# Muslim Women of South-Asian origin's constructions of Assisted Reproductive Technologies in the UK: a Foucauldian Discourse Analysis.

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# Abstract

This study employed Foucauldian Discourse Analysis (FDA) to explore South-Asian-Muslim women's talk about Assisted Reproductive Technologies (ARTs) in the context of their socio-cultural environment.

A critical review of the literature demonstrated the problematization of ARTs and women in the context of their socio-cultural and bio-medical environments, in the United Kingdom and worldwide.

Six South-Asian-Muslim women who underwent NHS ARTs in the UK were interviewed. Collected data were analysed using FDA and with a social constructionist positioning. After available discursive constructions of ARTs were mapped out, their impact on subjectivity, technologies of self and practice were addressed, along with the role of National Health Service fertility clinics and social environment on these constructions.

The analysis identified that participants construct their understanding of ARTs in relation to: (1) biomedical and sociocultural hegemony; (2) being a woman's problem and (3) being a liberating event. They all presented dualities and contradictions resulting from the subject positions made available. For all three sites, participants alternated between the subject positions of 'eligible patient', 'respectable woman' and 'responsible woman', with a pattern of being silenced.

This study has demonstrated that the way South-Asian-Muslim women talk about ART is complex, problematising and marginalising through dominant biomedical and sociocultural discourses. Participants in this research used silencing as well as their talk to resist dominant discourses.

This research recommends that the humanistic approach of CoP could potentially encourage awareness about issues regarding ART and how it is perceived/framed within the South-Asian-Muslim minority and later, via pluralism and interculturalism, support the formation of new, perhaps more positive discourses.

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# Abbreviations

**ARTs**: Assisted reproductive technologies

**BMI**: Body Mass Index

**BPS**: British Psychological Society

**CCGs**: Clinical Commissioning Groups

**CCTV**: Closed-Circuit Television

**CoP**: Counselling Psychology/Counselling Psychologist

**DP**: Discursive Psychology

**ESHRE**: European Society of Human Reproduction and Embryology

**FDA**: Foucauldian Discourse Analysis

**FG**: Focus Groups

**GP**: General Practitioner

**HFEA**: Human Fertilisation & Embryology Authority

**ICMART**: The International Committee for Monitoring ART

**ICSI**: Intracytoplasmic sperm injection

**IUI**: Intrauterine Insemination

**IVF**: In vitro fertilisation

**IPA**: Interpretative Phenomenological Analysis

**NHS**: National Health Service

**NICE**: National Institute of Clinical Excellence

**RERP**: Research Ethics Review Panel

**UK**: United Kingdom

**WHO**: World Health Organisation

# Glossary

**ARTs**

Assisted Reproductive Technologies; this term is given to fertility treatments that help people to get pregnant without intercourse. There are many treatments included under the umbrella term ARTs; some of them are IUI, IVF, ICSI (explained below) and donor sperm (donor insemination) or eggs (egg donation).

**Blastocyst**

After fertilisation occurs, the egg divides and about five to seven days after this, the blastocyst forms. The fetus develops **from** within the potion of the placenta (shaped by the blastocyst).

**Cycle**

One complete attempt using a treatment such as IVF, IUI or ICSI.

**Donor**

A person providing their gametes (eggs or sperm) for use by another person or couple.

**Donor insemination**

Using donor sperm to produce a pregnancy by inserting it into the woman's womb.

**Embryo**

A fertilised egg at up to 8 weeks of gestation.

**Embryo transfer**

When an embryo formed outside the womb is transferred into the womb.. Normally, within the NHS, only one embryo is placed into the womb; however, two can also be transferred, though it brings higher risks of miscarriage, for example, when multiple pregnancy occurs. The number of embryos transferred is highly controlled in the UK; however, in other countries, there might be more liberty regarding how many embryos can be transferred on one occasion.

**Endometriosis**

A condition in which endometrial tissue, which normally grows in the uterus, can be found in the ovaries or fallopian tubes, for example.

**Fatwa**

A legal pronouncement of Islamic law recognised by a mufti, which is an Islamic scholar.

**Fertilization**

Happens when a female egg and male sperm join together; the result of this union leads to the production of an embryo.

**Gametes**

The reproductive cells; female egg or male sperm.

**Hadiths**

Refers to a collection of traditions (day-to-day activities, routines) and sayings of the prophet Muhammad (who established Islam) that forms the second main source of direction for Muslims after the Quran.

**Infertility**

When a couple cannot get pregnant/conceive naturally within a year, despite having regular unprotected sex (every 2 or 3 days).

**Intracytoplasmic sperm injection (ICSI)**

A technique in which an individual sperm is injected into an egg. Following this, the IVF procedure, such as embryo transfer, is carried out.

**Intrauterine insemination (IUI)**

A fertility treatment that consists of inserting a prepared sample of sperm into a woman's uterus; to carry out this procedure a fine tube is used. Prior to inserting sperm sample, hormonal medication is often used to stimulate the ovaries and increase the chances of pregnancy.

**In vitro fertilisation (IVF)**

IVF treatment involves the removal of eggs from a female's ovaries to be fertilised with sperm outside the body. Following this, the fertilised egg is transferred back into the female's womb to implant into the lining of the uterus. When this process is successful, the embryo grows and develops into a fetus. IVF can be carried out using a person's or donor's eggs and sperm.

**Miscarriage**

A spontaneous loss of a fetus before 24 weeks**.**

**Retrieval of an egg cell**

One of the procedures during IVF treatment. An ultrasound probe is placed into the vagina to find and select the best follicles, which is determined by their size. A long needle is then used to retrieve eggs from the follicles.

**Stillbirth**

When a baby is born dead after 24 weeks or more of pregnancy.

**Unexplained infertility**

Inability to conceive naturally when there are no obvious fertility problems.

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# Chapter One: Introduction and literature review

## 1.1. Overview

This chapter introduces the topic of ARTs concerning South-Asian-Muslim women and their sociocultural environment in the UK, by presenting the worldwide context of this research, the biomedical framework of fertility clinics within NHS, and statistics surrounding ARTs. Subsequently, my fascination about this topic, my position and the vocabulary used in this research will be discussed. I will begin by examining how ARTs and 'infertility' impact people within certain cultures based on their gender-prescribed roles, before looking more closely at specific 'South-Asian culture' and minorities, and the consequences of being 'infertile' and undergoing ARTs for women who come from these socio-cultural groups. I will conclude with the rationale and aims of this research, its relevance to Counselling Psychology (CoP), and my research questions.

## 1.2. Positioning

Throughout this research, I adopted critical realist (Coyle, 2016; Walton, 2016) and social constructionist (Willig, 2012) ontological and epistemological positions, embracing a feminist ideology (Al-Hakim, 2005, 2013; Gough & McFadden, 2001; Lennon & Whitford, 2002; Sawicki, 2020), grounded in humanistic values in line with the CoP approach (Cooper, 2009; Joseph, 2008). Thus, the language I used in this research is tentative to reflect FDA's social constructionist epistemological position and CoP's pluralistic stance. This said, I adopted a critical stance to highlight the impact of language and how individuals' experiences can be constructed through social interaction; this will be elaborated on in chapter two.

I use the first-person pronoun to embrace my ideological positioning, (Willig, 2013) and to show the constructed nature of this research that I am a part of. I do not claim objective 'truths' but demonstrate one of the many considerations of this research.

I refer to my participants, who identified as Muslim, South-Asian, or British with South-Asian origins, as South-Asian-Muslim women. I use single quotation marks to indicate my criticality of terms such as 'infertile' where scope did not permit further discussion. Finally, I use italics to indicate that I am quoting from transcripts.

### 1.3 My involvement in ARTs

I have chosen to present different reflexivity sections across the thesis to accommodate the natural flow of reflexivity as I was writing; thus, I will start by explaining my involvement in ARTs and in the process of approaching this topic. I identify as a convert Muslim white-European woman married to a South-Asian man. I was introduced to in vitro fertilisation (IVF) by my General Practitioner (GP). During my five-year journey of fertility treatments within the NHS and private clinics, I noticed interesting relational dynamics where many things were left unsaid. For instance, I observed how my partner would let me do all the talking during IVF appointments and how this made me feel both lonely and empowered at times. Additionally, when I needed to deal with painful emotions after failed treatments, I encountered lack of understanding in my sociocultural environment and hesitance about ARTs, leaving me feeling shame. At this point, I encountered Professor Inhorn's work about 'infertility' and ARTs, uncovering a new perspective on how 'infertility' and ARTs affect women worldwide. Thus, this thesis has been an opportunity to research the topic of ARTs, whilst enabling South-Asian-Muslim women who undergo it to become more visible. I hope that this research will contribute to the current literature and increase awareness about the unique needs and experiences of these women, especially among psychologists and doctors.

### 1.4 Literature search

To ensure rigour and establish what is currently known on this topic, I completed an organised search for literature published in English using PsychINFO and Google Scholar. The main search terms I used were: Intrauterine insemination (IUI), fertility, infertility, procreation, Asian culture, South-Asian society, South-Asian-Muslim women, Foucauldian Discourse Analysis (FDA), Discourse Analysis, pronatalism, hierarchical family culture, minorities, Muslim women, feminism, Islamic Feminism in conjunction with ARTs, IVF and 'infertility'.

### 1.5 Issues of definition

It is important to discuss issues related to ARTs and 'infertility' terms, to highlight the impact of language and how individual experiences can be constructed through social interaction. Foucault (1982) framed this in terms of discourse and power, explaining that contemporary power is linked to central forms of language/dominant discourses that operate in everyday talk. Also, one of the CoP core values is to avoid living by the normalising practice that can subjugate personal values (Cooper, 2009). This section thus addresses definitions of ‘infertility’ and of ARTs (IVF/IUI), which are often used interchangeably.

### 1.5.1. ‘Infertility’

The term ‘infertility' is often used to describe the inability to get pregnancy after 12 months of regular intercourse (NHS, 2020). ‘Infertility’ can be diagnosed according to male factors (low sperm quantity or/and quality); female factors (tubal blockage, endometriosis and problems with the uterus or ovulation); or no factors (unexplained ‘infertility’). In the UK, ‘unexplained infertility’ accounts for approximately 25% of all diagnosed cases of ‘infertility’ in the NHS (NHS, 2020), and it is the predominant diagnosis given to those who decide to pursue ARTs in fertility clinics (Adamson & Baker, 2003; Brandes et al., 2010). This could indicate a significant gap in the biomedical approach. Wade and Hilligan (2004) argued that psychological and/or environmental factors are not given much attention when looking for potential explanations for ‘infertility’. They also suggested that the dominant biomedical model of illness within health care cannot entirely describe many forms of illness.

Although people are labelled ‘infertile’ by clinicians to access ARTs, none of the women interviewed for this research referred to themselves as ‘infertile’. Instead, when talking about ‘infertility’ in the context of their ARTs journey they used phrases such as ‘we are having some medical problems, ‘conception is not as straightforward for everyone' and ‘at the moment it is just a waiting time’. This seems relevant from a language perspective; what is different about ‘infertility’ from other medicalised conditions is that unless people choose parenthood as a social role (Greil,1997), they would not know, experience or say that they are ‘infertile’ and/or decide to undergo ARTs. Thus, I would argue that a socially constructed approach can provide deeper understanding of how individuals identify not conceiving as a ‘problem’ and recognise ‘suitable’ courses of action (Greil et al., 2010; Greil et al., 2011). Thus, ARTs play a central role in establishing many people as ‘infertile’ (Throsby, 2004), because the matter of being fertile or ‘infertile’ would only become a relevant concept upon attending a fertility clinic.

NHS (2020) websites predominantly refer to ‘infertility’ in terms of women’s age. For example, women over 40 are considered eligible for only 1 cycle of IVF in comparison to women under 40, who are eligible for 3 cycles (NHS, 2021). Feminist Throsby (2004) criticises this ‘biological clock’ approach which problematises women’s reproductive capacities, particularly women who decide to have children at the start or the end of the reproductive period, who are described as “selfish” and “irresponsible” (p.28). Specific practices are recognised as a question of health and illness which are subject to the authority of fertility clinics; this can be referred to as medicalisation. (Conrad & Schneider,1980; Hudson, 2008; Thorsby, 2004).

Additionally, from a medical sociological perspective, health can be comprehended not only through statistics but in conjunction with socially constructed categories negotiated by experts, patients and sociocultural contexts (Greil et al., 2011; Hudson, 2008; Wade & Hilligan, 2004). Within this perspective, judgements about what is ‘abnormal’—and how it should be addressed—are made within the social-environmental context; how the person is perceived by others and how they see themselves result from processes of social definitions. This underscores the importance of adopting a socially constructed lens to understand the topic of ARTs and ‘infertility’.

### 1.5.2 ARTs

ARTs is an umbrella term for various treatments that can be implemented to help achieve pregnancy such as IVF, IUI, and Intra Cytoplasmic Sperm Injection (ICSI). Couples who struggle to conceive naturally often are referred for IVF treatment, during which women take hormonal medication to stimulate the ovaries to produce follicles, after which eggs are collected, mixed with sperm and, when fertilised, transferred back into the womb as blastocysts (The Human Fertilisation & Embryology Authority (HFEA), 2020). IUI is considered less invasive than IVF; it involves injecting sperm directly into a woman's womb and requires less hormonal medication (HFEA, 2020) .

In the UK, approximately 1 in 7 couples may have problems conceiving; one of the available options for them are ARTs (NHS, 2020). The European Society of Human Reproduction and Embryology (ESHRE, 2018) reported that by July 2018, the global total of babies born resulting from ARTs was over 10 million. The International Committee for Monitoring ARTs (ICMART) estimated that between 1991 and 2014, there were more than 2 million treatments cycles performed and only around 0.5 million live births from IVF and ICSI (ESHRE, 2018). This suggests that the success rate of ARTs is still relatively low, leaving many people devastated after unsuccessful treatments. Similarly, in 2018, about 68,724 IVF cycles were performed in the UK, but the IVF average birth rate per embryo transferred was only 23% (HFEA, 2020).

Normally, the first source of information when someone cannot get pregnant 'naturally' in the UK is a GP (van den Akker, 2002). Then diagnostic tests to establish causality of potential 'infertility' are run. Depending on diagnosis, different treatments such as IVF, IUI or ICSI might be available. Typically, one cycle of IVF may cost over £5,000, and each cycle of IUI costs between £700 and £1,600 (NHS, 2020). How long a couple will remain in treatment may thus be determined by their finances or their eagerness to continue (Peddie et al., 2005). Eligibility for free NHS fertility treatments also varies between zero and three cycles based on location in the country, with 60% of cycles funded in Scotland but less than 30% in some parts of England. Local Clinical Commissioning Groups (CCGs) decide who can have fertility treatment and how many cycles (HFEA, n.d.), despite the National Institute for Clinical Excellence (NICE) advising that ARTs should be funded equally across England.

For some people, IVF or IUI are the last resort for pregnancy, and many people will never be able to afford ARTs, possibly increasing stress, depression and anxiety due to the potential lack of acceptance of 'childlessness' within some families or communities. Furthermore, when IVF fails, patients also need to deal with processing non-pregnancies, miscarriages or stillbirths. Throsby (2004) criticised universal definitions of ARTs for not mentioning the potential for multiple unsuccessful and invasive procedures and for lack of consideration of the financial strains. Within the medicalised approach, ART is often referred to as 'giving nature a helping hand'; as Thorsby (2004) argued, this construction obscures the fact that ARTs are complex, both morally and technologically, and IVF providers tend to discursively construct IVF as more successful than it actually is. IVF providers may aim to create these 'natural' and 'uncomplicated' constructions because as Spar (2006) argued, 'infertility' is a big business and could point to one of the potential reasons why 'fertility' is medicalised. The UK IVF market was valued by Allied Market Research (2019) at $514 million in 2018 and is predicted to reach $928 million by 2026. This is particularly relevant since IVF has become the treatment of choice for many who can pay, despite evidence that many 'infertility' problems can be effectively diagnosed and treated with cheaper and less invasive methods such as IUI or alternative hormone treatments (Ombelet et al., 2008).Throsby (2004) also highlighted how the relatively low success rates of ARTs make the experience predominantly one of 'failure'; this will be discussed next.

