past
sunny banks or lie still in quiet, reflective pools; peaceful, content, at rest. There were jagged rocks creating turbulent rushing torrents, dangerous whirlpools dragging the river into deep dark eddies, traumatic tumbles over turbulent falls. There were streams to follow into cool, refreshing and reenergizing lakes which eventually returned to the natural flow of the river moving ever closer to its welcome end and new beginning; their renascence and flow in the clear, open ocean of life.

The co-researchers gave me extraordinary gifts; the experiences of travelling along a river with each woman, guiding me to places on the river where they had rested, rushed ahead or been held, trapped in swirling currents. It was a unique and extraordinary voyage each time. The generosity and patience of these women in sharing their stories, as I struggled with personal issues was heartwarming. My unshakeable commitment to these women as I carried their sacred vessels in my embrace over these years has given me renewed strength, vigour, and purpose in my life. Now the telling of their remarkable and compelling stories is complete.

From Cochrane & Claspell (1987):
"Perhaps grief is not as elevated as myth and rites of passage, but it seems to partake of an ancient form nevertheless. In grief, one embarks on a very old journey as though for the first time. And when one returns, there is indeed a boon. For grieving persons, life is precious."
They have achieved some degree of transcendence that allows them to have enormous compassion for others and they yearn to do good."

REFERENCES


Anne’s story: Anne was born in Alberta in 1948. She resides in Vancouver with her life partner. She is a counsellor in a secondary school in Vancouver.

Anne’s own family experience was chaotic. Her alcoholic and violent mother was abusive to her. Her father, with whom she had a strong attachment relationship, died when she was in her teens. As a young child, Anne’s play with other children never included fantasizing about having a family. Childlike chat about having kids when grown up didn’t happen. "I had no expectations or fantasies."

A completely unacknowledged part of Anne’s identity emerged for the very first time in her early 20’s; by 23 years of age, she was married. At great personal cost, Anne had to quickly bury any hopes and dreams for children. This was Anne’s first "unbearable loss". She was in a traditional heterosexual marriage and realized that she could not continue with the marriage. Miserable and alone in her profound unhappiness, Anne realized she was a lesbian. That knowledge immediately made her aware of the barriers and dangers she would face, intensifying her profound loss. "I wanted my genetic stuff, my D.N.A. in the universe but realized that I must never have a child."

Anne buried her desire for children because of overt social, political and legal barriers. She was terrified by the inevitable prejudices and losses she would be forced to endure if she tried to have a child. "If I had a child, I
would lose custody and lose my baby to a male." Anne was confronted by powerful political, legal and societal bigotry. The climate in Alberta, in particular, and in the rest of the Canada when Anne was in her 20's, was fraught with danger for lesbians trying to have children. "I couldn’t have a child because of judicial dangers." The courts did not support same sex partners and Anne knew the courts would favour a heterosexual father over a lesbian mother. Later when Anne was in a committed relationship with a same-sex partner, the courts opposed same sex partners from becoming legal guardians of partner’s children.

In the late 90’s, some laws which were prejudicial to homosexuals have been eliminated. However, social and political challenges to most legislative changes on such issues as same sex partners rights remain extremely contentious in both the public and private domain. Anne was exposed to legal, social, political and medical prejudice and condemnation. "There are all kinds of hidden barriers out in place that you cannot prove. Prejudice is hard to prove."

After leaving her marriage, Anne realized she needed to focus on her own personal growth and development. Again, she put aside any hopes of having children. It was an impossibility and unsafe to even consider. Anne’s move to come out of the closet was cautious and purposeful. "I wanted to make sure I felt very secure in myself before I
brought another human being into the world."

The shift into Anne's third decade again brought her buried hopes and dreams to the surface. For the very first time, she could risk sharing her hopes for a child with her same sex partner. They had been together for 5 years. Talking about it was one thing; how to achieve it was beyond Anne's understanding. "It was like saying I would like to be an astronaut." Nonetheless, Anne's desires for a child, for the experience of childbirth and the opportunity to parent were powerful, although seemingly impossible to achieve. "It was absolutely in the realm of dreams and wishes."

Two years later, Anne's hopes and desires moved her to action. "At 35, I decided to fight to find a way to do this." She felt confident about herself and about the level of commitment in her relationship with her partner. She believed that, for a child of theirs, an abundant community of family and friends existed who would offer support. As well, Anne believed she and her partner would provide a very nurturing and loving home which would ensure their child knew how special he or she was.

Anne knew engaging in a relationship with a male to get pregnant was fraught with danger. "My partner and I were keenly aware if we made a bargain with a man and he said he never wanted to have anything to do with the child...fine. Six years down the road, he would change his mind." The outcome legally would likely be shared custody
with Anne, but her partner would have no legal connection to the child. There were also moral and high risk health issues surrounding the very idea of sleeping with a male. "It was just unacceptable." Anne and her partner were committed to each other. They had participated in a unification ceremony at their church. Anne recognized the potential of undermining their relationship. "The emotional baggage that choosing a one night stand put the idea way beyond consideration".

Anne’s quest began. She did vast amounts of research, examining viable options for pregnancy. Once again, there were risks. Most agencies were unscrupulous and sold untested sperm. In the 90’s, the abundance for serious health risks were ones Anne and her partner would not take. Anne persevered, looking for safe sperm. "Artificial insemination was the best way. It didn’t have a triad as parents with some man in the background."

Eventually, Anne found two clinics which would provide safe sperm. One clinic was in the United States. The costs were utterly prohibitive. Anne also learned that this clinic would prioritize heterosexual women versus lesbians. If she paid her $3,000 U.S. up front, she could still get bumped if a heterosexual woman’s ovulation timing coincided with Anne’s. There were no guarantees of services, much less a successful outcome. "This prejudice was beyond my morals. My sensibilities, my integrity were wounded. I was being told 'you can ride the bus, but you have to ride at
the back', over and over again."

The second lab was in Toronto. Anne contacted the lab, found out the costs, and learned that sperm would be sent to a physician; most important of all, the sperm were tested and safe. The costs were high but Anne and her partner believed they could try A.I. a dozen times. "With 12 times, your chances are very high for conceiving." Anne had done all her research and found the sperm she needed. Now she needed a doctor for the procedure.

After Anne and her partner moved to Vancouver, she developed a good relationship with her new G.P.. This doctor actually asked Anne if she had thought about having children. Anne was astonished. "My jaw dropped. My G.P. knew I was a lesbian and she was still asking if I wanted to have children." When Anne talked to her G.P. about the Toronto lab, she received absolute support. However, her G.P. could not do the procedure or she would lose her license. Much later, her partner's gynecologist performed the artificial insemination procedure on Anne.

In her search for a doctor to perform the A.I., Anne was confronted by overt medical prejudices and rejections of homosexuals. It took Anne two years before she could find a doctor to do the A.I.. Single heterosexual woman could get treatment but not a lesbian. Anne's G.P. was furious about this injustice and suggested Anne go public with this clear violation of her rights. "I wasn't prepared to appear on the front page of the Globe & Mail." Her G.P's
second suggestion was that she lie to a gynecologist to get herself in. In tears, Anne went home. "I had lost. I had to lie, say I was single, heterosexual and wanted a kid. I had to lie and provide needy reasons versus good ones."

Anne’s anger over the injustices and inequities rose. It was so unfair to Anne that, despite having a stable family situation, she had to represent herself as a neurotic, lonely heterosexual in order to gain respect and receive treatment. She was furious. "Why did I have to deny the goodness of my life."

It had been five years of dreams and wishes until Anne had a conversation with her G.P. about her decision to pursue artificial insemination. It took another two years to find a gynecologist to perform the procedure. Before having her A.I. attempt, the specialist sent Anne to have a barrage of fertility tests to ensure she was a good candidate for the procedure. Anne realized that, finally, she was actually going to have a chance to fulfill her dream and nothing was going to get in her way. "I tolerated the intrusive, cold, heartless and extremely painful tests as it was means to what I wanted."

At Anne’s first attempt, the specialist tried to create a positive and respectful context, which Anne and her partner appreciated. The actual A.I. procedure was extremely painful. Anne had to have two such procedures at every attempt. "I was terrified of the pain." There was also the pain of having to go through cold, mechanical
medical procedures. To Anne it was dehumanizing. "There was no love, no touching, no union."

Then a miracle occurred: Anne became pregnant after her first A.I. procedure. "I don’t think there are words to express the wonder, the wonder. It was all so wonderful." For Anne, this was a victory after nearly a decade of fighting prejudice and barriers, after investing so much energy in her quest. Her child within had profound meaning. "I don’t think I was ever more connected to myself in my life."

She and her partner were completely overjoyed and invested every ounce of their being in this new life. The wonder never ceased. Every night, Anne and her partner would review a book on gestation, check out the normal developmental stages for their fetus: they would communicate with it, pouring their love and nurturing into this new life. "We thought it was so beautiful, so remarkable."