### 1.6 ARTs, gender and psychological distress

Since the beginning of the 1980s, a large number of studies have been carried out on the relationship between stress and ‘infertility’, most of them investigating couples undergoing IVF. Several studies have analysed gender differences in levels of psychological stress concerning ARTs and agreed that women are more vulnerable to this than men. For instance, in a cross-sectional sample of 613 Portuguese men and women seeking ‘infertility’ treatment, Martins et al. (2013) found that women experienced greater stress than men. In another quantitative research of 113 Turkish couples undergoing IVF, Akyuz and Sever (2009) investigated causes for termination of IVF after one unsuccessful cycle of treatment. For women the principal cause was ‘unsuccessful treatment and fear of coping' and for men ‘depletion of financial resources'; ‘psychological and physical burden' was the next most principal cause for women but not for men; ‘depletion of financial resources' was the least significant cause for women. These contrasts between genders highlights the differential psychological impact that IVF might have, which could indicate different emotional needs for women and men. There is also qualitative research on the socio-psychological impact of ARTs and the differences in the ways that males and females experience this. Ying et al. (2015) investigated the perceptions of Chinese couples going through IVF. They found that both genders see IVF as a hardship; however, women described the physical pain of the treatment as bearable compared with the emotional trauma. Another study identified ‘psychological burden' as the most important reason for women to terminate treatment (Rajkowa et al., 2006).

There are also numerous quantitative studies measuring psychological distress in women concerning ARTs. For instance, Wischmann et al. (2001) conducted a study in Germany which compared scores of depression and anxiety from a sample of women seeking ARTs with a sample recruited from a gynaecologist register, who were not seeking ARTs. They found that women from the fertility clinic scored higher on depression and anxiety than the sample of women who did not undergo ARTs. Additionally, most studies showed elevated depression scores for women whose ARTs treatments failed (Demyttenaere, et al., 1994; Domar et al., 1999; Smeenk et al., 2001; Strauss et al.,1992) and an increase in depression scores throughout IVF treatment (Chiba et al., 1997; Domar et al., 1999; Slade et al., 1997). It seems undoubtedly the case that for many patients—notably women—ARTs are a major emotional strain (Burns & Covington, 2006; Martins et al., 2013; Merari et al., 2002; Rajkowa et al., 2006).

Additionally, the literature also contains many studies looking at the potential consequences of these high levels of psychological distress for women undergoing ARTs. Wischmann (2003) and Pook et al. (2004) argued that ‘infertility’ in women is a source of psychological distress which in turn hinders fertility. A recent study conducted in Kazakhstan assessed the effect of stress, depression and anxiety in 304 women who underwent IVF (Aimagambetova et all., 2020). The results indicated that these three factors were higher than in the general population and high enough to put women at risk of developing clinical depression. Importantly, these higher levels of ‘infertility’-related stress correlated with lower IVF success rates. Furthermore, Boivin et al., (2001) reported that about 15–20% of all couples undergoing ARTs considered it stressful enough to require psychological counselling. The emotional struggles experienced during such treatments are often referred to by participants as an emotional roller coaster (Alesi, 2005; Widge, 2005). Wischmann et al. (2002) argued that psychosocial counselling should be offered at all stages of treatment and not only when it fails; moreover, the studies indicate that women undergoing ARTs may be particularly in need of psychological counselling.

The qualitative and quantitative literature on gender and psycho-social consequences of ‘infertility’ and specifically ARTs present these phenomena as devastating experiences. Nonetheless, the studies presented here have their limitations. Non-representative and convenience samples were common, resulting in some ethnic minorities being neglected and under researched. Most of the studies recruited participants from across different countries (UK, Germany, Portugal, Kazakhstan, Turkey and Sweden); however, they involved mainly white middle-class samples and failed to consider what implications the socio-cultural background of participants might have on results (Greil, 1997).

The quantitative research presented in this literature review provides a great volume of data about the socio-psychological strains but is limited in terms of data on the socio-cultural consequences of IVF, perhaps because the key focus of such research is to improve service delivery and gauge needs for psychological therapy (Burns & Covington, 2006; Greil et al., 2010; Jaffe et al., 2005). Quantitative studies also normally rely on the use of questionnaires, which may provide some indication about participants’ experiences but may also overlook the socially constructed nature of human life.

## 1.7 The relevance of the socio-cultural environment

Due to the wider accessibility and popularity of ARTs, conceptions of parenthood are changing and who become parents is diversifying (Greil et al., 2010). However, within the social sciences, curiosity about ARTs is a fairly new phenomenon (Parke, 2004). For several years, research on reproduction was led by biomedical science, focusing on what prevents conception, for example, whilst overlooking the sociocultural contexts in which reproduction happens. There are many reasons why such issues relating to ARTs were overlooked by the social sciences in the past (Van Balen, 2002). Firstly, 'infertility' was comprehended as a medical problem that needed to be cured and was later associated with ARTs; therefore, less attention was perhaps given to how couples experience the process of ARTs. Secondly, the dominant discourses of nature and science which persist in representations of ARTs and the 'truth' status of those discourses are overwhelmingly powerful and uncontrollable, producing contemporary ethical, moral and legal problems (Throsby, 2004); ARTs, and especially IVF, often divides the fundamental understanding of motherhood into social, gestational and genetic categories through the technologies of egg donation or embryo transfer, and the status of frozen and stored embryos remains highly contentious. This has created new legal debates regarding disputes over the guardianship of embryos in case of a couple's separation (Overall, 1993) or the status of abandoned embryos (Hartouni, 1997). Additionally, pre-implantation genetic screenings of embryos raise ethical and moral debates about the bases upon which particular embryos are selected for transfer (Throsby, 2004). From the feminist perspective, what is striking about these debates is that women are absent from them: during the parliamentary debates about the legislative framework of ARTs in the UK, the talk was focused on embryos, eggs and sperm and not women (Franklin, 2005; Throsby, 2004). Thirdly, there are still social implications such as the stigma and taboo associated with talking about 'infertility' and ARTs (Khetarpal & Singh, 2012). Even in western countries, 'infertility' is still an issue that is not easily discussed with others, even with researchers (Inhorn, 2013; Nene et al., 2005; Widge, 2002).

However, science has more recently become interested in ARTs from a social-scientific perspective which focuses on the experience, and on encouraging conversation (Greil et al., 2010). Based on more recent sociocultural research, it is argued that for many people, parenthood is a crucial part of their lives, and all societies emphasise the importance of childbearing (Greil et al., 2010). Nevertheless, societies differ in regard to why having children is considered important, what the 'right' number of children is, the importance of a child's sex, and whether ‘infertility’ is considered a problem. Although ‘infertility’ may lead to significant suffering, ARTs have opened up prospects for people in the West who experience fertility problems. When they are still unable to achieve pregnancy following a course of ARTs, adoption is often pursued (Greil et al., 2010; Spar, 2006; Throsby, 2004). In non-Western countries the situation can differ, especially in relation to women, who may be subjected to poor treatment if they do not have children. For instance, in Egypt, India and Pakistan, remarrying has been reported as one of the solutions for childless men, highlighting the importance of patrilineage (Bhatti et al., 1999; Inhorn, 1996; Pashigian, 2002). In India and Pakistan, ‘infertility’ can be given religious explanations, thus resolution involves asking for help from a spiritual healer (Bhatti et al., 1999; Gerrits, 2002; Neff, 1994).

The meaning of childlessness may thus vary across societies and may be moderated by sociocultural and religious factors. In the West, ‘infertility’ is now defined as a medical issue and this is a result of medicalisation of reproduction and women’s bodies in general, medical progress within fertility clinics, the demand for services, delays in childbearing, and ARTs being presented as a ‘miracle’ answer to ‘infertility’ (Greil, 1991). Additionally, feminism criticises the ARTs debate, where embryos are positioned at the centre and women are silenced and instrumentalised as suppliers of eggs and embryos. From this perspective, women are objects of treatment and absent as active agents in that process (Franklin, 2002). All of this is relevant when considering the importance of placing women at the centre of exploring the meaning of ARTs and constructing a new discourse of women as active and liberal agents in their reproductive journey.

### 1.7.1 ARTs within social, cultural and religious contexts

In the past 15 years, research has moved towards situating ARTs in the social context of the participants (Callister, 2006; Lee et al., 2010; Lee & Kuo, 2000). For example, it has been shown in a sample of Chinese participants who underwent ARTs that women’s desire to have a child was stronger than men’s and women were the ones taking the responsibility for a couple's ‘infertility’ (Ying et al., 2015). Inhorn and Patrizio (2015) say that in shaping the experience of ‘infertility’, gender roles are more important than the matter of who is infertile, and this is important because it reveals that what is primarily a social variable carries greater weight than a clinical diagnosis. These gender roles and characteristics contribute to understanding ARTs as a socially constructed process (Greil, 1997). Lee et al. (2010) applied a quantitative method to analyse 66 women who experienced at least one failed IVF. The results of this study were analysed in the context of 'Chinese cultures'; it was found that women found it problematic to express their feelings directly due to cultural conservatism and familial and social expectations to be patient; thus, somatization of emotions had a high prevalence (Lee et al., 2010). Similar responses in relation to ARTs and 'Chinese traditional childbearing attitudes' were found by Lee and Kuo (2000), Lin et al. (2014) and Lin et al. (2016).

Within Chinese traditions it is emphasized that conception of new life gives meaning to human existence and purpose to marriage (Lee et al., 2010); motherhood is considered the most important role women can have (Lee et al., 2010). This idea has been also recognised among people who identify as coming from 'Hispanic', 'West' and 'South Asian cultures' (Bhatti et al., 1999; Meleis & Sorrell, 1981). Due to this, gaining an understanding of the sociocultural aspects of childlessness and ARTs have valuable implications for practice (Callister, 2006). Indeed, research by Lee et al. (2010), Ying et al. (2015) and Lee and Kuo (2000) suggest that there is a greater need for awareness in CoP of the socio-cultural background of clients undergoing ARTs to apply informed interventions.

What is also an important limitation of research presented here is that studies on the consequences of 'infertility', are mainly based on the treatment seekers (Greil, 2011). This means that these studies provide no information about the other significant proportion of population who did not seek any medical fertility interventions. As Grail (2011) indicated current research of 'infertility' and ARTs is representative of a subset of infertile women who have strong desire to become pregnant and the social and material resources to undergo the fertility treatments. Therefore, most of the characteristics of 'infertile' women such as for instance, highly distressed describes only treatment seekers.

Cultural constructions of 'infertility' have also been explored in Nigeria. Dimka and Dein (2013) interviewed 14 'infertile' and fertile males and females from Christian and Islamic backgrounds in Nigeria. Focus groups were held with women and men, all of whom were recruited randomly from marketplaces. A common belief of the participants was that children are a natural occurrence and the main reason to have them is for physical, financial and emotional support in old age. Perceptions of the reasons for female 'infertility' revolved around spiritual or supernatural reasons such as the will of God or curses, running out of eggs, having bad blood, and extramarital relationships, whilst fewer causes of male 'infertility' were identified (supernatural, bad blood, and weak sperm). It was also concluded that 'infertile' women were more vulnerable to verbal and physical abuse than fertile women. This study was conducted on a relatively small sample; however, the data collected accord with previous longitudinal research analysing the experience of ‘infertility’ in Nigeria. Hollos (2003) conducted an extensive ethnographic, qualitative and quantitative study over 20 years with 150 households. This research aimed to broaden understanding of the consequences of female ‘infertility’ on the individual level in sub-Saharan Africa. Results showed that ‘infertility’ prevents these women from attaining full womanhood and gaining respect in the community, due to divorce, polygamy and abandonment, for example. Yet because the data were collected within households this takes away the focus from women. Additionally, both studies presented here by Dimka and Dein (2013) and Hollos (2003) focuse on ‘infertility’ rather than on artificially reproductive technologies.

There is a tendency to separate science from religion and to explore these phenomena independently; however, people might not separate their experiences in this way (Layne, 2006). Religion also shapes family life, women’s roles and the meaning of childbearing (Layne, 2006). Inhorn (2012) showed that ‘infertility’ is a source of stigma in ‘Arab-Muslim societies’. Some Orthodox Jews and Christians believe that children are given by God to the deserving ones; thus, ‘infertility’ is sometimes constructed as shameful and a punishment from God (Layne, 2006). Islamic scripture says that your heaven lies under the feet of your mother (An-Nasai, n.d.), which might be understood as an elevation of a women’s status when she becomes a mother; this might suggest why ‘infertility’ is often perceived as the worst affliction for Muslim women (Bhatti et al., 1999). In this context, Bhatti et al. (1999) conducted a qualitative study of ‘infertile’ women in Pakistan. Through interviews with 17 women, they explored the contextual factors influencing the “health-seeking behaviour” of ‘infertile’ women of lower socio-economic status. The research indicated that women who struggle to conceive within pro-natalist societies are notably vulnerable, and that religious background may also contribute to how these women are socially pressured, isolated and shamed.

In Judaism, another major world religion, reproduction is one of the most important religious and moral responsibilities; Israel is a specifically pro-natalist society, supporting and funding IVF and surrogacies, even for single women, which seems particularly important considering Jewish family structures (Birenbaum-Carmeli, 2004; Kahn, 2000; Kohler, 2000). Remennick (2000) interviewed 26 ‘infertile’ Jewish women in Israel, exploring their experience of childlessness. To cope with their “hidden disability” (Remennick, 2000, p.821), women were selective in disclosing their ‘infertility’ or avoided exposing it altogether. Remennick (2000) holds that resistance to the stigma of childlessness is only achievable when women dare to question the importance of becoming a mother, which is not the case with most Israelis. She argues that only a few educated, professional women have the money and emotional awareness for resisting the stigma; this can be also understood through writer Jana Sawicki’s (2020) feminist lens as she talks specifically about ARTs, power and women, using Foucauldian concepts. She argues that ARTs can be understood through the concept of biopower (explained further in 2.5.3). Power in this context is not applied as explicit violence but appears through disciplinary practices over bodies and governing practices over populations. In this way, power is seen as productive and the medicalisation of ARTs creates specific types of abnormalities such as ‘infertility’ or ‘women’s biological clock’. Thus, Remennick’s participants could be seen as ‘self-disciplining', adhering to what has been constructed as ‘normal’ or ‘acceptable’ by pursuing lengthy and difficult ARTs, whilst only the minority had the ‘mental or financial capacity’ to resist the biopower. Moreover, this research focused mainly on secular Israeli women, most of whom were employed and whose lives, therefore, were not focused solely on the family. Therefore, considering the undeniable prescription of childbearing as females’ main life purpose in Judaism it seems that this research is lacking the perception of religious women who are unable to give birth.

Inhorn (2012) explored ‘infertility’ in another strongly pro-natalist society, Muslim Egypt; the focus of this field research was male ‘infertility’ and how this affects female partners. Semi-structured interviews were conducted with males and females from lower and middle-to-upper classes, investigating 66 cases of ‘infertility’. Like in China and Bangladesh, it was found that Egyptian women bear the burden of ‘infertility’ irrespective of who is ‘infertile’ in marriage, indicating deeply gendered social consequences of ‘infertility’ (Inhorn et al., 2012). This research demonstrated how male ‘infertility’ in Egypt have detrimental effects on women’s lives who, by virtue of marriage, must share or take the whole responsibility for men's ‘infertility’ to protect their masculinity (Inhorn et al., 2012; Inhorn &Van Balen, 2002); thus, Inhorn et al. (2012) argued, the patriarchy can impact women’s experience of childlessness.

The studies presented here show that negative experiences of ‘infertility’ and ARTs are magnified by the strong social, cultural and religious imperative of childbearing, particularly in certain societies (Hollos 2003; Inhorn et al., 2012; Remennick, 2000). These negative constructions and uneven power relations will surely have damaging consequences on some women’s’ well-being; this is specifically of interest to CoP, which aims to lessen distress by adopting a holistic approach. This suggests the importance of acknowledging sociocultural aspects when researching ARTs; additionally, more research might be needed to explore the pro-natalist ‘Muslim and Judaist societies’ where ‘infertility’ is seen through a lens of stigma.

### 1.7.2. ART and social support

The literature presents women as psychologically distressed to a great extent by their inability to fulfil their culturally sanctioned roles as ‘mothers' (Inhorn, 1996). Sometimes their situation is worsened by social attitudes towards childlessness and ARTs, often depending on cultural and religious values (Inhorn & Fakih, 2006). Studies by Akizuki & Kia (2008) and Mindes et al. (2003) have found that ‘infertility’ and undergoing ARTs are associated in both genders with psychological distress, which is in many cases aggravated by negative reactions in the social environment. Likewise, in a quantitative study of 213 couples who were seeking ARTs, Martins et al. (2013) found that women associated ‘infertility’ stress with stressors in their socio-cultural environment. It has also been shown that ‘infertile’ women can be blamed or abandoned by their spouses and families (Inhorn et al., 2012; Ying et al., 2015), which adds to their already distressing experience of being unable to conceive. Yet studies such as Ying et al. (2015), who explored the support between spouses going through IVF, suggest that couples who share feelings and support each other feel that this increases their psychological well-being and improves their marital relationship.

In a unique ethnographic study, Isupova (2011) explored life experiences of childless Russian women using IVF and their need for support within their socio-cultural environment by analysing forum discussions. Isupova used hermeneutic text analysis with elements of the ethnography of communication to study discourses in an online forum. ‘Distancing’, ‘minimizing’ and ‘blaming’ were commonly used to describe the participants’ experiences in relation to their social networks. Most participants reported that they mostly received undermining support and that other people perceived their situation negatively. When possible, the women hid the fact that they were going through ARTs, and most women suspended their relationships with people who they perceived as judgmental in relation to their health strategy or who gave unwelcome advice regarding ARTs. As Isupova suggested, being a member of this virtual community enabled them to remove themselves from such people and increase their feelings of belonging and solidarity. This research shows the presence of negative societal attitudes towards women who undergo ARTs, and the negative impact of these in women, as well as their need for support, belonging and acceptance.

Recognition of the psychological burden on 'infertile' women and the need for psychological and social support when undergoing IVF treatment is important, since accessing such positive social support can increase the psychological well-being of ARTs patients and increase their chances of success (Williams et al., 2007). Moreover, social support plays a critical role in adjustment after failed IVF (Throsby, 2004; Verhaak et al., 2005).

### 1.8 ARTs and Ethnicity

This section provides a brief summary of recent research regarding ARTs and 'infertility' within ethnic minorities. It then presents an outline of the South-Asian communities in the UK, containing information on migration, socio-economic position, employment, household, religion, family structures and marriage. Finally, it discusses health patterns in minority ethnic groups and how these have been interpreted by social scientists. Through this, I hope to present how they might potentially impact South-Asian-Muslim women in the UK in context of ARTs.

Whilst there have been studies conducted within ethnographically specific areas such as Egypt, Israel, Nigeria, Bangladesh and Pakistan, according to Barnreuther (2021), ethnic minorities in the UK in relation to 'infertility' and specifically ARTs "[have] remained invisible" (p.3). This omission contravenes CoP's intercultural approach that allows members of minorities to hold on to their differences (Bell & Tribe, 2018). Additionally, substantial quantitative research within ethnic minorities shows lower success rates of live birth after undergoing ARTs compared to Caucasian groups (Almeida Ferreira Braga et al., 2015; Jayaprakasan et al., 2014; Purcell et al., 2007; Van de Wiel, 2020), yet the reasons for this remain unclear. Thus, there have been calls for qualitative sociocultural research to further investigate this phenomenon (Barnreuther, 2021; Dhillon et al., 2015; Jayaprakasan et al., 2014).

In 2006, Inhorn and Fakih examined the ethnic minorities of men who identified as African and Arab American, in the context of 'infertility' and social, structural and ideological factors. Some of the significant barriers affecting 'infertility' care were economic, communicational and cultural, as well as social discrimination in wider USA society, particularly after September 11, 2001 (Inhorn & Fakih, 2006). Participants also showed a preference for being seen by an Arabic-speaking, American Muslim physician, who they believed would respect their religious and cultural beliefs. Additionally, Armstrong and Plowden (2012) highlighted in their qualitative research that racial and ethnic inequalities have been described in all fields of medicine, and despite progress in ARTs, the literature has continued to reveal worse success rates' in minority groups. This suggests a need for more research within minorities to explore whether lack of social support or other socio-cultural-environmental factors contribute to poorer outcomes of fertility treatments.

Research also suggests that religion may influence both the formation of ethnic identity (Ramji, 2006) and the experience of 'infertility' (Dutney, 2007; Roudsari et al., 2007). This is important in light of the current research because all participants recognised themselves as Muslim, and according to the 2011 UK Census, 92% of respondents in South-Asian Pakistani and Bangladeshi groups and 13% in the Indian group described themselves as Muslims, indicating a large Muslim population in these ethnic groups. Additionally, mainstream Islam (Sunni and Shia) accepts IVF and related techniques of ART (Culley et al., 2012) and thousands of Muslim test-tube babies are born every year; however, across different Islamic countries and societies, there are still legislative inconsistencies. For instance, only Iran and Lebanon accept gametes donation or third-party reproductive assistance, whilst most other Muslim countries prohibit this, as well as surrogacy (Inhorn & Tremayne, 2016).

A significant number of new studies in this area discuss various issues of 'infertility' and ARTs in South-Asian-British ethnic minorities (Culley & Hudson, 2006, 2012; Culley et al., 2007b, 2013; Culley et al., 2012; Culley et al., 2006, 2007c; Hudson 2008). They are all based on data collected in the first major study of ethnicity and 'infertility' in the UK by Culley et al. (2004), which examined the public understanding of 'infertility' within Pakistani, Indian and Bangladeshi communities and clinics. Initially, 14 single sex focus groups with a total of 93 participants were carried out to explore how 'infertility' is perceived by randomly recruited people within the community. Later, semi-structured interviews took place with 37 women and 13 men who had experienced 'fertility' problems and undergone ARTs. Additionally, 23 'infertility' healthcare professionals were also interviewed about their views of cultural differences and how fertility clinics deal with such differences in everyday practice. The collected data were analysed using a qualitative, interpretive approach. The focus groups revealed that childlessness is highly stigmatised within these communities and that 'infertile' couples are socially scrutinised by family and community, which is consistent with previous research on Muslim communities and ARTs (Inhorn & Van Balen, 2002; Reissman, 2000; Remennick, 2000). Also, women were found to take the responsibility for infertility in couple, and participants' understanding of ARTs was superficial, showing generational and religious differences. Furthermore, the data collected from interviews revealed concerns about stigma attached to childlessness and that, as in other communities, the experience of ‘infertility’ is associated with increasing distress and feelings of disruption and loss of control, particularly for women. The ARTs process was described as an emotional, practical, and financial struggle.

Similarly, Culley et al. (2007c) discussed perceptions of infertility issues and attitudes towards ART in the community using data collected in the 2004 study. This research highlights the stigma associated with infertility which, as the authors argued, may also extend to ARTs; thus, couples might be hesitant to talk about their fertility journey. Furthermore, younger generations of participants identified stress, obesity and sexually transmitted diseases as obstacles to getting pregnant, whereas older people included religious or iatrogenic causes. Also, most participants talked about infertility as a phenomenon that can be approached medically. However, the analysis showed a general level of dissatisfaction with GP services, which is consistent with new research suggesting that primary care has not been effective in providing accessible care for South-Asian communities (Hussain-Gambles et al., 2004). The findings of Culley et al. (2007c) and Culley et al. (2004) are particularly relevant to the development of my study, as they emphasise the need for more research on the socio-cultural environment in the context of ethnic minorities and ARTs, and for healthcare providers and policy makers to take account of cultural differences in their practices. However, this research focused mainly on issues related to ‘infertility’, treating ARTs as a secondary problem. Additionally, Culley and Hudson collected data within general population of South-Asian communities rather than focusing only on women. This is also expanded on p.19.

### 1.8.1 British South-Asian-Muslim

The figures from the 2011 Census (2021) show that South-Asian communities constitute the largest minority in the UK, with 4.5 million (7.5%) people in England and Wales alone. Furthermore, the most socio-economically accomplished South-Asian groups are Indian. This is in contrast with relatively poor socio-economic levels in the Pakistani and Bangladeshi groups (Nazroo, 2006; Peach, 2006). Additionally, Pakistani and Bangladeshi minorities have the lowest level of qualifications and experience higher rates of unemployment when compared with other minorities (Peach, 2006). This would arguably make them more disadvantaged in terms of accessing ARTs when it is not free. Culley et al. (2004) reported that eleven out of twelve couples who used ARTs had been required to pay for at least some components of their treatments and they all reported that this had contributed to financial hardship.

Data on health differences also suggests that members of Pakistani and Bangladeshi groups have worse self-reported health compared with other minority groups. These disparities can potentially be explained by socio-economic status, migration processes, racism, and cultural and biological factors (Smith et al., 2000); but again, such disparities could potentially affect fertility issues. In 2018, the percentage of White patients receiving IVF treatment was lower than their proportion in the UK population as a whole (78% and 87% respectively), whilst the percentage of Asian patients who received IVF was double that of their proportion in the UK population (14% and 7% respectively). (HFEA, 2018). This shows that there is clearly demand for ARTs treatment within the South-Asian minority in the UK. Given these statistics and the numerous studies about low success rates of IVF within this ethnic minority, it seems important to extend our knowledge and understanding of this under-researched population in the context of ARTs.

Finally, research on access to health care highlights the institutional racism that happens when the regulations of a healthcare system lead to discrimination for ethnic minorities; such structural discrimination is not always instantly apparent, and is instead rooted in taken-for-granted institutional regulatory practices (Atkin, 2018). Atkin talked about racism within the NHS that impacts ethnic minorities via common normalizing practices depicting South-Asian people as “calling out doctors unnecessarily”, being “trivial complainers” and “time wasters” (Atkin, 2018, p. 11). These opinions can serve as obstacles to accessing services for South-Asian people, given that clinicians and social services professionals hold significant discretion in their everyday work. Atkin (2018) also acknowledged that not every aspect of poor health can be attributed to ethnic background; thus, he urged for more reflective research looking at these issues. Also, Hussain-Gambles et al. (2004) argued that if populations from ethnic minorities are not consistently encompassed in trials, the generalisability of results is compromised.

This literature suggests that it is important to consider the socio-cultural aspects of my participants’ environment; however, I am determined to avoid essentialising South-Asian-Muslim women as being part of a homogenous ‘culture’ that strictly fixes their practice and experiences (Culley et al., 2013). Health service research is often criticised for over-relying on cultural essentialism, setting differences between groups of people that are actually more fluid; some differences between cultures might seem more distinct than they really are (Phillips, 2007). Cultural essentialism overlooks the diversity within cultures and minimises the presence of variations and hierarchies of power within racialised minority groups (Culley et al., 2006). New research acknowledges minority women as active agents and describes the ways in which women are able to use social and cultural resources to resist or challenge ‘traditional’ elements of culture (Ramji, 2006; Phillips, 2007; Hudson, 2008), which I also hope to embrace. Thus, in this research I aim to show how culture can influence and shape behaviours without necessarily determining them.

### 1.9 Rationale for the study and relevance to CoP

This section will highlight the limitations of the current literature, identifying gaps related to population, feminist perspective, topic, and methodology; it will also locate this study within the current body of knowledge to support its rationale and demonstrate its relevance to CoP.

Firstly, it appears that the body of literature currently available on ARTs in the UK mostly overlooks ethnic minorities (Barnreuther, 2021; Culley et al., 2013; Hudson, 2008), as most research was conducted with white, middle-class participants (Earle & Letherby, 2007; Franklin, 2002; Greil, 1991; Greil et al., 2010; Sandelowski & de Lacey, 2002; Inhorn & van Balen, 2002; Thorsby, 2004). Nevertheless, ethnic minorities may attach different meanings to ‘infertility’ and ideas about the acceptability and appropriateness of ARTs in comparison with White British communities (Culley et al., 2007a). Thus, being ‘infertile’ and belonging to a minority in a country such as the UK could potentially contribute to stressors when undergoing ARTs, showing a potential gap in the available literature and the need for further exploration of ARTs in the context of ethnic monitories in the UK. Furthermore, considering that South-Asian community is the largest in the UK, the lack of research within this group seems even more concerning, and therefore it is my intention to use this opportunity to contribute to wider understanding of this invisible research group. Thus, narratives from this research could potentially enrich society and contribute to the development of a pluralistic framework, informing practice within CoP and fertility clinics.

Secondly, the study of ARTs was intertwined with ‘infertility’ in most of the research, whilst I argue that ARTs could be approached as a separate aspect of fertility that can be a ground for distinct and specific issues which, if not explored separately, could remain ‘invisible’. For instance, Hudson and Culley are significant researchers in this area who specifically studied ‘British South-Asian’ communities and ‘infertility’. Their main concerns were access to fertility care within the NHS, lay understandings of ‘infertility’, how these arise and what impact they might have on treatment-seeking behaviour (Culley & Hudson, 2006, 2012; Culley et al., 2007, 2013; Culley et al., 2012; Culley et al, 2004, 2006, 2007c; Hudson 2008). Although ARTs formed part of these inquiries, the researchers were primarily interested in 'infertility', which seemed to be used as an umbrella term covering phenomena such as reproduction, childbearing and ART. There is, therefore, a dearth of literature exploring ARTs exclusively within South-Asian women. I argue that studying ARTs in this way might potentially uncover an additional layer of complexities related to moral and ethical dilemmas within this specific population, culture and religion. These dilemmas may become more problematic in societies with strong religious, patriarchal and pronatalist traditions. Many studies, for instance, mentioned the ethical issue of religious permissibility of gamete donations and how Muslim societies differ on this issue (Culley & Hudson, 2009; Culley et al., 2007a; Franklin, 2002, 2005; Inhorn 2012; Inhorn & Fakih, 2006). Potentially this studies are lacking the an important perspective of how ethical or moral concerns of South-Asian-Muslim women undergoing ART might be impacting them. For instance they might be required to endure numerous tests requiring exposure in the presence of male doctors, considering the religious and cultural narratives regarding 'modesty' that include specific dress code, 'appropriate' conduct and gender segregation (Inhorn, 2012; Mujallad, 2016; Sered & Sered, 2000); as Inhorn (2004) said, "Muslim women prefer to avoid physical examination by a male doctor" (p.10). Exploring this gap in the research could assist in understanding how women from this minority group in the UK construct ARTs within their specific culture and religion, which is in line with CoP pluralistic and intercultural approach.

Thirdly, the literature reviewed in the current thesis, and specifically the work done by Hudson, Culley and others within the British South-Asian communities, focused on explorations of perceptions of the general public, couples, women and medical staff from fertility clinics about 'infertility' and ARTs. However, none of the reviewed studies focused exclusively on the narratives of women concerning only ARTs. In line with the feminist view of placing women at the centre of the debate, I would like to approach this gap in the literature by paying specific attention to British South-Asian-Muslim women in the context of ARTs. I hope that by doing this I can bring a new layer of awareness to the issues that surround fertility treatments. Additionally, by bringing the focus onto women in current research it should not be assumed that male experiences are not relevant or less important. As Throsby and Gill (2004) argued men are also made invisible in context of ARTs, but perhaps are not predominantly tied to the problematic outline of reproduction therefore I have chosen to focus this research, on women.