When Anne began this journey, she held a belief that she would get some support from their families and community. Instead, the opposite was true. The cloud over their unparalleled joy was the singular lack of support. Their homosexual and heterosexual friends and colleagues gave little or no support throughout Anne’s years of struggling or, later, when her dream was fulfilled and then stripped away. Her family were condemning. Anne and her partner were seen as freaks. "Everyone was telling me I was
either crazy, selfish, completely anti-nature, anti-society, anti-world, anti-everything." Anne’s sister told her that she revolted by her lesbian sibling wanting a child. What little support there was came from a few woman friends, none of whom were gay, and from her partner’s office. One niece sent a card.

Anne’s established coping style under extreme duress is self-imposed isolation and this made it difficult for her to accept the limited support that was offered. As well, it was almost impossible to embrace any support after enduring so much vilification and hate from others. "We absorbed some of that negativity and hate." The hate had been so pervasive that, at times, Anne questioned her right to have a child, to parent, to be a mother. Her sister’s disgust also instilled fear in Anne: "It reminded me of how dangerous the world is for people with my lifestyle."

Anne’s unspeakable joy with her pregnancy disintegrated when she started to bleed at nine weeks. She was terrified and he contacted her specialist immediately. Her doctor normalized the spotting and suggested Anne rest at home, which she did. However, the bleeding and intensely painful cramps continued. After two more days, Anne’s doctor sent her to hospital for an ultrasound.

She endured the ultrasound, holding her breath. The technicians questioned her about the timing of her pregnancy. She had to repeat "9 weeks" twice. They told Anne to go back to her doctor. They told Anne the fetus had
no heartbeat. Anne went into complete shock. "They told me nothing but they told me everything." She wouldn’t believe it. She couldn’t believe it. "I was terrified the process of grief would begin." Anne clung to her desperate hope that the radiologists were wrong.

She saw her specialist who, in a matter of fact way, told Anne to go home and wait for the miscarriage. Anne was to call back when it happened. Anne was stunned and disbelieving. It was the follow up call from her doctor to apologize for her curtness that forced Anne to face her greatest terror. "I could have lied to myself longer, but I hung up the phone and started to cry because I knew it was dead."

Within a day, Anne miscarried. She chose to be completely alone, sitting on the toilet, waiting for her wondrous little one to be expelled from her body. Anne chose to go through this tragedy alone as she wanted to experience everything that happened, including acute pain. "I felt the fetus slip out. It was perfect in that sack, about the size of a walnut. It was my child." She put the embryonic sack into a yogurt container and kept it in the fridge. She took painkillers for the first time in months and woke her partner. "We lay together and cried and cried and cried." Anne’s acute pain and bleeding wouldn’t stop so her doctor sent her to emergency as there was a risk of hemorrhaging. Her partner took care of her and drove Anne to the hospital.
Anne felt the negative forces of more prejudice and rejection from the medical system. At the hospital, her partner of nearly a decade could not sign herself in as next of kin. Her sister, who resided in Ontario and considered Anne a disgusting freak, had to be recorded as next of kin. After waiting in emergency for 8 hours, a doctor approached Anne and told her he had to do an internal exam. Anne's reaction was immediate. She ordered him out. No one was going to touch her. "Just leave me alone." Later, a notably pregnant nurse arrived with water for Anne. She was shaken by the apparent insensitivity to her own despair and profound loss.

Anne found the ultrasound examination humiliating; her need for privacy was shattered. She had to manipulate a vaginal and uterine sensor in front of these strangers which was acutely embarrassing. "Being a lesbian, this was not my expression of sexuality. I did not do this for myself so it was doubly embarrassing." The time in the hospital was fraught with angst, despair, hopelessness, loss of control, rage; all at a time when Anne was terribly vulnerable. "We were second class citizens because it was a lesbian couple in there. We even had to fight to get the ultrasound." Anne's doctor had to contact the hospital to expedite the procedure.

There was no risk of hemorrhage, so Anne was sent home. Her strength was sapped, her body was wounded and she was overwhelmed by the violations she experienced. Anne
felt paralyzed, as if she was standing still. The paralysis was enduring. "Six months after the miscarriage, I was standing in front of the door, not wanting to move." In contrast, the rest of the world was racing by.

After miscarrying and being hospitalized, Anne and her partner went out on a December night and buried their fetal sack in a park. "We brought flowers and candles and buried the container." Anne has never returned to the site, although she now feels ready. She's waiting for her partner, who cannot yet visit the fetus's resting place.

It took six months before Anne could even consider another A.I.. In order for her to begin again, she had to bury her grief. She knew at some point she would have to face it, but grief had no place in her determination to try again. "I had to put it away if I was going to try again. I could not live with it."

Anne knew that she had to deal with her profoundly overwhelming losses. "I had lost a life, I had lost spiritually, physically, politically. I had lost." She decided to see a therapist at her university's women's counselling centre. The experience was shattering. She shared her story about her years of struggling against enormous barriers and the tragedy of her miscarriage. Her therapist told Anne her problem with grief would be less intense if she had not told anyone she was pregnant; that Anne should have waited until she knew she would keep the pregnancy. "I had it on the best authority what we did
wrong. We told people we were pregnant. That's why we hurt now. That's why we cry every night." Anne walked out of the session, her vulnerability and needs betrayed and judged by another woman: a therapist. Eventually, Anne found some comfort in a book about women having miscarriages and, much later, from a supportive, caring therapist as well as from a group experience.

Before trying her second A.I. attempt, Anne experienced acute pain and guilt. She didn't want to abandon the child who had lived its short life enveloped in Anne's profoundly loving care. "We didn't want to forget about our child, to turn our backs on our little one. It was really depressing." She swallowed her grief in order to go on.

Anne ordered a new sperm catalogue for her second attempt and she and her partner made the selection. "It's like looking through a Sears catalogue". The isolation and artificial, dehumanizing aspects of the whole procedure generated more grief and isolation. "We couldn't share this with anyone, we didn't know anyone else who had to do this."

Anne had her second A.I. procedure. For nearly two years, Anne was enveloped in a chaotic torrent of intense emotional experiences. She was trapped on a roller coaster of profound hope followed by devastation with each A.I. attempt. Anne and her partner would prepare for each procedure with rituals. They tried to do everything possible to enhance their chances of conception. "We
would light candles, put the silver out, and did lots of ceremonial things and say our prayers. I wore a coral necklace because it was supposed to increase fertility."

Anne invested so much in this agonizing process. After each attempt, they would begin their rituals and wait, clinging to hope, believing Anne’s period would not begin and that she would be pregnant again. "Our emotions would go up the roller coaster...hope, hope, hope, hope and then come crashing down. It was an insane desperate whirlwind."

Anne’s quest was fueled by the knowledge she could in fact get pregnant. Apart from the repeated devastation that Anne faced every month, there were also huge financial pressures mounting with each attempt. Anne’s need for control intensified with each attempt. She continued to try everything to enhance her chances and questioned everything. What should she eat, drink, if she should lie down or sit up, if she should breath at a specific rate, etc.. "It was insanity because I had no control." As well, self blame intensified. Anne had absorbed everyone else’s hate and castigation and, with repeated futile attempts, she turned that condemnation towards herself. "I had done something wrong. I must have. Everyone was blaming us and saying we were wrong so I must have done something wrong."

Anne struggled on despite her self-condemnation.

Anne and her partner had saved enough money for 12 attempts. For her 10th A.I., Anne paid $700 for the sperm, etc., however she never ovulated. Anne waited for
three months and ordered more sperm in anticipation of ovulating in 7 days. Once again, Anne didn't ovulate. $1,400.00 had gone in four months. $7,000.00 was gone in two years. The personal cost was immeasurable. At this time, Anne was 39 years old. There was just enough money for one more try.

Anne's physician suggested that she start a trial of fertility pills to increase her chances of pregnancy. Anne's pursuit of her hopes and dreams was brought to a halt. Fertility pills frequently resulted in multiple embryos. Multiple births from fertility pills often made the news. The risks associated with multiple fetuses miscarrying were ones Anne would not take. As well, she felt she had been violated so many times throughout the testing and medical treatment. "I could not bear the agony of having science interfere once more and lose five babies." Anne had experienced violations, gross intrusions and now was confronted by a potential trauma she struggled to avoid. "It was like a door shut for me." Her options were over. There was to be no child.

One more emerging barrier to Anne's hopes and dreams was her diminishing fertility with age. As she and her partner's savings were depleted, Anne had to wait for two more years to save enough money for any more A.I. attempts. She would be in her early 40's. "It was obvious to me that my ability was going down." Anne began to understand the importance of her biological clock, and started to
listen to her body. She knew if she commenced treatment with drugs there was no certainty of pregnancy and her body was less able to maintain a pregnancy with the passage of time.

Anne had always received support from her life partner and both faced enormous losses. After years of hoping and years of trying, Anne felt the risks to the relationship were too great to try again. "How long can we battle at this wall, knowing it's tearing flesh from our bones and jeopardizing a 12 year long relationship?"

Both Anne and her partner were totally drained and their relationship was under great strain. "We have no energy for hope." Both women questioned how much more could they endure individually and together. They reached a decision over time without actually stating it was time to stop. "There was a deeper understanding between us that it was finished."

Anne experienced intense rage about the prejudice and gross injustices she faced with the medical system. She deeply resented the ability of married women in heterosexual relationships to have "free access to sperm". In addition to her rage and resentment, Anne's self-blame was pervasive. She questioned her right to have a child and a family. "Maybe God knew what He was doing." She continued to absorb all the hatred and rejection and turned more blame on herself, questioning her goodness and ability to parent. "Maybe this was a sign, who did we think we
were?" Anne’s self-blame existed prior to her miscarriage and increased throughout her 2 1/2 years of trying and beyond. She was convinced she must have done something wrong. She felt accountable for the tragedy of her miscarriage and the ongoing failures with the artificial insemination procedures.

Her self-blame and self-deprecation hit her hard when she decided to stop. How could she stop? She was overwhelmed with self doubt and self vilification. "I should have sold my car, sold all my furniture, gone to work at MacDonalds to get enough money, get two jobs. I was pretty horrible basically." She also absorbed all the blame for remaining childless. "I failed my partner."

Anne’s symbolic metaphor, the door, was firmly and finally shut. She was paralyzed in front of the door again for months. However, there were no more A.I. attempts ahead. Anne eventually turned from the door and threw herself completely into her work. "Once I turned from the door, I broke into a dead run." She was submerged in overdrive and didn’t come up for a breath. It was not until her health was seriously comprised by her furious pace, that Anne was forced to slow down. She suffered acute stress symptoms and was near collapse. During this time, she and her partner’s relationship came under tremendous pressure. They were fighting, blaming each other, and Anne’s life was in turmoil.

Anne’s coping style, emerged under such enormous
stress. She minimized the extent of her trauma, put on a mask of coping well and ensured that no one could get close enough to reach towards her. "I withdraw and lick my wounds." Anne intended to hold on to her self isolating coping stance, however, she had a chance to attend a group workshop that she knew would also be attended by a few close friends and colleagues. It was a place where she would have some support.

Anne was caught in an agonizing struggle. To grieve her child meant she must relinquish her hopes and dreams forever; she would be forever childless. She was frightened by the potential weight of her tremendous grief. She was also terrified that her self blame and self hate might overwhelm her in such an experiential workshop. With great courage, she joined the 2 1/2 day group sessions. "I did try the handle of the door when I went through that psychodrama."

In one psychodrama enactment, Anne bore witness to a woman who was grieving her two dead unborn children. "I could feel the love this woman had for her children. It was an astounding experience." This woman's deep love and grief for her unborn children enveloped everyone in the room. Anne felt her self blame and sense of failure easing as the tide of this woman's feelings swept over her. Just as she had taken on the hateful, prejudicial and condemning blame from her community, she was able to take on the profound love this mother held for her children. "It quenched my
hurt, my blame, my own wrongness."

By bearing witness to this grieving mother, Anne recognized within herself her own profound depth of love, nurturing and care for her child during its 9 weeks. "It filled me with the experience of how much that child was loved, how good the experience was of being a mother, even if it had only been for 2 1/2 months." Anne integrated into her identity the loving, nurturing mothering she had given and the honest and compelling grief that she had to face in mourning her beloved little one. "It was a kind of grace."

Anne acquired a deeper understanding of her grieving process and continues to grieve. Anne was no stranger to loss, having grieved for her father for more than 20 years. Her understanding of how she lives day by day with those lives she treasures and safeguards is clear. "It's precious. I wouldn't be human if I hadn't the experience of loss as much as I've had the experience of gain". Anne welcomes the opportunity to care for and carry her grief within.

It has been seven years since Anne miscarried. Anne never stopped being a mother. She knew she had the fullest experience of mothering with the very best and the very worst of experiences. "I can feel the loss because I feel the having." Coupled with this realization was Anne's new awareness of a long thread of pain that had stemmed from her own family experience. She had no sense of family from her childhood. She lost the family she yearned for. "I
have no sense of family - past or future and that's what made the agony so deep." However, now Anne has a clear understanding of herself as a mother to her little one, her child. "At my eulogy, they will say she was briefly a mother".

Part of Anne’s healing process was her growing understanding of the distinct and significant theme of duality. She had experienced losses in the past and for the future. She experienced profound wonder with every cell in her body and equally experienced tragic losses. The theme of duality weaved into her definition of self and the relationship with her unborn child. The child became a treasured being placed in a sacred, private place within Anne, the mother.

Anne experienced profound losses, fought against political, societal, legal and medical barriers on one hand. On the other hand, she had fought tenaciously for years and had achieved victory. She had a child and discovered her own capacity as a mother. "It was two fold. How could I fulfill the need in myself with the loss of my personal dream."

Anne understood her need to mother, to nurture and care for someone. She found a dog who had a great need for special care and whom Anne mothers in every sense of the word. She anticipates many other opportunities in her lifetime to mother.

Anne also allowed her creative self to express many of
her lived experiences. She put pen to paper; something which had been blocked during the intensity of her grief. Her creativity poured out. She also painted; her artistic expression freed her to mourn. "That artistic expression told me that I was immersed in dealing with the grief."

Anne continues to express herself creatively. She may write a short story about the images she keeps within. It is all part of the reconnecting and reintegration of herself after being tramelled and tortured for so long. "Artistic expression is my touchstone of emotional health."

Other indicators of Anne's renewed strength and integration of her experiences relate to her family of origin. She had the opportunity to show her sister a painting she had drawn of her child "Finnegan", and put the artwork right in front of her sister's face. "I felt really good and strong."

The early chaos of her early family life related to her mother. Anne has a new role with her mother; that of mothering her mother. Her mother is extremely ill and Anne has taken responsibility in many ways, including making decisions for her mother who can no longer make good healthful choices. A measure of peace and acceptance their relationship had already begun before Anne took on such responsibilities.

Anne acknowledges her own tendency to withdraw and distance herself and the problem that creates of self isolation. She is also absolutely clear about her complete
isolation from so many by their hate and bigotry. "Non acknowledgement or non validation at my right to even have this experience made it more difficult." Her community were vigorously and vociferously opposed to her right to such a quest. There was rejection and little support when her dream collapsed. Anne has had the opportunity to review those individuals whose friendship and support evaporated with her stated desire to have a child. She is also trying to be more open about her experiences with those who have always cared.

Her own sense of her health is her openness to socializing with children, talking about babies and clearly identifying herself as a mother. Her grief has lessened and Anne knows it will never stop showing her something she needs to know. "It has more things to show me and it’s now an element of my autobiography." She knows at other life stages that her experience may be coloured by grief. She is not afraid. She looks forward to all that she has to learn.

"It’s kind of a gift. I say I’m very fortunate. I know exactly what its like to live with a man. I know exactly what its like to live with a same sex partner I embody a person who knows what it is like to be a mother. Who knows what it’s like to be childless. I get two lives for the price of one."
Appendix "B"

Barbs story: She was born in Leiden, Holland in 1950. She moved to Canada with her family in 1974. She got married in 1978. She lives in Vancouver and works as a Program Director for one of the Christian churches.

Barb was married at age 18. She described herself as young and naive, with romantic ideas about love and marriage. Her youthful naivety and romantic imaginings found security, safety and fulfillment in marrying her husband. "I felt like Cinderella and my handsome prince had come."

Barb's naivety resulted in little understanding of the real responsibilities and work involved in maintaining a marriage. "It was inconceivable that he and I would ever have a disagreement." Barb simply expected that life would progress with joy, continued fulfillment, and with a family.

Early in their marriage, Barb and her husband shared their mutual desires to start a family. They had no thoughts about any difficulties in having children. Both were young and healthy. They also had faith in modern medicine should any problems arise. Barb believed that everyone who wanted to have children could have children one way or another.

Barb's naive wonder was enhanced by the early days of her Cinderella-like marriage. She was deeply in love with her spouse, who loved and adored her. Their days together were filled with romantic closeness, wonder and love. Her naive belief in the inevitability of having children fostered wonderful dreams. She dreamed of she, her spouse, and
children playing together, going on holidays together, and a host of other anticipated events and delights; all about what her family would be. These were "Brady Bunch ideas": innocent, naive and ever hopeful.