Fourth, a significant number of studies approached the topic with a quantitative methodology, focusing on the study of patients and offering substantial data on the socio-psychological impact of specifically IVF as one of the most popular forms of ARTs (Burns & Covington, 2006; Greil et al., 2010; Jaffe et al., 2005). Quantitative research offers what could be argued to be a medical model of the psychosocial consequences of undergoing ARTs. This method of collecting and presenting data may divert attention from the available discourses which shape how people experience life (Greil et al., 2010). Perhaps researchers with a medical approach to 'infertility' see it as a physical condition; however, I argue that bringing a social constructionist lens to the current topic could enhance our understanding of 'the reality' of women moulded by medical variables and by their social environments (Greil, 1997; Greil et al., 2010; Hudson, 2008). Additionally, this way of paying attention at the specific socio-cultural environment could potentially help to avoid essentialising ethnic minorities as single, homogeneous 'cultures' (as discussed in 1.8.1).

CoP constructs meaning by drawing upon various cultural discourses; this pluralistic and inter-cultural approach acknowledges numerous ways of looking at psychological and scientific problems (McLead & Cooper, 2011). Thus, enhanced comprehension of the available social constructions of ARTs by South-Asian-Muslim women could extend the knowledge and ability of medical staff to take the sociocultural context into account in their practices. It is my intention that by becoming aware of the available social discourses that construct ARTs, particularly in the South-Asian-Muslim community, clinicians could develop more informed and culturally sensitive interventions to support women who may be struggling with the complexity of a multi-layered experience and help create a de-stigmatised identification, which could ultimately benefit their psychological and general wellbeing. This seems to be strongly aligned with the values of CoP, a discipline which seeks to minimise distress by addressing multiple factors, particularly in relation to social justice, which lies at the centre of our profession (Bell & Tribe, 2018).

## 1. 10 Research Questions

This study aims to advance critical understanding of how South-Asian-Muslim women construct ARTs in the context of their socio-cultural and biomedical environment, and the implications of this for subjectivity, focusing on the use of language. Specifically, it aims to address:

1. How do South-Asian-Muslim women talk about ARTs in the context of their socio-cultural environment?
2. How do South-Asian-Muslim women undergoing ARTs become constituted through the available discourses?
3. What are the social practices guaranteed by these discursive constructions?

The following chapter will present the methodology used to answer these questions, including ethics, participants, recruitment, interviews, steps of analysis and reflexivity.

# Chapter Two: Methodology

## 2.1 Overview

This chapter begins with a reflection on my methodological and epistemological approach to this research, then information about the research procedures will be outlined, including recruitment, data collection, ethics, transcription, and analytic steps, concluding with reflexivity.

## 2.2 Epistemological and ontological position

For this research, I have chosen the epistemological position of critical realist social constructionist (Willig, 2012) with a feminist stance (Al-Hakim, 2005, 2013; Gough & McFadden, 2001; Lennon & Whitford, 2002), which I will now explain further, together with my rationale.

The field of CoP places great importance on a researcher's understanding of their ontological and epistemological positions and these being congruent with methodology to ensure quality and rigor (Harper, 2012). Additionally, the BPS (2017) definition of CoP stresses the prominence of humanistic values that unite with socially constructed 'truths' (Kasket, 2012; Orlans & Van Scoyoc, 2009), creating a devoted curiosity about the human condition and relatedness (Cooper, 2009). Thus, CoP commits to recognition of subjective experiences facilitating empowerment within sociocultural contexts (Cooper, 2009). Additionally, its pluralistic embracement of therapeutic models creates tensions, reflective debates and a critical stance opposing scientific modernism. Therefore, as a CoP researcher, it is important for me to take a stance that can accept uncertainty and contradictions, subjectivity, individual narratives and differences, and recognition of power imbalances.

Furthermore, from a critical realist position, I aim to go beyond the analysed text, critically reflecting on ontological claims about human existence and epistemological claims about how knowledge is produced. This is in opposition to a realist view arguing that analysed data are independent from researcher's interpretations (Harper, 2012). Therefore, I have chosen to explore the narratives of my participants with a reflective, realist critical stance that assumes that each effort of 'knowledge' creation is impacted by the researcher's subjectivities. Also, as Parker (1999) argues, the critical realist position facilitates considerations of power as institutional and historical structure; this is specifically relevant within the NHS and sociocultural contexts of the current research. Additionally, it is widely agreed that a social constructionist stance involves a critical approach to knowledge that is taken for granted, which considers historical and cultural contexts, and which recognises that knowledge is created by social processes and actions (Burr, 2006); this aligns well with CoP's intercultural approach (Bell & Tribe, 2018). Social constructionism also recognises the role of human ethics and sociocultural powers in the process of rearranging and constructing realities (Burr, 2006; Hollway, 1989; Kimball, 1995), which position individuals in certain ways, sustaining inequalities of power (Harper, 2012). This is particularly relevant for my study, as it places power at its centre.

Finally, the feminist stance is important in this thesis because of its approach to knowledge and power; for instance, feminists Lennon and Whitford (2002) argued that to legitimise certain knowledge-claims, systems of authority and exclusion/segregation are needed. In Western countries, there has been a range of secular, socio-political movements aiming to settle the economic, political, and socio-personal equalities of the sexes. Islamic Feminism also advocates women's rights, but it grounds itself within an Islamic framework; it advocates the Quran's equality doctrines and questions patriarchal interpretations of the book (Al-Hakim, 2005). Therefore, taking a social constructionist stance informed by feminism means enabling the visibility of women as 'worthy of investigation' and acknowledging the necessity for a shift within social justice by readdressing power imbalances; these, again, are at the centre of CoP's social justice agenda (Bell & Tribe, 2018). Thus, this thesis aims to explore women's constructions of ARTs, acknowledging the power relations and subjectivity this produces.

### 2.3 Rationale for Methodology

I have chosen to use a qualitative methodology because it aims to understand what is going on for people and between them, and the meanings that they convey in social contexts, rather than defining variables or cause-effect relationships (Willig, 2013). As described in chapter one, there is extensive research on 'infertility' and ARTs based on a modernist approach to science. Thus, I have adopted FDA to address my research questions, as it is a method that privileges a social constructionist view of knowledge which emphasises how social action creates power, 'truth' and discourse. There are alternative methods that I could have chosen, such as Interpretative Phenomenological Analysis (IPA; Smith, 2004); however, this would not allow exploration of the wider social-cultural contexts of the topic. IPA has been criticised for lacking acknowledgement of the vital function of language in lived experiences and for limiting understanding because it aims to explore lived experiences without elucidating why they occur (Tuffour, 2017). I also considered Discursive Psychology (DP); however, this method aims to put attention exclusively on discourse itself: how it is constructed, its purposes, and the consequences of different discursive constructions. Within DP, memory, personality, and attitudes are known to be shaped via language, ignoring other factors that might potentially impact identity outside of a person's dealings and use of language (Harper, 2012).

Foucault (1961) talks about silence as a form of oppression and as a key feature in the discourse of power relations, through which society marginalises certain groups and behaviours; therefore, FDA seems appropriate for investigating the invisible/silenced minority (Arribas-Ayllon & Walkerdine, 2008) in qualitative research on South-Asian-Muslim women. Further, there is a strong pronatalist and patriarchal tradition within 'South-Asian-Muslim' societies, which impacts certain individuals' status and recognition (Cross-Sudworth, 2006); specifically, for many women struggling with 'infertility', this may provoke shame and act as an obstacle to obtaining any help such as therapy or ARTs (Baraitser, 1999). In this context, FDA offers the chance of paying attention to the social impact of power and hierarchy, by focusing on language with a critical lens, which would allow to analyse the conditions of possibility out of which ARTs may be constructed as something that needs to be silenced (see Appendix I). Thus, using FDA can help localise dominant and subjugated discourses and enable exploration of how discourse impacts subjectivity and practices. Additionally, how local knowledges are ranked and what composes 'true' knowledge can be analysed using FDA (Sarup, 1993). Therefore, I have chosen this method for its emancipatory characteristics and its focus on political frameworks and power relations congruent with CoP's aim of redressing power imbalances. (Cooper, 2009; Casket, 2012).

## 2.4 Foucauldian Discourse Analysis

FDA is a variant of Discourse Analysis with its origins in the work of Michel Foucault (Arribas-ayllon & Walkerdine, 2008). FDA adopts a critical stance towards language and is interested in the role of language in shaping discourses and social and psychological life (Willig, 2013). It focuses on the analysis of discourse as a system which constructs objects in specific ways, shaping peoples' realities (Parker, 1992). Correspondingly, an object is at the centre of discourse, and discourse provides culturally available and shared ways for communicating about that object. Discourse also offers positions that individuals can take up or resist concerning an object; these are known as subject positions. These simultaneously enable and constrain the way individuals, understand their thoughts, feelings and experiences (subjectivity) and behaviour (practices) (Arribas-Ayllon & Walkerdine, 2008; Willig, 2013).

The role of FDA within psychology is to be critical about psychology as a body of knowledge and to provide the discipline of CoP with tools for conducting research (Willig, 2013). Although there is no formalised approach to FDA, there is a common understanding regarding what 'discursive practice' includes (Arribas-Ayllon & Walkerdine, 2008); these are: (1) recognising mechanisms of power and how these operate; (2) a historical enquiry, named 'genealogy'; and (3) analysing practices in which subjects are formed (subjectification). In other words, FDA helps to understand contrasting 'subject positions' within discourse and power, as well as how these positions limit what is thinkable or sayable about a social object or practice at a particular historical time (Arribas-Ayllon and Walkerdine, 2008). This approach allowed for diverse silent subjects to be heard, such as patients, homosexuals and the 'mad', by connecting them with certain practices in which they were placed by the focal point of the idea or action and the historical era (Arribas-Ayllon and Walkerdine, 2008). This directed attention towards constructions of subjectivity and institutional practices; the concept of discourse and power created ways of diffusing 'the subject' between the variety of discourses, speaking positions, and power relations that create the boundaries of 'who we can be/are' (Arribas-Ayllon and Walkerdine, 2008).

Previous conceptualisations of power saw it as oppressive; however, Foucault saw power as a productive force generating settings within our social world, privileging specific discourses over others, and producing knowledge, subjects, and institutions (Gordon,1980; Jorgensen & Phillips, 2002). As Foucault argued, "Individuals are the vehicles of power, not its points of application" (as cited in Balan, 2010, p. 38)

This idea of power has two main claims: 1) a network of relations within the whole society, rather than only dealings between the oppressed and the oppressor; 2) people are not just the objects of power, but they are the point where power and resistance to it are applied (Balan, 2010). This new concept of power and knowledge was embraced in England as 'social-constructionism' and allowed the discipline of psychology to move away from discovering objective truth and towards questioning the conditions of possibility for psychological knowledge (Kendall & Wickham, 1999).

Foucault’s influence is also seen in post-structural and feminist theories (Weems, 2005). Stanworth (1987) holds that the main concern is not whether ART is technologically invasive to women’s bodies; rather, it is about creating political and cultural settings in which ART can be used by females to construct a discourse of reproduction fitting with their own definitions. Due to normalising conditions in women’s environment, she argues, ART can become a threat to women, but this can be overcome by engaging them in the technological processes and providing information and resources.

## 2.5. Foucauldian ‘toolkit’ for analysis

Foucault studied how different kinds of subjectivity are formed by certain practices, and this directed him to link discourse to social groups of silent subjects such as homosexuals, the ‘mad’ and prisoners (Arribas-Ayllon & Walkerdine, 2008). Moreover, enquiry into the effects of discourse has shown diverse connections between “institutional practices and the construction of subjectivity” (Arribas-Ayllon & Walkerdine, 2008, p.6). By identifying how theory and practice interact, Foucault developed several concepts which he hoped could act as tools for exploring the impacts of discourse on social change (O'Farrell, 2005). The following section discusses FDA concepts that I used in my analysis.

### 2.5.1 Disciplinary Power

Foucault wrote about disciplinary power in ‘Discipline and Punish’ (1977), using the example of Jeremy Bentham’s Panopticon prison, which was designed to ensure that prisoners could not detect when guards were watching them. In this context, prisoners began to ‘self-discipline’. Thus, rather than being imposed through violence, disciplinary power is controlled through conformity, with permanent surveillance located within the person. For Foucault, knowledge and power relations are principal and the Panopticon prison shows this clearly. Features of the Panopticon can be seen today in the use of Closed-Circuit Television (CCTV). Surveying people constantly allows their behaviour to be systematically assessed; this produces knowledge that enables the effect of power, which in turn produces a ‘norm’, moulding people’s practices. Anything outside of the ‘norm’ can be punished or compensated.

### 2.5.2 Technologies of power and technologies of the self

Technologies of power embrace control on a greater scope by, for instance, controlling contraception within a country, whilst technologies of the self, involve how the subject selfdisciplines and follows guidance, for example, following GP advice and taking contraceptive pills. Technologies of the self, elucidate the 'process of internalisation' through which a person turns into a subject founded by the mechanisms of power or practices accessible in the discourses inhabited (Sarup, 1993).

### 2.5.3 Normalisation

Subjectification—the construction of the socially known specific subject—is related to society's knowledge/power systems; Foucault (1978) claimed that subject positions are not predetermined but can be constructed through practices of power and knowledge. This process is changeable over time, creating an imbalance of power relations when certain knowledge becomes advantaged over others at different times (Foucault, 1978). Specific scientific discourses of regulatory practice, such as 'the right Body Mass Index (BMI)' in the context of ART, could be argued to conceptualise individuals as 'docile bodies' that conform to dominant normative standards. Thus, subjectification is the effect of adhering to what is 'normal'; in consequence, we change our behaviour, possibly suppressing our individuality.

### 2.5.4 Biopower

In *The History of Sexuality* (1978), Foucault reconceptualised power as productive as well as repressive, operating through regulatory practices and scientific discourse. The productive aspect of power can be demonstrated via the concept of biopower (Foucault, 1978): a system for the socio-political control of societies which controls the health and wellbeing of people and is achieved by medicalisation and bio-scientific knowledge. Biopower operates not only at the individual level but also within biological processes of population such as fertility or mortality.

## 2.6. Ethics and Procedure

### 2.6.1 Ethics

I received Ethics approval from the London Metropolitan University's School of Social Science, Research Ethics Review Panel (RERP) before starting recruitment (see Appendix A). Based on the University's Code of Good Research Practice (2002), the British Psychological Society (BPS) Code of Ethics and Conduct (2018) and the BPS Code of Human Research Ethics (2014), I followed ethical principles such as respect, openness, competence, accountability, and integrity to guide my conduct and decisions during this research process. Subsequent sections describe the ethical issues that I considered and reflect on the ethical challenges that I experienced during this project.

### 2.6.2. Informed Consent

To ensure accountability, respect, and integrity (BPS, 2018), women who wished to participate were sent an invitation letter describing the study's purpose and how the data would be used (Appendix B). Before interview, re-reading the invitation letter resulted in further questions about the research. I also reminded participants about the fact that they could withdraw from this research within a month after the interview without any obligation to give a reason.

Most women asked me about my cultural background and their anonymity before interviews started; thus at this point I explained confidentiality (further discussed in 2.6.3). Their concern about anonymity resonates with Foucault's concepts of 'surveillance and control' and the theory of Panopticism (1977, 1981). As previously discussed, he claimed that this kind of surveillance prompts individuals to self-discipline, creating a sense of being under 'the gaze'. Thus, the concerns about confidentiality expressed by my participants could indicate how mechanisms of power may be operating within the wider South-Asian-Muslim community. Discussing the anonymity and confidentiality of their data were important to remove any constraints on their participation. When participants agreed with the research terms, I asked them to sign the consent form (Appendix C).