Barb’s hopes, expectations and overall belief in the certainty of having children never dimmed in the first three or four years that she and her husband tried to get pregnant. Her experiences in life with her own family and in the years of her marriage had taught her that she had the right to have such hopes and expectations. Things had just inevitably worked out for Barb when she had faced problems in the past. Her life progressed without a ripple.

Barb’s Christian faith added an even greater depth to her certainty. Because of her faith, she believed God would ensure she had a child. With the combination of her youthful belief in the inevitability of having children as well as her faith in God’s will for her, Barb was able to keep trying for nearly four years without any worries or concerns. She accepted the delays believing that, in the end, everything would be fine. Her natural optimism and beliefs created an outlook of inevitability regardless of the steps that were necessary.

After four years, She decided it would be a good idea to check with her physician to see if there were any physical barriers to pregnancy that might require treatment. Her optimism was intact. Barb considered the possibility that her fertility level might be low; however, by going to
the doctor she knew any problem would be fixed. It was just
a matter of time and the right treatment.

Her doctor recommended she see a fertility specialist. She was offered two choices; one was extremely competent with a cold personality, and one was described as a warm, caring specialist without the reputation of the first. Barb wanted to expedite her progress to pregnancy so she chose the seemingly more competent doctor. With hindsight, she considers this choice a "huge mistake". Barb knows that the cold, uncaring treatment from her specialist intensified her own pain and trauma. She now considers it essential to find a doctor who really cares and who can provide meaningful support to hopeful women and men who long for children.

Barb's experiences with her fertility specialist were painful, shocking and isolating. Prior to commencing conventional fertility tests, Barb and her spouse began the exacting routine of monthly temperature charts to monitor ovulation and thus optimize their chances with sex-on-a-schedule. The specialist insisted that they have a period of time of scheduled sex before doing any tests. Barb was also told that she would be informed beforehand about any painful tests; in fact, the doctor did nothing of the kind. "She did the most painful right away and then told me afterwards." Barb wasn't prepared for the intense physical agony and violations she would have to face.

She experienced excruciating emotional and physical pain from the series of fertility tests. The pain was
unrelenting and pervasive. "I was never afraid of pain until then." Barb described one of her flashbacks which she said encapsulated the terrible trauma of these medical tests. "I remember the tearing of a piece out of my uterus without any anesthetic and then seeing the bottle, filled with blood with a piece of white meat in it." Her fear of pain from this trauma continues to this day.

The ongoing infertility tests were physically debilitating. Nonetheless, Barb carried on with each painful test after painful test. Throughout this process, the specialist kept telling her that nothing was wrong as each result became known. Barb’s desire and belief about having a child was gradually replaced by desire and desperate hope. Her tenacious desire helped push her through this maze of agonizing trials and tests. Still, there was never a definitive diagnosis nor news of a medical problem that could be fixed.

The specialist concluded that hormonal treatments would provide the best result, and Barb was put on fertility pills that left her feeling nauseated and always chilled. She was working as a nurse’s aide at that time and, while everyone else complained about the excessive heat of that summer, Barb ended up using a patient’s coat because of her extreme cold. She always felt physically unwell while on these pills.

Her sexual relationship with her husband grew more tense and problematic. Every month was a cycle with a
recurring pattern: hope followed by collapse and Barb burying her pain, followed by renewed hope and then more devastation, etc. The investment involved with their sexual relationship gradually took on an extremely intense meaning: sex meant having a child rather than their past intimacy and sharing.

Despite her illness from the fertility drugs, Barb pressed on. Her hopes remained very high and she was never completely discouraged. "I was positive, absolutely positive that it would work because, being a Christian, I believed that God would answer my prayers." Her commitment to God had developed through a lifetime of active involvement with her faith and church. This commitment nurtured her certainty about an inevitable pregnancy. She was certain that the goodness of her desire and her understanding of God's plan that Godly couples would have children was the truth. "I really believed that was in His plan so I had no doubt it wouldn't work." God had the power to do something for Barb. "I couldn't imagine He would let someone go through all that and not do anything." Her conviction and faith were powerful forces.

As Barb's use of fertility pills continued, her frustration and concerns began to mount. The pills didn't seem to be working as quickly as they should. She still held onto hope, but didn't have the same level of confidence as before. Fears began to emerge. To quell her anxiety, Barb exhausted every possibility to enhance her chances and
exhausted herself by accepting help from well-meaning friends. She heard such platitudes as "well, don’t give up hope, lot’s of people eventually get pregnant, there is this new way I have heard".

As her fears grew, Barb’s desperation also grew and she tried anything that might increase her chances. "They told me to drink Robitussin so I did that. They told me to stand on my head afterwards and I did that. I did every old wives tale". Eventually, Barb didn’t want to hear any more platitudes nor receive any more advice. She didn’t want helpful pats on the back with admonitions to pray more. "Just pray more and leave it to God. Smile, God loves you". Barb began to hate the admonitions and answers from others.

Slowly Barb began to accept that the fertility pills were not helping. She began to steel herself for more agonizing tests. No sooner did she begin to seriously question the benefit of taking fertility pills, when she became pregnant. After nearly four years of trying and with year or more of tortuous tests and physically debilitating fertility pills, her long awaited miracle occurred. Her period was late and Barb knew in her heart that she was pregnant.

She was overjoyed. "I was so thrilled, I can’t imagine how exhilarating it was." Her lifelong hopes and dreams for a family were finally met. She had driven purposefully ahead, despite traumatizing pain; she had charged ahead, not only for herself and her spouse, but also
for the wishes and hopes of her parents. Barb chose not to share the news immediately with her husband. She just wanted to savour her romantic idea of how she would share her wonderful news and how this would effect their relationship. She imagined how her husband would treat her, caring for her, nurturing her and their baby. She anticipated incredible pleasure and romance in her baby’s first movement and her husband’s first touch on her stomach. "What a perfect, beautiful thing God has made between a man and a wife. What a gift."

Joyfully, Barb immersed herself in building a nest and bonding with this new being inside her. She thought about buying maternity clothes, worried about her figure changing, thought about the unique and wonderful connection between mother and child while breast feeding.

Eventually, she told her husband, who was overjoyed. Barb was joyful for her parents who would become grandparents. Her first purchase was cards for the grandparents-to-be. She wrote in one card from her baby, which she intended to send a little later on. Her prayers and desires had been fulfilled as she had hoped and she was eager to share the news of this miracle with her family. The chance to share never developed.

Barb’s pregnancy ended prematurely. A high percentage of pregnancies never proceed past 10 to 25 days. Tragically, Barb experienced such a phenomenon. Her period resumed much later than usual. She was at work when she began to bleed.
"I was devastated. No one at work knew what had happened. No one understood her pain. She experienced her agonizing and traumatic loss completely isolated from her working and social community.

She struggled to quiet her tears, finish her working day and immediately put her loss aside. Her hopes were not yet dashed. Barb returned to her specialist and to the hospital for more tests. One test was to determine if artificial insemination was necessary. The conclusion drawn was that there was no clear impediment to her getting pregnant so an A.I. wasn’t an option. Barb went back to her specialist. Her goal was unchanged and she steeled herself to face another barrage of tests.

Barb was exhausted from the strain, the pain, and her profound loss. New worries also emerged. She had experienced such acutely traumatic psychological and physical pain during fertility tests and she became scared that childbirth would be as painful or worse than the tests. "If the baby’s (delivery) is worse than this, I don’t know if I’ll survive." Despite her intense worry and fear, Barb pushed on, determined to endure whatever pain was necessary. She awaited instructions from her specialist.

Her doctor’s response was to the point: "Sorry, there is nothing I can do for you. It’s over. I’ve done every test. You are fine. You are perfect. There is nothing I can do." The coldness of her doctor’s delivery, combined with the impact of her words, were totally devastating to Barb.
She was at her most vulnerable time in her life, having just lost her lifelong dream. She suffered from the matter-of-fact brittleness of her doctor. "I don't think she realized how much damage she did." The doctor referred to Barb as "one of those unexplainable incidents." Barb apparently had some undetermined phenomena somehow connected to her spouse as the doctor told her that Barb and her husband were 'likely a wrong mix'. Now Barb was hearing that the problem was that she and her husband were a bad fit. Barb was still in the office of the doctor when she slowly began to realize the real possibility that a pregnancy wasn't a certainty. She experienced a rapidly sinking feeling as she left the doctor's office. "That was the first time it hit me. I panicked. I was in crisis."

The shock and grief of this realization gripped Barb with overwhelming fear. "I felt this horrible black thing just come upon me, I felt like I had a dozen bricks on my back." She was completely lost, terrified, shocked and despairing, utterly overwhelmed by her devastation. "I was really in crisis and sort of shifted into automatic, feeling like a robot, not capable of really expressing emotions. I was totally out of control."

Barb made her way home in complete shock. She shared her tragic news with her husband: the terrible loss of their hopes and dreams. Both were overwhelmed. Barb immediately tried to bury her own grief and support her grieving husband, but the enormity of his grief was just too painful
for Barb to cope with. Barb recognized she was struggling to bury what was overwhelming her and realized she didn’t have the strength and energy to support her partner. "I wanted to reach out to him and help, but I turned the other way because I was so hurt." They both fell into a "pit" and Barb couldn’t help herself, much less her husband.

Barb’s descent into a severe depression and living hell was not gradual. In one moment, she toppled over the cliff in the specialist’s office. Everything after the doctor’s news just deepened the pit.

In the nearly six years of their relationship, both partners had always supported each other. In this, their first overwhelming crisis, both wanted to help the other, but neither could. Both retreated with their pain. Barb isolated herself from her prince and he could not support his Cinderella. Barb’s dream and fantasy life were brutally over. The dark pit grew deeper.

The specialist suggested that Barb and her husband keep having sex and "just maybe" a pregnancy might occur. As before, Barb’s monthly periods returned on time, a devastating reminder that nothing was working. Barb had equated having sex with creating children for a very long time. She and her spouse’s sexual relationship continued to deteriorate, adding greater distance between the vulnerable couple and greater depth to Barb’s depression. The blackness intensified.

Her husband could not support her, her family and community
isolated her further and her grief was prolonged. Barb needed validation for her feelings and needed her community to recognize her acute pain. "It made it harder and that's why we didn't deal with it." Barb was isolated and lost. She didn't know where to go, and knew of no one who might be experiencing something similar. There was no one who would really listen and offer support. She was alone and sinking, deeper and deeper.

Barb's belief in her own goodness evaporated. She felt she had failed as a women by not conceiving. "I didn't feel like a real woman". As well, she felt she had failed her spouse, her parents, and in her role as a wife and mother. "I felt my husband should have married someone else." The doctor had told her they were a "bad fit" for which Barb took on all the responsibility. There was a lot of self-blame. She began to question her very existence. She was sliding away from the light.

She had to grieve her deeply felt investment and belief, the joy in preparing and making plans for her future and longed for pregnancy. She had to grieve the loss of her romantic and naive ideals, her view of the world as it should be. She had to grieve the loss of her hopes, desires and expectations. "The fact of going to the delivery room together, the first time look at what came out from you and your husband, the miracle of it, the beauty of it all."

At work as an aide, Barb was the only woman without children. She was also the only one of her friends without
children. She watched nurse after nurse get pregnant and deliver a baby. "Every single one. I watched everyone grow, watched everyone bring their babies to work except for me." Her friends and working community knew she had tried to have a child, yet none of her friends or work associates were able to relate to her experience of grief and never approached her about her loss. They celebrated arrivals of babies without any consideration for Barb. "I felt so isolated because they knew I wanted a baby." Nurses who became pregnant avoided talking to Barb, excluding her from baby showers, etc. Her sense of belonging to her working community was shattered. "They devastated me because they isolated me while they thought they were ministering to me."

Depression filled every corner of her life. "I found depression to be paralyzing." She had increasing difficulties with day-to-day tasks; tasks which were once second nature to her. She had always been a fastidious housekeeper. Things were always cleaned up immediately. She used to be an organized employer and homemaker and had boundless energy. Everything changed for the worse and her depression deepened. "I felt paralyzed and everything became a huge task. What I had taken for granted became Mount Everest."

Mornings became the worst time. Barb used to wake up with joy and anticipation. Now, she didn’t want to face each day. "Oh God, I don’t want to wake up, I don’t want to be here." Barb would remain in bed, try to go back to sleep or
pretend she was still asleep. She didn't care anymore. Her motivation, her interests, enthusiasm, optimism, joy and energy were gone. Her house collapsed around her in terms of its orderliness and cleanliness. "The first time he found me sitting on the couch and that worried him and that depressed me more. He would ask what is wrong because I wasn't eating, I wasn't sleeping, I couldn't do anything and that depressed me more. My house got dirty and that depressed me more. The things I used to enjoy, I didn't enjoy and that depressed me more." She sank deeper into the pit.

Barb made vain attempts to bury her grief, but she was overwhelmed. She continued to lose control in more areas of her life. She was able to keep working, but life at home collapsed around her. "I honestly didn't know whether to eat, sleep, drink, what to say, what to do, how to express myself." She believed she would never be able to get over the agony of her losses. "I'm not going to be able to live." She experienced her first thoughts of suicide.

She lost interest in all her surroundings. She lost interest in her house, in her love of nature; it all disappeared. She turned away from all the familiar objects she attended to and she lost interest in herself. Her suicidal ideation intensified. "I took for granted everything in life and now it's all gone. Nothing." Her behaviour at home was functionally on automatic. "I was like a robot inside a shell." Barb had no idea how to escape from the shell, she lost confidence that she would find a way
out. Barb had landed at the bottom of a dark pit. She had lost all hope, could not find anything to look forward to and her life was meaningless. "I felt at the end of my life. What’s the point? Get it over with! That’s when the light at the end of the tunnel gets turned off and you are in total darkness." She was at high risk for suicide at that time.

One incident with a friend added yet another burden, and yet, the final outcome actually brought a tiny amount of light into Barb’s dark world. Her girlfriend had a casual sexual relationship with a man and got pregnant. There was no love match, but the couple married and then divorced shortly after. The only joy out of that union was a baby girl.

Initially, Barb’s experience of this birth was a burning sense of injustice and the failure of her God. The slight glimmer of light and energy came when she found the energy to express her intense feelings towards someone; her God. She had a captive audience for her rage and experience of betrayal. "You know You’re supposed to be so loving, so just, so kind, so good and yet you let them get pregnant and they’re not even married." Barb found new strength with this opportunity to fully express her intense feelings. She found the strength to question her faith and to challenge her God. Suddenly, she was not alone and isolated. She had found someone to whom she could share her deepest feelings and it provided her with a long awaited and much needed relief.

This challenge to her faith was her very first and
critically important step towards healing. She got in touch with her God. It was her faith that would not allow her to take her own life. "That was God’s decision, not mine."

Barb had found her audience with God and her expression of anger and loss helped her take steps towards leaving the pit. That’s really where my salvation was." The voice that pulled her from the very darkest, blackest and most dangerous moment in the pit was her own voice; angry, despairing and challenging to God.

In sharing her depth of feeling with God, Barb began her long process of gradual acceptance that she might never have a baby. By getting on this newly discovered path towards acceptance, Barb’s depression gradually lessened. After finding the freedom to express intense feelings towards God, Barb began to express her intense feelings on paper, "Like a diary, I spit out all the poison and I left it on the paper."

Throughout her healing process, Barb remained isolated from her social and working community. She was also isolated from her spiritual community, but she had her relationship with God. A good pastor would say "put your faith in God". She rejected that. God had nothing to do with her pregnancy hopes and desires. Barb also felt He had not much to do with her return to mental health. Barb believed she had to heal herself, without compromising her relationship with God. She could talk to Him. She struggled to find some resolution. "I just had to find my own coping skills." She also asked
God to help her get to know Him better. Her earlier understanding had convinced her that Jesus had come to give light and truth and that God's plans for the future were filled with hope. She struggled trying to grasp the meaning of light, truth and hope. Her struggle led her towards deeper understanding of God's relationship to her and His plans and purposes.

Barb referred to a poem where a man asked God where he had been while this man walked alone in his pain. God had carried the man, which was why there was only one set of footprints in the sand. Barb came to realize that she too had been carried in her pain. "He is so acutely aware of pain and my agony. He is not in the business of alleviating pain, but He is interested in the development of your spirituality and having you know Him so much better."

Gradually, her relationship with her husband moved to a new and welcome place. While her early family experiences taught her to keep her painful experiences to herself, she was resolved to share her experiences with her beloved spouse. She began by sharing her writings. He not only understood, but he also identified with her pain. Over time, both partners began slowly sharing more of their loss and grief experiences with each other. Husband and wife were reunited by slowly rebuilding mutual understanding, openness, and support for each other. "We freely shared the hurt together." It was a long, slow process, but the benefit of such sharing brought Barb even closer to the light, to
her own healing.

Barb’s expression of loss and anger, her new insights and understanding were part of a healing process that continued for more than 5 years. "It was years for the acceptance, it took years for me to open". Lack of support was a major factor in her isolation, the blackness and hopelessness of her depression. "It made it harder and that’s why we didn’t deal with it." No one in her social community seemed to understand her experience. Instead she continued to receive many well-intended platitudes and admonitions to "never give up hope". "People tried to give me hope. It was frustrating to my healing process, because that was what I was trying to accomplish. The way for me to survive was to give up that hope."