### 2.6.3 Confidentiality

All identifying information has been removed in this research, ensuring anonymity and confidentiality. I informed participants about the data protection procedures, including transcripts being locked in a cupboard, audio recordings being password protected and accessible only to me, and transcripts being read only by me and my supervisor. I also explained that the audio recordings would be destroyed once the study was completed; however, transcripts would be kept securely for five years, in line with the Data Protection Act (1998), so that findings resulting from this research could be published (See Appendix I).

### 2.6.4 Protection and safety of participants and researcher

I conducted a risk assessment and no specific risks were identified. However, I anticipated that interview questions could trigger stronger emotions, and this was monitored throughout the interviews using guidelines from the Distress Protocol (see Appendix D). Participants were offered the choice of meeting at a place they had chosen or a place I would arrange. Most interviews were held at their homes; only one was conducted at the university and one by video-call. During the interviews, I considered participants' safety and comfort, thinking about the concerns they expressed about 'the gaze' (Foucault, 1977). For instance, when at their homes, it was important to ensure that no other family member was present. Finally, to protect my safety, my partner was informed of the time, date and location of each interview and an expected return time.

### 2.6.5 Debriefing

After the interviews ended, I offered time to debrief and to acknowledge any feelings that were evoked, so that they could leave the interviews feeling comfortable with their experience; at this point, I gave them a debrief letter (Appendix E). All participants were interested in the research; they asked me about my experience of undergoing IVF. I elaborated on my critical approach to ARTs and shared my personal experience of undergoing IVF as a minority in the UK living in a mixed household of European and South-Asian cultures and religions. I was touched by their questions and expressions of appreciation for the research; these made me reflect on and increase my understanding of how deep-rooted the problem of silencing is within this South-Asian community. Therefore, I aimed to leave these women feeling heard, showing that I care and want to increase awareness about their struggles.

## 2.7 Participants

### 2.7.1 Sampling and Recruitment

Whilst quantitative research collects less information from a wider population to unravel an objective knowledge, qualitative research employs fewer participants, looking for data beyond statistics (Baker & Edwards, 2012). FDA participants are intentionally selected for the insights they can provide into an experience within a specific context, in this case, ARTs. Accordingly, this study's sample of six South-Asian-Muslim women was selected purposively from a potential pool of around 10 participants who responded to my research advertisement. Given submission timelines, I considered the length of interviews and the time it would take to transcribe and analyse the data when choosing the number of participants. Nevertheless, to secure presence of significant themes in FDA (Harper, 2012), I used inclusion criteria to ensure a homogenous sample. Participants were thus South-Asian-Muslim women who had undergone IVF or IUI within NHS, and had their last experience of ARTs within the past 5 years. Participants had also decided to use ARTs in mutual agreement with their male partner, because whilst single women can undergo fertility treatments, their socio-cultural experience will not include a partner or partner's family and, based on the literature review, it seemed important to explore the hierarchical structure within families in context of ARTs (Cross-Sudworth, 2006; Eugster & Vingerhoets, 1999; Wirtberg et al., 2007). Originally, I included an age and a 'childlessness' criterion, but these were removed (see further discussion below). Additionally, I used ART as an umbrella term, helping me to recruit participants who not only experienced IVF but other fertility treatments such as IUI.

After gaining ethical clearance, an advertising poster (Appendix F) was distributed to Fertility Network in the UK, a fertility support charity, and on Facebook fertility support groups. I also employed the snowball method (Salganik & Hrckathorn, 2004) by emailing the advert to personal contacts, asking them to forward it to potential participants. All participants were recruited through the snowball method and were provided with an invitation letter by email, which was followed up by a phone call to confirm their willingness to participate and arrange their interview (see Appendix I).

Initially it proved difficult to recruit participants; however, after reflecting on the recruitment criteria, I removed any age limit, as my participants' ages would have been determined by the NHS age criteria for ARTs and socio-cultural constraints that influence decisions about when to embark on motherhood. Initially, childlessness was also one of the recruitment criteria, because research suggested that women who already had children seem to cope more effectively with failed IVF than childless women, so childless women are an arguably more vulnerable population (Baram, et al., 1988). However, upon further reflection, I decided to remove this criterion. Perhaps the way my participants talked about ARTs would relate more to their culture, religion and upbringing rather than whether they were childless or not. These changes to the recruitment criteria, together with the snowball technique, finally enabled me to recruit six participants.

### 2.7.2 Participants profile

The type of participants required for the current study was determined by the research question. The population for this study was represented by women whose age ranged between 32 and 43; they all identified as South-Asian-Muslim (Pakistani and Indian). Out of the six participants, five completed higher Western education and all participants had the experience of working professionally in the UK. All women had had at least one cycle of fertility treatment such as IVF or IUI in UK NHS fertility clinics in the past five years; as a result of their experiences two of the participants attended psychological therapy. Also, all participants were in heterosexual partnerships; three participants were childless at the time of the interview and three had children as a result of fertility treatment.

### 2.7.3 Researcher Profile

I am a European, Muslim, white-Polish, female, trainee, critical CoP. My curiosity about Muslim communities and ‘infertility’ began during my first round of IVF and when I embarked upon the CoP Doctorate. This motivated me to reflect on how women construct ART within their communities.

## 2.8 Data collection

Guided by Foucault’s (1972) approach to discourse and my critical realist social constructionist position (Willig, 2012), I selected semi-structured interviews as my data collection procedure, to access my participants’ ways of talking and thinking about ARTs; semi-structured interviews are considered an effective method for eliciting detailed data on participants’ views and attitudes (Byrne, 2004). Also, from a feminist theoretical perspective, it is encouraged to use interviews within silenced groups, giving them the opportunity to speak about their experiences (Byrne, 2004). Nevertheless, in accordance with my epistemological position, I did not treat my participants’ accounts as direct reflections of their experiences. Social constructionism argues that we cannot find the ‘truth’ or ‘facts’ in interviews (Gough & McFadden, 2001); rather, interview content should be comprehended as a discourse standing for culturally available ways of uttering understanding and knowledge (Seale et al., 2004). This approach redirects attention from ‘raw data’ to discourse which represents the experiences of a specific person in socio-cultural context (Seale et al., 2004). Therefore, and considering Kitzinger’s (2004) view of FDA analysis, I comprehended participants’ accounts as discourses embodying contemporary culturally available ways of talking about (in this instance) ARTs. Thus, I did not use these interviews as a tool to learn ‘truth’; instead, I used them to engage with my participants in a conversation about ARTs, co-constructing their meanings. Though FDA is less concerned about the richness of data compared with other qualitative methods (Coyle, 2016; Walton, 2016), it is important to enable engagement with participants to co-construct adequately meaningful material to answer the research questions (Langdridge, 2009; Willig, 2013).

One issue that concerned me regarding recruiting South-Asian-Muslim women was that my name, which appeared on the poster and invitation letter, is European in origin and may falsely identify me as outsider to the culture and religion. After reflecting on this in supervision, I decided to use my non-official Muslim name next to my birth name. I made this decision based on the suggestion that participants may be more willing to talking about intimate topics to someone who is perceived as more like them. However, people are individuals, and it is crucial not to accept that other people’s experience or how they see the world is the same as I might see it. The feminists Mohanty et al. (1991) argued that white women cannot be experts on all women, initiating a debate about recognition of ethnicity and gender of both participants and researcher as significant in understanding experience. Recognition of such power dynamics by these feminists was significant because it was no longer taken for granted that, for instance, the interview interaction itself was a neutral space for data 'collection'. Additionally, Sawyer et al. (1995) argued that it is essential to ‘match’ the key social characteristics of the participants and researcher to have an effective interview. Collins (1990) suggested that similarities between those engaged in research may enrich understandings and may also displace traditional power relations during data collection.

Focus Groups (FG) were also considered; however, they are a better method when participants do not have a personal stake in the topic (Braun & Clarke, 2013). Using FG in the current study might have limited the expressive richness of individuals’ experiences (Braun & Clarke, 2013). Also, working with Muslim minorities, in context of childlessness that is associated with shame (Inhorn, 2012), might have increase hesitation regarding participating in FGs due to worry about breach of confidentiality (Culley & Hudson, 2009).

### 2.8.1 Interviews

Semi-structured interview questions (see Appendix G) were developed based on interview questions used in research on gays, parenting and social networks (Clarke, 2006; Clarke, 2007). They lasted around 60 minutes, with a variation of 15 minutes. hihic information was confirmed at the beginning of each interview to check whether women met the recruitment criteria; however, it is not provided here, to protect participants' confidentiality (see Appendix I). Also, the contexts in which the interviews were done was considered, as they will affect the co-constructions of understandings by the participants and me as the researcher, not the objective viewer. Therefore, reflexivity has been an important CoP tool helping readdress power imbalances, by, for instance, positioning myself not as an expert (Cooper, 2009) but as a researcher and trainee CoP. Although this position could still potentially establish a position of power, the interviews were conducted in the participants' locations of choice, which may have helped reduce some power imbalance. Furthermore, being a white-European woman positioned me as an outsider; however, as a Muslim married to a South-Asian man, I occupied the insider perspective. On reflection being an insider/outsider researcher regarding this women's culture and religion created many challenges for me. On reflection being an insider/outsider researcher regarding this women's culture and religion created many challenges for me. One of them was the constant need for switching between the different aspects of insider/outsider positions, depending on what the participants were talking about and needing from me. For instance, I greeted them with traditional Arabic/Muslim Alsalam ealaykum (peace be with you) since we had common understanding of each other being Muslim. This was then followed by me shifting to the researcher position, introducing confidentiality and staying within the frame of the researcher which meant that when asked about my personal experience of IVF I needed to maintain the boundaries as a researcher and only elaborate on this after the interviews were finished. This was particularly challenging due to the need to be mindful of the different positions I was holding in relation these women + benefit. More reflections on the insider/insider positions are included in Appendix I.

Before interviews, all participants showed curiosity about my links with IVF. At this point, I only confirmed their suspicions that I had had IVF; I expanded on this after the interviews. Therefore, their awareness that I underwent IVF might have given the assumption of shared knowledge and experience which possibly encouraged disclosure and helped with managing the power imbalances. Once I started interviewing and analysing, I also began to develop that insider position more strongly, especially when I could recognise my own struggles in these women's stories. This in turn became a tool for forming a level of relatedness and triggered valuable reflections. The recordings of interviews were transcribed and anonymised; a sample extract can be found in Appendix H.

### 2.9. Analysis

Reflective engagement with the data started during interviews, transcription and re-reading the data, with the help of a reflective journal. At this point, I decided to rephrase the title of the thesis, changing the focus of analysis from the construction of support networks to constructions of ARTs. My decision was a result of noticing while reading transcripts that participants did not talk about support networks as much as they did about ARTs, despite my interview questions directly asking about their support networks. Focusing the analysis on the support networks would result in losing a great amount of data; thus, after reflection and discussion in supervision, I decided to rephrase the title and research questions (see Appendix I).

To answer the research questions, I adopted a reflexive stance following Willig's (2013) six stages for conducting FDA; questions guiding the six stages are:

1. How is the discursive object (ART) being constructed in the data?

2. In what different ways is the object constructed?

3. What are the functions of such constructions?

4. What subject positions are available within wider discourses?

5. What are the implications for practice of the identified subject positions (subjectification)?

6. What are the technologies/subject positions used in the talk, and what are the implications for subjectivity?

To deepen my understanding of the process of subjectification fundamental to the current research, I decided to incorporate Arribas-Ayllon and Walkerdine's (2008) guidance on studying the making of subjects through technologies of power and technologies of the self (Sarup, 1993). See Appendix N for an example of how I used the analytic steps.

### 2.9.1 Analytic Process

The analytic steps started by searching in my participants' talk for different constructions of objects and subjects such as family, friends, medical staff, husband, IVF, 'infertility', miscarriage, medication, and injections. Later, I narrowed this down to all explicit and implicit constructions of ARTs present in the transcribed data. Once this was completed, I identified all discursive constructions of ART, for example: ART as treatment/shameful/taboo (Willig, 2013, steps 1 & 2; see Appendix J & L). Here, I began to note other aspects of the analysis, such as subject positions (Willig, 2013, step 4) and technologies of the self (Arribas-Ayllon and Walkerdine, 2008; Willig, 2013, step 5). A powerful example of the technology of the self was when one of my participants talked about 'disciplining herself' in accordance with her family's disapproval of IVF and disposing used syringes in bins outside her house to hide the fact that she was undergoing ARTs. Next, I summarised the discursive constructions that were repeated across interviews on a large sheet of paper (see Appendix L); having all the data directly before me also enabled me to identify some links and contrapositions between different discursive constructions. This is when I noticed the predominant problematisation of ARTs in the women's talk (Willig, 2013, step 3). Following this, I identified initial discursive sites which seemed to consistently represent the constellation of constructions identified (see Appendix M).

At this point, I also engaged more with issues of power and naming possible subject positions and their implications (Willig, 2013, step 4). For example, I identified 'eligible patient' position and how this allows and limits women to talk about ART as a biomedical event, and what they can do or not do (practice) (Arribas-Ayllon and Walkerdine's, 2008; Willig, 2013, step 5). Following this, I also focused on linking subject positions to technologies of the self and technologies of power, through asking the data a number of questions guided by Arribas-Ayllon & Walkerdine (2008; Willig, 2013, stages 5 & 6); a detailed description of this process can be found in Appendix O.

After reorganising the ways in which the participants seem to construct ARTs, I selected three predominant discursive sites across the interviews that were relevant to my research questions:

1. Constructions of ART in the context of biomedical and sociocultural hegemony;
2. ART as women's problem: the problematic self; and
3. On the way to liberation from biomedical and sociocultural hegemony.

After this, I started the writing-up process and selected extracts to represent the data. Throughout this process, I consulted and shared my progress with my supervisor and peers, as well as writing in my research journal, to enable reflexivity and quality of research.

### 2.10 Quality of Qualitative Research

Additionally, to ensure quality of this qualitative research, I was guided by four stages recommended by Yardley (2008). Firstly, I showed awareness and sensitivity of various contexts by engaging with the relevant literature, ethical issues, empirical data and participants' perspectives. By engaging with in-depth methodological analysis, I aimed to demonstrate commitment and rigour. Additionally, through clarity in presenting arguments, fit between theory and method, and reflexivity, I intended to show transparency and coherence. Lastly, I presented impact and importance of findings within theoretical, socio-cultural and practical contexts. See 4.2 for reflection on the quality of this research.

### 2.11 Reflexivity

Reflexivity is a central part of qualitative research and the practice of CoP concerning how the researcher impacts/co-constructs the process of research. Therefore, I aimed to demonstrate reflexivity throughout the research process. Detailed reflections and evidence of my reflexivity can be found in section 4.4 and Appendix I. Finally, I maintained the process of reflexivity by consistently discussing the research issues with the supervisor, peers and by keeping a reflective journal, as recommended by Coffey and Atkinson (1996).

# Chapter Three: Analysis and Discussion

## 3.0 Overview

This chapter presents analysis of how this group of South-Asian-Muslim women who underwent fertility treatments within the NHS construct ARTs in the context of their biomedical and sociocultural environments. By examining the participants' talk, I analyse discourses available to them and how their talk is impacted by different sources of power (Willig, 2013), using concepts such as technologies of the self and technologies of power, together with how these technologies are used to arrange ways of being (subject positions) and make certain social practices possible (Arribas-Ayllon & Walkerdine, 2008). Extracts from the interviews aim to demonstrate how constructions of ARTs are enabled; I organised them into three discursive sites, which uphold specific positions inhabited by the participants:

- Constructions of ARTs in the context of biomedical and sociocultural hegemony, including discourses of the problematised 'infertile' women and their subject positions of 'eligible patient' and 'respectable woman'.
- ARTs as a woman's problem: the problematic self, presenting ARTs as a problematised event located in women, who are made responsible for conception in the context of their marriage, wider society and religion.
- On the way to liberation from biomedical and sociocultural hegemony in the context of ARTs, whereby women place themselves in a position of educating others, introducing contrasting accounts, challenging problematic constructions, and resisting the subject positions of 'obedient' and 'responsible' woman and 'eligible' patient.