Barb worked to create a different focus which led to a reframing of the positive aspects of having children. She started focusing on the negative aspects of having children in terms of her new calling with her work and the freedom in her relationship with her husband. Barb also began taking birth control pills. The agony of each monthly period over many years had trapped her in a cycle of hope, dashed hope and devastation, following by rebuilding hope again. Barb knew this desperate cycle had to come to an end. She made the decision to take birth control without consulting with her doctor. God and her husband were the only persons she could talk to at this point in her life and she knew something had to be done to remove the existing tension and
stress. "This would take away my everlasting hope on a monthly basis." Without any hope, Barb could begin to accept the inevitability of no pregnancy. Dreading the monthly periods, which had eaten away at her resolve and drive came to an end.

Being on the pill was a major factor in improving her sexual relationship with her spouse. Their long held hopes for a child was no longer a part of their relationship. "I don't even think about getting pregnant because I know it's not possible." Barb continues to take birth control pills which, for her, guarantee she will never experience the debilitating and desperate cycle of hope and devastation again.

Barb recognizes that her healing process is not on a finite, linear path. Sometime ago, she pulled out a long buried box and came across the cards she had written to her parents. At the time of her pregnancy loss, she had tossed the cards into a box; they were a reminder of her acute pain. Barb had thought about them a few times in the past and had never felt ready to toss them out. When she came across the cards by accident, she was surprised and shocked by the extent of her tears and emotional outburst. "Things can resurface that you didn't even know were there inside you." She questioned her own healing and has learned that there will likely always be some reminder of her loss. "There will always be this sensitive tingle."

She reflected on her tears and was able to connect them
to issues with her parents, who never knew about her cards, about her pregnancy and agonizing loss. She decided to tear the cards up and throw them out. "I felt like I was throwing out a lot of my pain." Later, she experienced regrets because of her desire to share her experience with her parents, despite her knowledge that they would have difficulty understanding. Barb thinks the cards might have helped her parents with their own grief.

Neither her parents nor her brother knew the depth of her experience. Her family taught her to put any problems out of the way of others and deal with issues on her own; a coping strategy, which she learned influenced both her desire to bury her own grief, as well as avoid being overwhelmed by her spouse's grief.

Barb's experience of losing the pregnancy, the birth of her baby and her chance to parent: these represented a fundamental part of her womanhood. She knows she has lost that part of herself forever, despite many compensations. She also accepts that small reminders may bring back images or experiences of pain but this doesn't disturb her. "There are still a few pieces of the skeleton in there but I am prepared. I won't be surprised with another outburst. I'm comfortable with it now."

Barb left her work as a hospital aide worker and was recruited by her Church to form her own ministry. Her calling to this ministry is something she is not willing to give up for any reason. The ministry is also part of her
healing salvation. Her work fills her with great purpose, direction, fulfillment, happiness and personal reward. "The fulfillment is mothering. People come here to be mothered. I recognize their pain and love mothering people." Her work consumes a large part of her life and she is determined to sustain that part. Her hopes and dreams for mothering a child of her own are behind her in large part: "I'd have to give up all the people that I have now and I don't think I am willing to do that."

Barb has a profound believe in the sanctity of married life, although she has lost much of her earlier naivety and innocence. She also realizes that her Cinderella fantasy would have been shattered by the reality of having a real versus a fantasy and ideal family. "If I had to do my life over again, I would marry my husband. Things aren't perfect, but I am very happy." She is thankful that her marriage has grown in depth from the experiences of the last 18 years. She finds her marriage to be challenging and full of compromises and responsibilities. "It isn't easy, it's hard work, but it's great, wonderful."

In terms of her faith, Barb beliefs have also matured. In the past her picture of God was naive and childlike. "I thought He was sitting up there in the sky, a kind of 'super daddy' to give you all you wanted and He would be perfect father and mother." She has learned that faith alone will not ensure any hoped-for outcome, having lost her earlier belief that she deserved happiness all of her life as a
devout Christian.

This struggle is a highly valued and important part of her maturation as a Christian. "I think it's very good for Christians to go through rough times, to not have their dreams realized because it makes them able to relate to the world and other people's hardships and pain". Barb thinks those born into privilege or who have a perfect life may lack the necessary challenges which come from painful struggles. She sees her own struggle as demonstrating a clear indicator of the depth of her commitment. "I am glad I've had a lot of pain and have suffered a lot." Barb sees herself as an example of faith held fast, despite the enormity of challenges posed to it.

Barb has learned that God's grace is in letting people suffer. "He wants to teach them in life and instill deeper qualities of caring and compassion." She believes her own caring and compassion have been deepened by her own depth of pain. "When I was put into the boiling pit, I've really been burned and hurt and only then that I can learn to love my fellow beings." Barb's belief is that God took her out of her romantic, naive, "sugar sweet" way of being and put her into the boiling pit, her agonizing ordeal was meant to be. "It was incredibly painful, but, in the end is so constructive because I have grown in my outreach."

She has gained many benefits from her ordeal. Barb continues to expand her ministry in her community, touching many more people and enlarging her own skills, energy and
encouragement. "God had bigger plans" and Barb has created new meaning and purpose in those plans.

Barb has a calling to minister to women who are unable to become pregnant. She hopes to be able to offer support to those who are going through the early stages of trying and hopes to help women develop realistic expectations. As well, her experience with depression has given her a profoundly new understanding of this frightening and painful place. She knows that from her own agonizing struggle her ability to better understand the struggle of other women is enhanced. "I am glad I am not a success story."

Barb is convinced members of her community, who remain devote despite hardship and struggle, convey a more meaningful message of faith beyond that of some more popular media icons. "God needs more people that go through hardship. Not those rich evangelistic characters with money and their lifestyle."

Barb fully understands the universality of loss and pain. She is able to recognize pain in others, even though it is not her own pain of childlessness. "Hopelessness is the same." Barb feels better able to reach out, to help in a truly meaningful way to those with the greatest need. "There is a special plan and a blessing comes with that." She is fulfilled.

In contrast to her earlier isolation, Barb freely embraces her community, thanks in large part to her ministry and her renewed relationship with God and her husband Barb
shared her present hopes and dreams:

"I'll be a servant in my life and in that there is great fulfillment. Hopefully, by the Grace of God, I will continue to be able to minister to other people to get them through their rough times."
Appendix "C"

Cathy’s story: She was born in Vancouver in 1948. She married her husband in 1982. She is a dental hygienist in Vancouver.

Cathy was a little girl when she first thought about having a family. She had one sister in her own family and didn’t have much experience with boys. Her great wish was to have daughters. As a child, she made plans with her friend Casey and intended to call her first child after her friend. "Casey and I played with dolls and fully expected to have children." So in play, Cathy first expressed her expectations. She had her family and, quite naturally, she expected to have her own family; her own children.

Her natural expectations for a family were delayed for a few years due to a number of factors. She had some relationships but none seemed like the kind that were material for Cathy’s expectations for a husband and a parent. She also completed professional training at university, as well as seeing something of the world. "I was single, didn’t have a good income and wasn’t really settled, so I didn’t think about having children yet. Although I had become a Godmother many times and enjoyed my friends’ children." Cathy didn’t feel any real pressure to have children when she was in her early 30’s.

In her mid-30’s, Cathy began to seriously plan for a family. She met her husband-to-be, Bill, and, to Cathy, having children was a vital part of her marriage. "I wanted to get
pregnant as quickly as I could and get started on a family."
There was no question in her mind. "It was my natural
assumption that I would have children, it was part of a
natural cycle of life. You have your own children and carry
on with your family." Her family ideas crystalized, once
she was married. "I hoped to have two children and assumed
it would mean a more balanced family".

Cathy knew friends who were only children and thought
they seemed lonely at times. Based on her own sibling
experience, she considered it important to have more than
one child. "The sibling experience...the fighting, the
squabbles and, later, the sharing experience". Cathy also
had clear expectations about certain features of her
children. "Unquestionably, red hair was an expectation and
a certainty." She also had ideas about her own parenting
values based, in part, on her own experiences as a child.
"My own mother never worried about self esteem." Cathy was
certain that she would instill self esteem in her own
children.

During her first year of marriage, Cathy didn't use any
birth control as she hoped to get pregnant fairly quickly.
She wasn't very alarmed after a year had passed since she
knew she was young enough to get pregnant. "It was just a
matter of time." In fact, she got pregnant in June 1984 at
38 years of age. Her hopes and expectations were met and she
was very excited by the unique and wonderful experience of
anticipating her family. "I counted through the days,
determining what day the baby would be born. I wanted a
girl." For Cathy, the pregnancy itself didn’t hold any
wonder. It was a means to an end; the safe delivery of her
first child.

Even before getting pregnant, Cathy experienced
negative feedback when she was sharing her expectations of
having children. Some of her friends tried to deter her.
Married men warned her about the commitment required. Her
closer friends were jubilant. "There was great excitement
about that." She received an initial positive reaction from
her mother, who went on to tell various relatives about
Cathy’s pregnancy.

Her partner was neither surprised nor elated about the
news of her pregnancy. Although Bill was quite neutral,
Cathy was very accepting of his attitude as she was so happy
within herself. While she shared her news with family and
close friends, Cathy decided not to tell anyone at work. "I
wanted to think about what I was going to do work wise."
Cathy had yet to determine what her future would be with
work after having a child.

Cathy’s pregnancy lasted seven weeks. One day while
she was at work, she began to experience some cramps and
felt some nausea. She was physically uncomfortable.
Emotionally, she delighted in experiencing what she believed
were pregnancy symptoms. When the cramps and nausea
eventually began to overwhelm her, "I began to bleed and
called my doctor who said I should go home and lie down."
Cathy left the office and her symptoms continued well into the night. It was then that Cathy miscarried.

She was alone, sitting on the toilet when the fetus was discharged. "The fetus was so small." Her doctor, whom she referred to later as a "hazard", told her to take the fetus to the hospital as the lab was interested in examining fetus samples after miscarriages for a research study.

In shock and following her G.P.'s directions, Cathy drove herself to the hospital with her fetus in a jar. At the hospital, Cathy was told by a lab technician that her fetus wasn't meeting the criterion of the research study; nonetheless, the technician took the jar and left. "I never knew what happened to the fetus. It was very traumatic." To add to her trauma and isolation, Cathy had to return to the hospital to undergo a D & C; a procedure to vacuum out any remnants of the fetus in her uterus. Once again, Cathy drove herself to the hospital. "I was alone in my anguish and was very vulnerable." Also adding to her isolation and trauma was the total lack of support from her spouse. "I was lying in a hospital bed, I was feeling really hysterical as I waited alone. I felt so miserable and alone."

Cathy was isolated, traumatized and completely lost in her understanding of how her husband could box up parts of his life so easily. During the time of Cathy's miscarriage, the surgical D & C and the ensuing trauma, her husband was focused on another box: his meetings with the carpenter or plumber. "Bill, of course, expected he was
doing his jobs at home, looking after the kitchen reno. He was just very busy with the house and was not terribly concerned with me." In fact her husband did arrive three minutes before Cathy went for her D & C, but he had no understanding nor support for what Cathy was going through.

After her experience with her husband in hospital and with other prior isolating experiences, Cathy wasn’t certain she wanted to try to get pregnant again. She was angry, disappointed and felt a coldness towards her husband. "I felt almost nothing towards him and turned away from him quite strongly. I was so angry and I didn’t know if I wanted to continue on with the marriage." She was also despairing and overwhelmed, trying to cope with her profound fears and trauma without any kind of meaningful support from her spouse. "He was like an emotional stranger."

While in hospital for a D & C, one well-intentioned nurse told Cathy that her fertility specialist was one of the best, and the fact that she had got pregnant were two very positive indicators. Cathy clung to her words of encouragement. "She sort of built me up with her comments and I listened very intensely to everything she said". The nurse’s comments about the specialist being some kind of miracle worker proved totally misleading. "He turned out to be a moron, very difficult, a beast and quite negative, awful and dreadful to deal with". She was treated indifferently and callously by the specialist and his staff and she had to pursue every avenue available to her without
any help or support from this alleged fertility medical giant.

Cathy's isolation continued on the family front. When she told her mother about her miscarriage, the reaction she received was criticism. Her mother judged that Cathy should not have disclosed her pregnancy to anyone until later on. Her mother also shared her great embarrassment at having to go back to relatives and break this latest news. "This was a typically insensitive remark from my mother."

Some friends continued with their discouragement and lack of support even after her miscarriage. She was 38 at the time. "Some friends were surprised that, at my age, I even wanted to have children." Fortunately, there was one key friend who was able to lend support to Cathy during some of her crises.

In addition to lack of support from her family, her partner and some friends, Cathy again chose to keep her devastating experiences from her colleagues at work. "I kept much to myself and didn't reach out for a lot of support."

It was the only way Cathy knew how to cope with overwhelming feelings.

Despite the enormity of tension in her marital relationship and the trauma and despair from her miscarriage, Cathy tenaciously held onto hope and her belief in her ability to get pregnant. Her physician told her that she should proceed with artificial insemination. At a preliminary test, there was a setback at the lab. The
technician told Cathy her eggs were not the typical size for the procedure but she was not deterred. "I put aside my concerns as I was getting on with it instead of brooding." Her tenacity was in charge. The fertility specialist showed his incompetence early on. At her first artificial insemination, her physician virtually stabbed her. "I felt him jab me painfully and I started bleeding and had cramps immediately and it was very painful." Cathy felt certain that this first attempt was botched due to her doctor's incompetence, and she felt very depressed about this first attempt. Still driven by her expectation and her belief that she could get pregnant, Cathy had several A.I. attempts. No pregnancy resulted from these insemination procedures.

Her specialist suggested she have a laparascopy. This investigative surgical procedure was to determine if there were any blockages in Cathy's reproductive system which compromised her ability to get pregnant. This recommendation for further surgery generated some anxiety in Cathy. "I began to worry that something was wrong with me."

After the surgery and while coming out of the anesthetic, her specialist told her that he found nothing wrong with her other than a slight fibroid which was not a problem. Cathy asked him if the next step was another artificial insemination. Her specialist replied 'You should get a new hobby'. The physician's cold and callous response was devastating to Cathy. "I was absolutely shattered and felt like I had been thrown out of the medical system. This
was the worst thing. I was in shock and felt like I was at a dead end."

With encouragement from a couple of people, Cathy changed doctors. At 41, she had not given up hope. She found a compassionate, caring physician who was astonished and horrified by her stories of medical incompetence and rejection. He was both calming and reassuring and put Cathy on fertility pills. Cathy knew there was nothing wrong physically with her nor her partner, so it was easy for her to hold onto hope.

Eventually, the relationship with her husband improved. While Cathy tended to hold in her feelings, her husband finally pushed her to share her experiences. "He made me talk and told me we had two choices." He realized the marriage could end. However, in expressing his first choice to keep the marriage together, he shared his great sorrow and regret that he had not been able to provide Cathy with much needed support during her many traumas. He sought her forgiveness and committed to support her during her quest for pregnancy. Cathy forgave him. "I made the decision to go on. I loved him and I felt better about him because he was willing to give it a good try."

Cathy was on fertility pills for six months with no pregnancy resulting. Her physician suggested she see a fertility specialist immediately. This specialist could not identify any reason why Cathy was not getting pregnant again. His suggestion to increase odds involved a regime of
timing sex with ovulations and assuming physical positions to increase odds even more. "A year after seeing the doctor and with sex on demand and nothing happened. I was another year older and nothing was happening." Despite this discouragement, Cathy tenaciously retained her grip on the threads of her hope. She simply could not accept that she would not get pregnant. "I still hoped, month to month." Her menstrual cycle worked like clockwork and her period arrived on time every month as it had for years. Cathy was caught in a powerful emotional roller coaster of hope and despair. "I remembered absolutely dreading the period that would arrive like clockwork. It was absolute dismay every month, it was very depressing."

The sex-on-a-monthly-schedule did nothing to benefit their marital relations. "Sex on a schedule was horrid, my husband was also horrified and found the schedule quite repelling and unsavoury." Cathy had no patience with his attitude, given what she had to go through. "It was the very least he could do". Cathy held onto her hope and faced despair and depression each month and each year. "My hidden hope was there each month until the symptoms of menopause began".

Compounding her stresses during her late 30’s and early 40’s was her mother’s illness. Her mother was seriously ill with both Parkinsons and Alzheimers and required a great deal of attention and care, which Cathy provided for several years. In addition to her scheduled sex
and emotional roller coaster, she was overwhelmed by these and other traumatic stresses. "I was run ragged between my mother, work and not getting pregnant." It took years before Cathy's mother was in put into care. Her mother's frailty and illness required more and more of Cathy's limited time and energy. Cathy eventually pushed herself beyond her limits and seriously compromised her mental, emotional and physical health.

While her mother was alive, Cathy became increasingly weak and suffered a significant loss of energy. "I was exhausted with everything, there was just too many things, I felt physically and mentally stretched to the end". She was diagnosed with Chronic Fatigue Syndrome, or Epstein Barr. "I remembered looking at the staircase from the bottom of the stairs and being too tired to climb up the stairs at the end of the day after I had face work, my mother and my day-to-day life."

Cathy's hopes for pregnancy were temporarily shattered at this point, which added to her experience of depression. She believed that pregnancy would be impossible when her health was so compromised. Shortly after her mother's death, when Cathy was 43, she received another traumatic blow. Her favourite uncle, with whom she was very close, died suddenly. This loss, compounded with others, was utterly devastating. "It could not have come at a worse time. I felt a tremendous shock and a great deal of grief."