These discursive sites should be seen as an interrelated system of discursive practices manufacturing the concept of ARTs and related subjectivities (Morris, 2003). Furthermore, since discursive practices encompass entire knowledges, my analysis could also be understood as one possible discursive construction, which is not only a product of the collected data but also my culture, history and position as a reflective researcher and trainee CoP (Van Dijk, 2011).

### 3.1 Constructions of ARTs in the context of biomedical and sociocultural hegemony

This section discusses the processes by which ARTs becomes constructed within this group of South-Asian-Muslim women's talk as a problematised biomedical and sociocultural event. It highlights disciplinary technologies and technologies of the self, specifically, how participants negotiate regulatory institutions of NHS fertility clinics to position themselves as an 'eligible patient' and the South-Asian-Muslim community to position themselves as 'respectable women' according to expectations. Additionally, it explores the problematised position of these women diagnosed with 'infertility' within the NHS and their sociocultural environment. This was identified in their reference to time, medical procedures, the physicality of their bodies, emotional strain, social isolation, blame, silencing and othering.

#### 3.1.1 Constructing being an 'eligible patient' within NHS fertility clinics

The extracts presented here demonstrate different ways of constructing ARTs as a biomedical event within the NHS institution. The Foucauldian concept of 'othering' is explored in the first extracts and demonstrates how the women perhaps constructed power relations between them and medical doctors. Additionally, the analysis draws on Foucauldian concepts of disciplinary technologies (1977), which can operate on the institutional and individual levels, to understand the process of constructing clinicians as 'experts' and women as 'eligible patients'.

The following extracts focus on the patient and doctor interactions that illuminated the 'eligible patient' subject position.

> [1] ***Catherine:…****Yes, yes, when the first [IVF] it didn't happen. We actually wanted to start it [IVF] immediately but, erm, the doctor said no... [sigh] It's just been a year, now we have to like monitor you for another six months and then we'll have a look...So then, so two years went by and nothing happens…the third year we started it [IVF]…*(244-251)
>
> [2] ***Chloe:…****So when they offered me the IUI I was just hoping that, okay, that would work and then when that one…I think they didn't do that one [IUI] they just went straight to the IVF so I was like "oh". So it was just following the doctors' guidance as to what steps to take, their advice yeah…*(207-212)
>
> [3] ***Barbara:****…So they are just stimulating your egg production and they are just checking when the right time is to put the sample in…*(917-919)

In these extracts, ARTs are placed within a wider biomedical discourse within which they can be recognised as a site of persistent, intrusive examinations: *they are just stimulating... checking... put the sample in* [3]. To access treatments within the NHS, women are categorised as 'infertile' and within the medical institutions this could be seen as a 'disease'; this is expanded on in 1.5.1. In this way, participants' constructions of ARTs could be interpreted as informed by the system within the fertility clinic and the clinicians' positions which are possibly framed as powerful and enabling: *doctor said no...we have to like monitor you* [1] and *they just went straight to the IVF* [2].

Additionally, the constructions of ART in [1] can be comprehended through the theory of the 'medical gaze' (Foucault, 1977) that originates in the Panopticon prison concept (see 2.5.1 & 2.6.2). Therefore, patients are approached as separate from their 'disease' and only the body is focused on. This can be observed in talk about physical examination (*we have to like monitor you)* that was here privileged over women's choices or emotional state (*We actually wanted to start it immediately).* Possibly, the process of control in this example, enacted through the doctor's advice to wait, can be seen as a disciplinary technology perhaps to regulate the patient's expectations and to inform her practices as an 'eligible patient' who must follow medical advice to receive treatment (*two years went by and nothing happens…the third year we started it [IVF]).*

Furthermore, these constructions highlight the use of outsider discourse to possibly create the difference between the in-group/doctor/expert (*they referred me...they just went straight to the IVF* [2], *doctor said no...we have to like monitor you* [1]) and out-group/patient/non-expert (*it was just following doctors' guidance…advice* [2]). This perhaps reinforces the doctor's expert status through the process of othering, a Foucauldian concept connected to knowledge and power through which a hierarchical structure is inferred. Thus, the focus on the *doctors' guidance as to what steps to take* [2] could potentially be seen as part of a wider biomedical discourse which privileges the medical knowledge deployed by clinicians, creating 'desirable ways of being'/subject positions for patients, such as 'eligible patient'. To access ARTs, participants must take these subject positions, which involves surrendering their bodies and voices to clinicians, even when this is against their intentions: *they just went straight to the IVF…so I was like 'oh'* [2]. This example demonstrates the participant's disappointment about the choice of treatment; however, she remained silent (*just following the doctors' guidance*), perhaps to occupy the position of 'eligible patient'; this may be regarded as a technology of power that acts to regulate the woman's behaviour. This may show a power imbalance between the patient occupying the 'eligible patient' subject position and clinicians occupying the 'expert' subject position, resulting in these women having less stake in determining their ART treatment plan. The silence in participants' talk may imply that there is a fear that if they do not silence themselves, they may become 'ineligible'.

Furthermore, the 'eligible patient' subject position may obstruct women's opportunity to challenge their situations, as their non-expert voices may not be privileged. Here the power is enacted in the interaction between the participants as patients and the system in which they occupy the 'eligible patient' subject position, informed by practices of power such as being scanned, stimulated and checked. They describe consenting to these practices by becoming passive/obedient and silent/not voicing their concerns or requests. In turn, these practices could become ascribed to the women, attaching them to the normative 'eligible patient' subject position.

The following extract expands on the subject position of 'eligible patient', using normative constructions of women's age and weight.

> [4] ***Catherine:…****I have lost again, ten kg. And, erm, after the summer I'll go back to the hospital and show them that, look, I've lost, erm, ten kg. So because that's their concern. I lost it, I gained it back and they say you have to lose it again because the pregnancy chances are going down because of your overweight. So, so those are the challenges for me…*(544-550)

Extract [4] demonstrates constructions of a woman's weight as a *concern* and as something that can determine pregnancy chances, rendering women's bodies problematic. The construction of ARTs as having a better success rate when women have the right BMI is reflected in the NICE (2017) guidelines that are set up by governmental bodies and act as disciplinary technologies; they offer bases for medical staff to determine the 'most efficient' pathway of care. In terms of ARTs, NICE guidelines recommend that "…female BMI should ideally be in the range 19–30 before commencing assisted reproduction…" (NICE, 2017, Section 1.10.4.1). Additionally, using quantitative data to demonstrate outcomes of ARTs are an important aspect of the biomedical regime; this may be a result of growing economic and efficiency agendas. It can be argued that ART as a modernist approach to 'infertility' endorses a realist epistemology which, through body measurements, promotes an objective truth, creating 'desirable ways of being' and consequently subject positions that can be defined by self-disciplinary practices (Foucault, 1988).

Therefore, in [4], Catherine manifests subjectification by internalising the dominant biomedical discourse to reinvent herself through obedience to its rules (right BMI); the construction of women's weight as a *concern/*problematic demonstrates the internalisation of dominant knowledges (*the pregnancy chances are going down because of your overweight*) and leads to self-disciplining behaviour under biomedical regulatory power: *I have lost again ten kg*. The implications for subjectivity might be that female patients construct the right BMI as a norm and as means to become an 'eligible patient'. Therefore, BMI possibly becomes one of the central components of normative womanhood within fertility clinics, with the aim of maximising the efficiency of women's bodies, which in turn becomes tied to procreation whilst women's challenges regarding ARTs (e.g., emotional) perhaps become constructed as less relevant. This is demonstrated in talk about losing and gaining weight repeatedly and the clinics demanding the right BMI without considering contextual factors possibly acting as obstacles in losing weight.

Additionally, on the institutional level, the 'medical gaze', can be seen as a technology producing power/knowledge by observing, monitoring, checking, and weighing subjects, and consequently categorising patients, generating a 'disease'/'infertility' (Arondekar, 2005); this approach can be regarded as the foundation of modernist science. The constitution and enactment of regulatory institutions about the discourse of the 'right BMI' for ARTs draw not only on medical guidelines that are part of the regulatory practices but perhaps also on gender-normalised social accounts of ARTs informing practice. According to Throsby (2004), some recommendations of clinics for women undergoing ARTs regarding dietary changes or the need to 'relax' puts pressure and blame on them if the treatment fails; that is, if they had done something different, it might have been successful. The effect of such discursive constructions is that women who do not meet the 'desirable ways of being' (i.e. not being overweight) might be positioned as to blame for not being offered ARTs or not getting pregnant; when she is then called upon to lose weight, to 'relax' or to change her diet, this forms a powerful process of subjectification. The fertility institution has additionally created a system in which mainly women are advised what they need to do to increase the chances of success, locating most difficulties firmly in women, rather than identifying possible environmental factors such as lack of support or understanding from close ones. Thus, women may be judged to be primarily responsible for the success of ARTs: *you have to lose [weight]* [4]; *we have to like monitor you* [1]; this will be further discussed in 3.2.

> [5] ***Sabrina:…****But I think sometimes as a woman you're more focused, you're more adamant. Where for a man sometimes I think you're just a little bit laid back and you're*

> *just like, calm down, we've got plenty of time. I mean I say that because I've had those conversations with my husband in terms of, well we have plenty of time, why are you rushing? You know we're still young. No, no, I don't want to fit in another category. When you hit the age of over 35, then you get told you're high risk, then it's your age factor. So, I think that's what I think when I say causes a strain, I know it has when we've had the in-depth conversations again and again each month…*(764-777)

Similarly, in [5] ARTs is constructed as a biomedical event that once again sets up ways of being for female patients; age is constructed as problematic and as a gauge of 'fertility capacity' (*When you hit the age of over 35, then you get told you're high risk*). This is consistent with research constructing women's fertility as something which declines with age; fertility is highest at 24 and declines from age 30 (Culley et al., 2012). Additionally, NHS fertility clinics emphasise a fall in ARTs success rates; for example, for IVF the figures are 32% for women under 35, 25% from 35 to 37, 19% from 38 to 39, 11% from 40 to 42, 5% from 43 to 44 and 4% when 44 or over (NHS, 2021). The NICE (2017) guidelines which inform NHS eligibility criteria for ARTs state that women under 40 should be offered 3 full cycles of IVF, women aged 40+ should be offered 1 full cycle of IVF and women aged 43+ are not offered it at all; thus, age has also implications for women's eligibility for ARTs.

In [5], the talk uncovers social control over women's age through technologies of power such as evaluation and categorisation. The internalisation of the position of 'eligible patient' perhaps happens via conscious awareness (*When you hit the age of over 35*) or through surveillance/'the gaze' (*you get told you're high risk*), resulting in self-regulation in accordance with NICE guidelines: Sabrina *as a woman* is *more focused, more adamant* about starting IVF soon, possibly to occupy the position of 'eligible patient' and to avoid being positioned as *high risk.* Possibly, science claims the expert knowledge position, transforming knowledge into 'truth' and creating criteria, in this case women's age, against which IVF success rates can be evaluated. Additionally, this modernist approach could be seen to marginalise a contextualised approach to fertility and favour objective knowledge common to economic and biomedical discourses. This is in line with Spar's (2006) argument that ARTs and 'infertility' are becoming a big business (See 1.5.2).

In summary, in [4] and [5], the biomedical approach to 'infertility' can be recognised as a disciplinary power due to its individualising and normalising effects, in line with which ARTs 'entry requirements' construct deviations from weight and age practices as risk factors for successful pregnancy. ARTs, then, become a site of persistent monitoring, scanning and weighing which consequently produce knowledge and therefore power. Furthermore, this evidence-informed approach to health care, which medicalises 'infertility' and ascribes to NICE guidelines for best outcomes, illustrates Foucault's concept of governmentality (1979). Age and BMI-related NICE guidelines can be seen as a representation of regulatory power within the NHS where threshold levels are produced using approved forms of modernist scientific knowledge. In turn, these practices within the NHS become valorised and this assures their impact. Therefore, the medicalised approach to 'infertility' is possibly privileged over a more holistic one, perhaps being more aligned with the specifications of commissioners.

The current analysis suggests that the evidence-based biomedical model of ARTs locates 'problems' within women through NICE guidelines acting as regulatory practices operating on a wider level. This could then perhaps create assumptions about who is at fault when the treatment doesn't work (*you get told you're high risk*). Moreover, the weight and age guidelines for women produce standardised ways of distributing ARTs to increase live births of healthy babies. The aspects of technologies of the self can be seen through the scientific 'truth' that is generated in these guidelines and then implemented through doctors, transforming the ways in which individuals construct themselves: *I don't want to fit in another category.* This perhaps links with neoliberal theory, where subjects are accomplished in life when they free themself from the state (Rose, 1990). The governmental neoliberal regime of power operates on a local level, via technologies of the self such as women following the NICE, 'right' age and BMI guidelines. Perhaps, individuals are transformed into self-regulating, neo-liberal 'eligible patients' through these technologies that seem to locate the 'disease' in women, thus minimising the impact of contextual factors and the onus on the state to provide solutions. Women constructed as neo-liberal subjects experiencing difficulty with 'infertility' may initially look for explanations within themselves and may initiate changes in their lifestyle, as per recommendations, which could perhaps be seen as maintaining the concept of 'infertility' and ARTs as being located within women, which will be expanded upon in section 3.2.

The next section explores how regulatory institutions of the South-Asian-Muslim family and society enact disciplinary technologies which impact on a woman's sense of self and require her to engage in self-disciplinary practices to warrant her position of 'respectable' South-Asian-Muslim woman.

### 3.1.2 Constructing being a 'respectable' woman within South-Asian community

The next extracts illustrate the culturally available accounts of ARTs, and the enactment of technologies of power on women's conduct when undergoing ARTs, in the context of the South-Asian-Muslim patriarchal family and community. Additionally, the extracts highlight the process of subjectification by which people recognise and act in response to certain powerful discourses to facilitate the development of a framework in which they can then see themselves as subjects. In this instance, the dogmas analysed are the sociocultural discursive practices recognised by and produced in the women's talk. The participants' talk revealed practices of technologies of the self (Foucault, 1988) which operated to apply power over their subject positions and practices, specifically as women within South-Asian-Muslim communities. All participants talked about sometimes using secrecy within their families to conceal their ARTs journeys. Five out of the six women talked specifically about needing to hide the ARTs from their husbands' families.

In the following extract, Kendra's talk demonstrates the influence of the South-Asian-Muslim family and community on the practices of silencing.

> [6] ***Kendra:****...Because we believe more normal or natural, we born natural, yeah, and our...we are very...the science is good, but the people in our...we people is like more...you can be, say, two faces, the many people is two faces. First they want to hear everything when you talk with them, oh yes, sister I did this, I did...for first thing she listen everything, and after she doing other thing. And she think, oh look...like back biting, like, oh she...look, she, she, she can't make the baby, and she going, she taken the medicine, she take the...she make the science kid, she had not normal kid, the people is, do you know. And I think many woman, that they have a IVF but they have a no trust to anyone or everybody that I have a IVF, only for this reason that when somebody know that, then they're thinking about bad on me, you know, that she's not normal, you know this is judgement, you know, and only this is. So that's where you keep your secret all the time...*(359-376)

In [6], Kendra problematises ART, constructing it as less normal then conceiving 'naturally'; this construction is informed by science (*the science is good*), which can be located within the biomedical discourse. Kendra perhaps also draws on sociocultural discourses in her talk about ARTs when she addresses the social environment, the *people* who say *she can't make the baby...she make the science kid, she had not normal kid.* She also draws on discourses of conception to inform her knowledge and practice, when using the construction of *not normal* versus *natural conception.* This talk perhaps generates subjugated forms of subjectivity for women who decide to undergo ARTs, as they are positioned as perhaps doing something less acceptable within the South-Asian-Muslim community: *we believe more normal or natural* *normal*. Additionally, *the science kid* is problematised as *not normal* and therefore also subject to judgment. This privileged knowledge of 'natural conception' (Farquhar's,1996), generated perhaps from within sociocultural discourses, applies disciplinary technologies subjugating women through the advance of regulatory practices regarding what is seen as normal/natural/acceptable conception (Malson, 1998). Perhaps to avoid being categorised as *bad, not normal,* women are encouraged to adhere to regulatory practices, a process enabled via self-regulation through secrecy. The implications for subjectivity are that these women perhaps become tied to the regulatory practice of getting pregnant 'naturally' as a fundamental element of standardised female identity. This is constructed in Kendra's talk: *…many woman they have a no trust to anyone….then they're thinking about bad on me…that she's not normal…So that's where you keep your secret all the time.* Thus, these women's identity becomes attached to reproduction and 'natural' conception becomes the ultimate way of conceiving; conversely, ARTs become an event that is 'abnormal, bad and needs to be kept secret'.