It was during this period of multiple losses, that
Cathy's husband offered a great deal of support as did her one girlfriend who had always tried to be there for her. In addition, some family members were also supportive, as they themselves had lost two relatives. "Bill kept things going on the home front I had really very little energy for anything."

Gradually, Cathy began to deal with her many losses and pick up the thread of hope again. Years later, when she was 46, her girlfriend questioned why she would want a child at her present age. Her friend's question was a hard hitting challenge. "I still felt extreme pain and felt it was not fair." While she gripped onto an increasingly slim thread of hope, Cathy also endured devastation when she realized that there was some truth in what her friend had said. Nonetheless, her friend's words generated an internal shift. "It was a turning point for me. Slowly I realized I simply had to do something with my life." Cathy realized that she needed to take steps to improve the quality of her life. It was a gradual process. On the one hand, Cathy still coped with pain and her belief in the injustice and unfairness of her situation while holding onto some hope. On the other hand, she gradually began to look at what was positive in her life.

This process of starting to look ahead took about a year. At 47, she was starting to create some new ideas about work and relationships. She was proud of her proactivity. "I didn't whine and say what am I going to do?" Instead, she
began to challenge herself with some self talk. "Well I can let this put me right down and stay down for another 10 years and I can wallow and feel sorry for myself or I can choose to do different things with my life." These changes did not occur overnight. "I started to think about doing something with my life probably occurred over a year."

Over this time, she came to realize that the experience of being so overwhelmed and trapped in her pain was an unhealthy and hazardous choice. She also realized that, while she had not had the fulfillment of her naturally held expectations and dreams, she knew she must create new changes in her life to provide her with some other fulfillment. These shifts in perspective and focus required time. "I was making motions from where I had been, but I didn't manage it completely at that time."

Some age-related changes also helped Cathy in her gradual shift past any of her parenting and family hopes and expectations. As she approached menopause, she knew the thread of hope was hanging on. "It's amazing that women's hormones do a last hurrah near menopause." Nonetheless, Cathy also realized that with menopause came other physical changes that helped her move beyond her hope. "The biological clock really hits the wall." The shift in her hormone levels was a clear factor. "They are no longer raging at me on a monthly basis. I am in menopause now and the pressures of my hormones is off now."

As well, Cathy recognized in her late 40's that she
and her husband were probably getting far too old to deal with babies. "It would not have been fair to a child and it would not make sense in our lives anymore." Cathy doubted that either of them would have had the energy to deal with a baby and its future development. At 50, Cathy suggested that "waking up to a small baby would probably kill me."

While Cathy has gradually moved past her pain, she remains stunned by the total insensitivity of some people. "People were very insensitive and brought up painful feelings." People would ask Cathy, when she was in her 40's, if she was going to have children or if it was her choice not to have children. "I used to find it very uncomfortable." While on a trip to China in 1990, she was grilled by her guide about her childlessness and its impact on her husband. "The experience upset me quite a bit." Nonetheless, she was able to focus on the other person's bluntness and inappropriateness. Cathy thought "get onto something else, lady!"

Today, when other people ask her at work or in other contexts about her childlessness, Cathy closes the conversation down and moves on. People can still be hurtful with their insensitive comments. "I have had a lot of growing over the years, but have found that difficult and rather upsetting."

Time was a significant healer for Cathy by providing her with opportunities to reflect on her life experiences and redirecting her focus towards her future as well. Over
a couple of years, Cathy began rebuilding by assessing her relationships, her career, etc. "I did start to assess where my life was going, what I was going to do, who was I going to share it with and how was I going to do it." She explored courses that she could take towards career and skill enhancement. She made a meaningful investment in her work. "I decided to look at it with fresh eyes in spite of having done the work for a long time. I am happy, I enjoy my work, I like my patients and want to do the best job I can." She renewed her commitment to work with a new energy.

Cathy reevaluated some friendships and the people who had helped her over her decade of losses. "I basically decided to invest more in my friendships and also with my family." A key relationship that she invested a great deal of energy into was with her spouse. "I tried to build a better relationship. We had gone through so many things and we deserved a better life than what we had been having." Cathy experienced personal growth through her process of review and reinvestment. "My experiences gave me strength and I got back in touch with it and developed meaning in my life." She identified this as an important process in working towards resolution. "I see my experience in stages; from the beginning, through the middle and to an end. I consider it an ending now as I can draw on my experiences."

Cathy has experienced significant adjustment and resolution to her multiple losses. She had to give up her idea of who she was supposed to have been and what her
future was supposed to be all about. "I was being denied a
future and thought having children was what my future was
all about. It was to have been a natural progression." She
recognizes some of the joys that are in her life. "I have
many Godchildren and I am quite close to them." She has also
found "new meaning" in life with a different kind of family.
"I consider our dogs our family and they are important, more
so than with people who have children and dogs. Our dogs are
a constant in our lives." Recently, Cathy and her husband
lost a pet and they were devastated. Happily, they found a
new dog and her family life continues.

A lingering aspect of Cathy's experience is her
self-blame. She still feels if she had been more aware,
educated and "on the ball", she might have had a family
after all. "I was oblivious and should have clued in." She
had no idea that infertility was a significant problem for
women in their late 30's and 40's. "I was naive and had not
approached it in a very sensible way. I basically have to
take credit for not being up on it myself to begin with."
She blames herself for her choice of medical personnel and
for not reading about issues of infertility. "I was kind of
stupid to forget details and was heavily deficient." She
blamed herself for being selfish and unsupportive in her
marital relationship. "I also had been pretty selfish in my
marriage." Today, Cathy still believes she is responsible
for some of her profound grief and loss. "I have to take
credit for not being up on it various issues around
infertility, miscarriage risks, etc., myself."

Cathy wants to ensure that others don’t fall into the same pitfall of lack of information. She does give advice to some of her patients whom she knows are considering having a child: "I have said, if you are considering having a family, don’t leave it. Get on with it and get good medical advice very quickly." Cathy now knows that fertility is a much higher problem beyond the mid-30’s than when women are younger. She shares her advice and passes along this information in a supportive way.

Cathy increased insight generated further learning and understanding. She acknowledged that a significant change occurred when her focus shifted from experiences of past losses to the here and now and her future. "I have just basically turned outwards rather than turning inwards for so long a period of time." With some humour, Cathy pointed out that if she had a child, it would be a teenager..which would have proved to be quite a challenge. She believes she would have been able to handle it. With a philosophical ending, Cathy concluded:

"I know I am missing one of life’s valuable experiences. I also realize you just don’t get everything you want in your life."
Dear

I am a master’s student in the Department of Counselling Psychology at the University of British Columbia. As part of my M.A. degree requirements, I must complete a master’s thesis. I am writing to request your participation and assistance in my research.

I am studying involuntary childlessness and the grief process that such childlessness women experience. I will be asking you to share your thoughts, feelings and experiences relating to your childlessness and grief process.

By participating in this research, you will have a chance to learn more about the experience of involuntarily childlessness and the grief process. You will also contribute to a body of knowledge that may be helpful to therapists, researchers and other people who work with those individuals dealing with their possible infertility and childlessness.

The interviews (2) will be approximately 6 hours maximum in total. The first interview will be tape recorded and transcribed. You will received a copy of the transcription.
The second interview is intended to answer any questions, obtain further clarification, etc., and I will take notes of anything you wish to add to what has already been recorded. You have the right to refuse to answer any questions or to withdraw from the research study at any time. I anticipate additional time will be required for you to review the evolution of your descriptions to their final form. As well, I will be providing chronological narratives which you will approve prior to their inclusion in the thesis. I will contact you by phone to see if you are interested in participating in my research study. If you agree to participate, I will arrange to meet you, at your convenience, to answer any questions and to describe the study in more details.

Yours sincerely,

Alison Mordell M.A. (Cand.)
almost all the material developed in this study if you wish.

All information you provide will be held in **strictest confidence**. Confidentiality will be maintained by changing your name to a letter code or name of your choosing. Once the tapes have been transcribed and analyzed, the tapes will be deleted. Any written material pertaining to this study which has any possible way of identifying the material to you will be shredded.

If you have any questions about the research or queries about the thesis outcome, I will be pleased to answer any questions. Once my thesis is completed, I will share the results and provide you with a copy of the thesis if you are interested.

Your participation in this study is voluntary. You have the right to refuse to answer any question or to withdraw from my research at any time.

I HAVE READ AND UNDERSTAND THE ABOVE AND CONSENT TO BE A SUBJECT IN THIS RESEARCH AND ACKNOWLEDGE RECEIPT OF MY COPY.

Name of Subject:_________________ Date:_____________

Signature:___________________