Extract [6] locates power constructions within family and society (*the people*) which are enacted through practices such as judging and back biting. Perhaps the sociocultural thresholds of what is acceptable and normal (*we believe more normal or natural*) act as technologies of power offering 'guidelines' for this group of South-Asian-Muslim women to inform their decisions and actions when they decide to undergo ARTs. Consequently, they perhaps turn to secrecy (*that's where you keep your secret all the time*), arguably so that they can inhabit the subject position of 'respectable women'. Furthermore, Kendra's talk shows that when silencing is not implemented correctly, the subject 'is punished'/suffers the consequences of inhabiting the 'non respectable woman' subject position, in which she is judged: *back biting…she can't make the baby*; *they're thinking about bad on me, you know, that she's not normal, you know this is judgement.*

Following extracts continue to present the problematic constructions of ARTs in sociocultural context.

> [7] ***Chloe:****…I didn't even know if they even knew what IVF meant. When it comes to medical treatment, they use the word dawa, dawa which means medicine which can cover anything and everything. So they just say "oh, she's doing dawa, she's doing medicine" that's what they would say…*(77-82)

> [8] ***Chloe:****…So the day that they gave me the appointment for them to put the eggs back in me was the day my in-laws were due to go to X, so I went…It was hard because I knew*

> *that a lot of guests were going to be coming, again I didn't tell them. Again I didn't know how, what language do you use to explain that? [with frustration in her voice] "Today they're gonna be planting embryos inside of me" I didn't…the language isn't there in our language to say those words. So I just thought "okay, I'll go to the appointment first thing in the morning and I'll come home and see all the guests" so that's what I did. They went to X that evening, I took time off work and they didn't know I took time off work and that's when I got pregnant with my son, yeah, so that was that really, yeah…(*106-120)

[9] ***Abigail****:…some sort of taboo about you had a baby through IVF…(637)*

In [7] and [8], Chloe problematises ARTs by constructing this as a phenomenon that cannot be described in a South-Asian language due to lack of specific vocabulary. Further, she shares that ARTs can only be described by one word, *dawa*, which means 'medicine'. This language limitation restricts/prevents her from talking to her husband's family about fertility treatments, silencing her: *the language isn't there in our language to say those words.* Additionally, due to lack of vocabulary to explain ARTs, people's awareness of what ARTs are may be compromised (*I didn't even know if they [in-laws] even knew what IVF meant*). This may perpetuate the cycle of silencing something seen as *taboo* ([9]). In the context of normalising practices within the South-Asian-Muslim community, 'natural' conception can perhaps be considered dominant. In line with subjectivity, the privileged truths and knowledge associated with 'natural' conception are adhered to here, leading to self-disciplining practice—silencing. Nonetheless, this can be also understood as a resistance to the dominant knowledge; silencing perhaps makes it possible for these women to undergo treatment whilst avoiding hostility from their community. However, this form of resistance does not alter the prevailing 'truths' about conception in the South-Asian-Muslim community, it only perpetuates them. Thus, both the absence of terminology to describe ARTs and the choice that women make to remain silent can be seen as perpetuating the dominant discourse 'truths' of 'natural' conception.

[8] displays the process of subjectification as Chloe internalises the sociocultural and normalising discourses to reform herself through adherence to its rules and allowing herself to be silenced: *again I didn't tell them.* Through this construction, it appears that family and society influences are positioned as dominant and the position of women undergoing ARTs is difficult (*It was hard*); perhaps it is hard for them as a result of the conflict between being expected to have children—they are already suffering in their communities because they cannot have children—and having to go through ARTs, for which there is no word: *the language isn't there*. Also, taking up the subject position of 'respectable woman' means that Chloe

inescapably views her sociocultural contexts from that perspective. Arguably, this limits to whom she can talk about her treatment and how to arrange treatment to maintain the secrecy, perpetuating the power/knowledge within the sociocultural and normalising discourses.

In [10] and [11], Kendra's talk seems to construct the experience of undergoing IVF as a South-Asian-Muslim woman aligned with the marginalised discourse of ARTs.

> [10] ***Kendra:****...Because I doesn't want the people [to] know the people know this (IVF) one, and they think bad about...me (tearful)…Saturday morning my husband going to buy the fridge, we have a fridge in my room, I take everything, I put it in a fridge. But in a room I did everything all the time, my husband, I keep my injection, medication, my rubbish...all the time I take when is finished, everything this one I take my purse and I'm going outside in a park…when you living in one house, when the doctor letters come, yeah, I know that because I suffering too much with this, everything here is because the letter coming from a hospital, yeah, the people [family] check all the time...(397-439)*

> [11] ***Kendra:****…everybody knows that this...about this IVF, yeah, and when some people doesn't like you, them back biting, talking about...bad on you, and that show to many people when they sitting, then they show more disrespectable to you, that you have a IVF kid, you know. More Muslim community, not European, no, only Muslim, they are...they think when they have a normal delivery or normal, they is...she had baby, but it's not like this, that what we have…(591-600)*

Here ARTs is located within dominant sociocultural and hegemonial family discourses, indicating that power is distributed unevenly in the family hierarchy, as Kendra talks about not wanting *the people [to] know*. Additionally, the dominant discourse and patriarchal ideas about 'natural' conception (Inhorn & Patrizio, 2015) are drawn upon to inform knowledge and practices; for instance talk about silencing and *"the people"* from whom she is making effort to keep the secret. This talk generates a dominated system of subjectivity for women as they are positioned as sufferers of hegemonial family power: … *the people know this [IVF]…they think bad about...me*; *the letter coming from a hospital, yeah, the people [family] check all the time*. This dominant knowledge, produced from within a sociocultural, patriarchal and hegemonial family framework, applies disciplinary technologies which subjugate women through the making of norms. Being disparaged and disrespected are key regulatory practices that are not challenged and seem to be made reasonable within the sociocultural discourse: *…they show more disrespectable to you, that you have a IVF kid, you know*. The desire to avoid people thinking *bad* of her, and possibly her child too, could motivate Kendra to not go against the ‘natural’ conception norm. Additionally, her talk again potentially problematises the *IVF kid* as disrespected and as outside of the norm. As such, hegemonial family power takes effect by attaching this group of South-Asian-Muslim women’s identity to ‘natural’ conception, perhaps as a way of earning respect in the community. In this way, this group of South-Asian-Muslim women become tied to ‘natural’ reproduction and ARTs become something that need to be kept secret. Kendra’s talk constructs the potential consequences of when her family find out about her IVF as her *suffering too much with this*. These powerful regulatory practices serve to maintain women in the subject position of ‘respectable women’. Challenging ‘natural’ reproduction may require these women to occupy the subject position of ‘non-respectable woman’ who can then be ‘disrespected’. They are thereby put back ‘in their place’ of silencing and hiding what the dominant discourse does not want to hear or accept as a ‘normal’ truth/practice.

> [12] ***Catherine****:…To me it would be an add on. I got married late and I, erm, am old, [laughter] according to a lot of people. I don’t feel old and Alhamdullila according to a lot of people. So then that would be an add on. Like, and now you don’t...you’re not getting children naturally you have to go to treatments and then add on you have to go to IVF so...I’m not...I don’t feel comfortable with (...) such judgemental [laughter] eyes or looks or, or comments because when I do take a stand...I, I feel easily guilty that I was rude or strict...*(354-363)

The impact of normalisation, a technology of the self, is demonstrated in [12]: IVF is constructed as an *add on*, perhaps something that is not desirable or ‘normal’, in contrast to normalised conception: *getting children naturally*. Catherine’s talk exposes that she does not feel comfortable with *such judgemental eyes or looks or, or comments* (‘the gaze’), probably as other women do through the effects of normalisation, where ‘natural’ conception is the ultimate acceptable pregnancy. Foucault’s (1978) concept of normalisation explains that regulatory practices are typically associated with certain aims. In this case, perhaps, the practices is for women to be healthy, able to conceive ‘naturally’ at an ‘early reproductive age’, and the goal is to have children who can support their parents physically, financially, and emotionally in old age, achieving lineage in the family (Dimka & Dein, 2013). Bordo (2004) argued that one example of social control is the disciplining and normalisation of women and their bodies. She also considered that women struggle to resist or shift the power relations which position them in several ways according to gender/relational patterns. For example, Catherine admits, *when I do take a stand...I feel easily guilty that I was rude or strict.*

Moreover, the practices of patriarchal family control the positions offered to this group of South-Asian-Muslim women and, via impacts of normalisation, position them as problematic: *you're not getting children naturally…and then add on you have to go to IVF*. In this way, it could be argued that the lack of 'natural' conception undermines their womanhood and status as 'respectable' South-Asian-Muslim woman (*I don't feel comfortable with (...) such judgemental eyes*) and could then affect their self-image (*I feel easily guilty*). These sociocultural, hegemonial family discourses privilege the 'natural' conception that women are responsible for (see further 3.2). If women do not comply with the norm, perhaps by being too old for 'natural' conception (*am old, according to a lot of people*)—which itself can be seen as an effect of the biomedical discourse of women's 'biological clock'—they can be made to feel uncomfortable with judgements, looks or comments.

In these extracts, undergoing ARTs is constructed as problematic and difficult; it is something women want to avoid and hide, because it can perhaps generate feelings of shame and guilt generated by thoughts that *they think bad about...me* [11]. Conversely, 'natural conception' is possibly seen as contributing to this group of South-Asian-Muslim women's position of 'respectable'.  To undergo ARTs is seen as doing something *bad* and being a failure as a woman, so in this context, 'natural' conception becomes a possible indicator of a successful/fulfilled woman. One part of being a 'respectable woman' is to have children and another is to have them naturally. Therefore, perhaps women can find themselves in conflict, wanting to be respectable by having children but then having to use a 'non-respectable' way to go about it. One could, therefore, deduce that hierarchical South-Asian-Muslim family power operates by ascribing the identity of 'respectable woman' to procreation and 'natural' conception through the disciplinary technology of normalisation.  Furthermore, I would argue that these regulations regarding what represents a 'respectable woman' operate to preserve the hierarchical South-Asian-Muslim family power.

The next section explores how regulatory institutions, such as South-Asian-Muslim family, marriage, and community, impact on a women's sense of self as the one responsible for conception.

### 3.2 ART as women's problem: the problematic self

Different accounts were adopted which positioned ARTs as problematic and as located in women this also had various repercussions for the subject positions of the women as problematic and being responsible for conception. The problematisation of ARTs can be seen across three themes: 1) the involvement of their husbands, 2) being blamed within society for not conceiving 'naturally' and 3) the permissibility of ARTs within Islam. Within this discursive site, the women seem to be positioned as responsible for procreation within their marriage and blamed for 'infertility' and for undergoing ARTs by their families and wider South-Asian-Muslim society. Although most ARTs are accepted within Islam, women still contemplate the permissibility of their treatment and fear that they will be judged by family or members of society if they decide to undergo treatment. The extracts below expand on this, highlighting the effects of patriarchal power and normalisation on maintaining dominant discourses (Foucault, 1978).

#### 3.2.1 Involvement of their husbands

These extracts highlight the disparity between the involved approach of women and the more withdrawn approach of men.

> [13] ***Sabrina:****…So, I went and spoke to my doctor, explained the situation, we'd been married over six months now. So, she started the ball rolling. So, I went obviously with the bloods and everything. I came home and explained to my husband, I think we need to start this journey. We need to get tested, we don't know if there's an underlying issue anywhere. Husbands and men being men think there's no problem it's fine, you're just overreacting. But I was very adamant, very adamant about it. So we did. X we started the ball rolling, we both went in together. When I sat down and broke it down to my husband, why, I think he got it. But men, I think they're a little bit more oblivious, a bit more laid back about the situation. So, yes, X we started our IVF journey…(35-49)*

> [14] ***Chloe:****…Yeah it was a mutual decision. My husband's quite laid back, he will just, sort of, let me decide what I wanted to do and then just roll with it. So I went to the doctors and then they referred me and I was just hoping that each stage that I wouldn't have to go more, take a more intense treatment…(202-207)*

In [13], Sabrina’s talk seems to construct ARTs as a problematic event in terms of her own view being problematised by her husband when she introduced the idea of starting IVF: you’re just overreacting. Talk in [13] and [14] seems to construct the participants’ husbands as more laid back, more oblivious [to IVF], and happy to let her decide about their fertility journey. Furthermore, Sabrina hypotheses that her husband is less involved because men never consider there may be a problem; these constructions possibly draw upon patriarchal discourse within which men are constructed as good financial providers, fertile, and not needing ARTs to become a father (Throsby, 2004). Consequently, perhaps by involving men in IVF, their ‘masculinity’ could be undermined and pose a significant social threat to them (Throsby, 2004). In turn, this dynamic may place women in the position of responsible for conception, with men being more withdrawn from this process. [13] and [14] demonstrate how the participants’ partners were not present or involved (*I went; I...spoke to my doctor*) in the process of IVF. This dynamic could be possibly seen as shifting the responsibility for conception onto the women.

Additionally, [13] and [14] illustrate construction of men being *laid back* about the process of ARTs. Dryden (2014) talks about this male approach to fertility as a strategy of silencing, serving to control and delimit change, and as she suggested, this silence is not a form of disengagement from the ARTs; however, potentially as a consequence of this, the male silence is constructed as a characteristic, rather than a strategy. This talk seems to construct them as unable rather than unwilling to be more involved; these characteristics are rendered as components of the masculinity discourse (Moynihan, 1998). Perhaps attributing being *laid back* to innate incapacity enables the women to take the position of *very adamant* without feeling left alone with the whole process of ARTs, since the marriage is essentially focused on mutual support (Seymour, 1999). Thus, it is the intention (agreeing to have kids) not the indicators (taking actions) that becomes the maintaining core for the relationship. Additionally, Seymour (1999) suggests that the problem-focused approach of women being *very adamant* is normally associated with being masculine, but in this instance, it is ‘gender-appropriate’ for women too, because it is constructed within the legitimate emotional context of wanting a child. Thus, taking a problem-focused approach as a woman perhaps seems to be limited to reproduction; consequently, the responsibility of ARTs is carried by women and continually orients them towards achieving motherhood. This circumstance prevents women from escaping the subject position of ‘responsible woman’.

The construction of conception as women's responsibility has a long history; for instance, they have been constructed as reproductive vessels bearing the man's offspring (Bordo, 2004; Stonehouse, 1994). Additionally, children's genetic conditions, not conceiving, or conceiving too many girls has been traditionally blamed on women within South-Asian cultures (Stonehouse, 1994; Inhorn & van Balen, 2002). All this is in line with the participants' talk, suggesting a sense of expectation that is informed by culturally available discourses about pregnancy practices which position women as responsible for the process of ART/conception, with little consideration of what she is experiencing and feeling. For instance, in [13], Sabrina positions herself as the one who is *very adamant* about starting IVF, whilst she is still unsure if her husband understands its importance (*I think he got it*); this is likely to affect who takes responsibility for the process, and subsequently, for the potential failure of the treatment. Another way of understanding why women might be more adamant and active in the process than men, is to look at this dynamic through the biomedical lens of women's biological clock and menopause. Through this discourse, women might experience a sense of responsibility and urgency in relation to the age-related deterioration of their fertility, reflected in egg quality, for example, which is emphasised within the NHS (NICE, 2017). This is analysed further in 3.1.1.

These constructions of women being more focused on managing the couple's fertility journey, compared to men being more laid back about it, possibly indicate the problematic position of 'responsible woman', perhaps creating negative implications for subjectivity, making ARTs a woman's problem. Given how Sabrina needed to *[break] it down* to her husband, she becomes 'responsible' and the one who takes the lead in the ARTs journey. The next section will explore women's constructions of ARTs in context of their wider South-Asian society.

### 3.2.2 ART in the context of the South-Asian-Muslim community

This section analyses the culturally available accounts of ARTs in relation to the enactment of 'disciplinary power' by South-Asian society and family members on a woman's conduct when experiencing fertility issues and deciding to undergo ARTs. All the women interviewed in this study talked about being possibly positioned as responsible for fertility. In their talk, the women focused on normalisation and disciplinary technologies that might inform the 'responsible' position and seemingly create the possibility for them to be blamed for both not conceiving 'naturally' and deciding to undergo ARTs. Extracts [15] and [16] highlight ways in which, despite the dominant representation of ARTs as private events between partners, they are very much a public practice and highly gendered, with women being expected to manage and negotiate public knowledge of this and its outcomes.

> [15] ***Barbara***:*…In the Asian society when there's an issue with fertility everyone automatically assumes that there's an issue with the woman. They will never automatically assume that there could be something wrong with the man….I feel that this is a big thing in why a lot of the ladies do not talk about the fertility issues because they don't want to be put in that position where the fault lies with them…So with my family…I will discuss it [IVF]…and I don't think it necessarily makes me vulnerable…but in my husband's view it might make me vulnerable…because he knows what people are like and how they think in the Asian community, he doesn't want anyone to say anything to me…if it's something to do with infertility it's the woman's issue, it's the woman's fault and I think because he doesn't want anyone thinking like that about me he wants that we keep it to ourselves purely for that reason…And I guess if it would be up to him he would rather everyone think that we've conceived naturally because I think he doesn't want anyone to think that there was something wrong with me and that we have to get treatment. So I think he mainly does it for my protection. And the thing is that when someone says something to me about going to so and so doctor and this, that and the other I always say to them I have been, I've had my tests done and there's nothing wrong with me and there's nothing wrong with my husband, our fertility tests come back fine…(1192-1237)*

> [16] ***Chloe****:…You just knew that it was a bad thing…it's not something that's someone's first choice but yeah they're happy now anyway. Now they can hold their head up in society and say "yes, all our children have children". 'Cause they do say it, they do say it when they…when we're in family gatherings they do say it "oh, this is my son he's got this many children…they never introduce me as just their daughter in-law they will say "this is my daughter-in-law she's got three children". It's my second name…(447-458)*

Extract [15] presents a construction of ART in highly gendered normative terms within South-Asian society, whereby *when there's an issue with fertility everyone automatically assumes that there's an issue with the woman*. Bordo (2004) argued that the disciplining and normalisation of women and their bodies are forms of social control. Thus, when this group of South-Asian-Muslim woman does not fulfil gendered regulatory practices, such as getting pregnant 'naturally', she possibly becomes subject to disciplinary disapproval of Asian society and the Asian community. Additionally, in line with the concept of normalisation (Foucault, 1978), women are expected to be able to conceive healthy babies naturally at the time that society expects them to, to achieve the political goal of being physically, financially, and emotionally supported in old age and achieve lineage in the family (Dimka and Dein, 2013).

Drawing on patriarchal discourses, motherhood and womanhood are treated synonymously (Throsby, 2004); not conceiving naturally establishes failure to femininity (*it's the woman's fault*). Barbara's talk perhaps demonstrates the moral and practical obligations of the couple undergoing ARTs, and the systems in which established understandings of the gendered body and social roles offer a framework for constructing ARTs as disproportionally disadvantageous to women: *everyone automatically assumes that there's an issue with the woman.* This may even include her husband, who might think like that himself. In [15], Barbara's husband seems to be constructed here as wanting to protect his wife, and this can be understood as part of the wider patriarchal discourse: *he doesn't want anyone thinking like that about me* so *he wants that we keep it to ourselves.* Possibly, men do not deliberately shift this responsibility on to women; instead, there might be a restricted scope of discursive resources available to account for the gendered reproductive body.

Barbara's talk also constructs ARTs, in terms of potential infertility issues that are accredited to women. Here 'infertility' might be considered a weakness, since this can be seen as a 'disease' which requires one to visit the doctor, get checked, and be diagnosed to receive 'treatment'. This talk is seemingly aligned with the social norm of emotional or physical expressions of weakness constituting a transgression of established constructions of masculinity discourse (Moynihan, 1998). This may be reflected in gender regulatory practices where women are more proactive with healthcare than men (3.1.1, [1] and [2]). Moreover, this again might create beliefs about 'infertile' women's bodies body being defective, positioning them as more responsible for procreation; therefore, *ladies do not talk about the fertility…they don't want to be put in that position where the fault lies with them.* Perhaps by being rendered silent, they manage to avoid the judgement or extra social pressure, although it may perpetuate the issue of the woman as responsible.

Talk in [15] also demonstrates how ARTs becoming public knowledge can generate significant vulnerability (*might make me vulnerable*) and social labour for women in managing the responses of others, perhaps to lessen their embarrassment or social awkwardness: *when someone says something to me…I say to them…our fertility tests come back fine*. Importantly, this gendered role is normatively prescribed and not performing this according to expectations risks significant social costs, such as judgments about a man's masculinity (Throsby, 2004).

In [16], ARTs are problematised as *not…someone's first choice* and, in accordance with the regulatory effects of normalisation, seemingly 'natural' conception via intercourse becomes a potent signifier of a specific understanding of conception. Additionally, the institutional practices of the patriarchal South-Asian family and wider society legitimise the positions available to women and, through the effects of normalisation, position them as responsible for the success of the husband's family within their community (*they [in-laws] can hold their head up in society*), which might be considered a weighty position to hold with no accompanying powers. The participant is constructed here as not having her own name, being defined in terms of mother, wife, and daughter-in-law. She is possibly defined in relation to the other: *they will say 'this is my daughter-in-law she's got three children'.* In this way, maybe the inability to conceive positions women as problematic and affects their self-image. It can possibly be argued that without a child, this group of South-Asian-Muslim women become almost dehumanised ('non respectable'), without a name and constructed as non-deserving of the space to be themselves and to be heard; they seem to become visible and respected only via the lens of motherhood.

Similarly, the next section elaborates on how the permissibility of ART is constructed in the context of an Islamic discourse with roots in gender segregation and men as purveyors of disciplinary power.

### 3.2.3 Permissibility of ART in the context of religion

Some of the inconsistencies regarding the permissibility of ART in Islam mentioned in 1.8 are perhaps reflected in participants' constructions of ARTs in relation to 'permissibility'. These constructions had different implications for participants' subject positions, both as patients who cannot choose the gender of their clinician, and as South-Asian-Muslim women who could be judged for undergoing ARTs within their society. In the context of Islam, when women choose to undergo ARTs, they are constructed as potentially doing something that is not permissible; if they make the 'wrong' choice, they may be judged. Thus, potentially Muslim women might not be receiving sufficient support from their community to help them make choices about ARTs, and it might also be the case that medical (NHS) staff may not be fully aware about the potential influences of Muslim women's religious beliefs when providing advice and support about ARTs; therefore, it could be argued that there is a key element of support missing for these women.

The talk in [17] problematises ARTs by highlighting the ongoing discussion about its permissibility within Muslim society.

> [17] **Barbara**:*…I was a bit more open with IUI and IVF even but my husband he was a bit reluctant with IUI and IVF and for him he just wanted that reassurance that it's [IUI or IVF] acceptable in Islam so I think he then sought advice from an imam that he knows, someone else very noble man, so he spoke to him and what he advised was that so far some scholars do say IVF is allowed and some say it's not allowed but with IUI... 'cause once a year all these scholars they meet once a year and in that one year they have loads of questions coming into them where people send in questions which are very grey areas and stuff. And that year they were focusing on IUI and IVF and so what they came back with was that IUI is permissible, it's allowed but with IVF some were saying it is and some were saying it isn't. So we decided then that IUI has come back permissible and we will go for the IUI…(891-906)*

Here, ARTs are constructed as potentially 'unacceptable'/'disallowed' and belong to *very grey areas* in Islam in terms of permissibility. Additionally, the term *very grey areas* evokes a sense of the unknown—and possibly worry—for women who must make decisions about their treatment options. It may also imply a need for 'black and white' thinking, extending from the construction of permissible versus not permissible within the dominant Islamic discourse. Barbara constructs IUI as permissible in Islam, which motivated the decision to undergo IUI rather than IVF. Consequently, women who decide to undergo IUI or IVF assume problematic subject positions and might be accused of doing something forbidden/unacceptable in Islam. These positions could create negative implications for subjectivity, particularly when Barbara constructs the permissibility of IUI: *IUI has come back permissible, and we will go for the IUI.* Additionally, her talk simultaneously positions Islamic scholars as active controllers of 'truths' (*some scholars do say IVF is allowed and some say it's not*). She may not question their fatwa regarding the ethical permissibility of ARTs, yet she may not feel confident about the authority of the fatwa.

Extract [18] highlights Catherine's constructions of being examined by a male doctor in a fertility clinic.

> [18] **Catherine:***…And then there was this male doctor and there was no lady doctor available and my husband was standing next to me when he was checking me and I was like [sucks in breath] okay, is this allowed in this land, there's no lady doctor available, and then he was so friendly and he said, I'm doing this for 35 years and everything looks good and you erm, just focus on happy times and then...Two weeks later it was only one egg. Instead of seven I was really disappointment but [unclear] it was a senior doctor…*(569-579)

In [18], Catherine constructs the act of being examined by male doctors as problematic in the context of IVF involving internal scans (*is this allowed in this land*). Some women feel more comfortable when these scans are conducted by female doctors; however, this might be difficult to arrange within the NHS. Also, this problematisation of gender may draw here on Islamic discourse around gender segregation, which may require women not to 'expose' themselves or even talk to men who are not their husband, father, brother or father-in-law. As a result of this construction, women who are treated by male clinicians may again be afforded the subject positions of 'problematic' or even 'sinful', which is often linked with feelings of shame and guilt within Islamic discourse (Inhorn, 2012). This may further lead to them silencing/hiding the fact that they are undergoing the treatment, to protect themselves from being judged for doing something potentially prohibited in Islam, and morally questioning their actions and decisions: *is this allowed*. Additionally, the wider sociocultural discourse that equates womanhood with motherhood is constructed as more superior/powerful than religious discourse in the hierarchy of power; this again demonstrates the potential conflict that these women may experience. It is possible that to make the choice of being examined by a male clinician, Catherine drew upon sociocultural discourse of motherhood within which the punishment for not having a child might be greater than for doing something potentially prohibited within the Islamic discourse.

In line with constructions of ARTs as potentially not permissible in the context of Islamic gender segregation, the following extracts demonstrate talk constructing judgements surrounding permissibility and also the constructions of lack of support within the community.

> [19] ***Chloe:****...So it has to be your own judgement at that time and how you apply your religion across the board not just go completely strict on one aspect and other aspects be relaxed...and so when someone judges you on it you feel, like, that not fair that you're judging me on something so harshly.*
>
> ***R: Have you had that happen to you that someone maybe judged you?***
>
> ***Chloe:…****Not directly, I mean, little things have happened, little things, like, I mean, once I was just talking to a lady and I thought I was getting into one of my relaxed conversations where I can, sort of, start saying "oh yes, I had IVF, you know". And but quickly I realised very quickly because she was talking about how she didn't have children for a period of five years and she goes that she went to…She goes "Oh, I had…"What did she say? Yeah, she used the word dawa again she goes "I did dawa in India" and I was like "oh really" I thought I was gonna get into, like, an IVF conversation. She's like "no, no, no, no, no, no only herbal stuff" I was like "okay" and I knew straightaway that she disapproves of IVF…(734-757)*

> [20] ***Chloe:****…They're [mosque/imam] talking about things like drug abuse and knife crime and porn and things like that but…and they're talking about domestic abuse*

> *and even women abusing men and lots of topics are talked about at that mosque. It's a mosque at X and there's lots of, like, monthly women's groups and mental health issues in women but I've never heard them talking about IVF and things like that so it would be interesting to see if, like, if that could be encouraged yeah. Just talking about it in the community and just, sort of, saying that this is something that is allowed yeah but I think something like that would help…(574-586)*

In these extracts, Chloe is positioned as a Muslim woman in the context of problematised ARTs that are not talked about in the mosque or the community. Also, ARTs are constructed as an event that women need to decide themselves regarding whether this is allowed within Islam (*it has to be your own judgement*); in consequence, although this could be seen as empowering women are left to do this on their own and in turn they might also be exposed to judgements. These ARTs constructions possibly draw on Islamic and cultural discourses; women who decide to undergo IVF might be positioned as doing something problematic that is potentially not allowed since there is no unity between Islamic scholars on this topic. Additionally, this group of South-Asian-Muslim women might practise silencing to avoid being judged; this might be a form of resistance to the dominant discourses. However, this resistance can be seen as productive only on a temporary basis. In the long term, it does not effect significant change; the power relations between these women and their society remain relatively untouched.

Additionally, the talk in [20] seemingly constructs lack of support for women undergoing ARTs. It also constructs concern about the Muslim community and mosque not attaching enough importance to ARTs related issues (*I've never heard them talking about IVF*), which may further impact upon the lack of understanding within the Muslim community which makes fertility and ARTs a woman's problem alone. Organising religious talks within the Muslim community about ARTs in the context of Islam might enable alternative discursive constructions of this phenomenon, such as it being permissible for a woman to be childfree, or for IVF to be a couple's 'problem'. Furthermore, the talk in [20] demonstrates that despite that, five out of six participants finished Western higher education and worked professionally they still experienced the tensions of the 'non-permissible' construction of ART, between their lives at home, community and work. Possibly the aspects of their Westernised identities contributed in [20] to their critical construction of the Muslim community as being silent on the topic of ART. Moreover, it seems that, despite their awareness about certain issues within their community in context of ARTs, it is still difficult for this group of South-Asian-Muslim women to not comply with the 'non-permissible' construction. Consequently, these women perhaps live in a duality of ARTs as 'permissible' and 'not permissible', alternating their talk and conduct, depending on whether they are with family members or someone in the community or just a work college, which is perhaps demonstrated in [19].

Extract [19] suggests that women's problematic positions potentially create negative implications for subjectivity when Chloe says *I thought I was gonna get into, like, an IVF conversation*; however, she quickly realises that her interlocutor does not approve of IVF, so she avoids further disclosure and silences herself. In this talk, Chloe presents her decision to undergo IVF as one that may lead to others judging her as problematic, which may affect her confidence in her own decision. Saying *it has to be your own judgement* could show that women are left on their own to make these decisions (as the one responsible), which I would argue seems to evoke a sense of loneliness.

In [20], the Muslim community is constructed as being silent on the topic of ART. In this sense, the Muslim community, mosque and perhaps scholars—who are mainly men—could be understood as purveyors of disciplinary power, in that they define which topics are considered valued or important enough to discuss, and do not perhaps address difficult topics with conflicting understandings or topics that are constructed as a woman's problem. The effect of this disciplinary technology is to potentially marginalise and subjugate women undergoing ARTs, positioning them and the topic of ART as less important to discuss.

The analysis in this section suggests that some South-Asian-Muslim women undergoing ARTs are marginalised for doing something potentially unacceptable in Islam that is not aligned with the norm or fatwa. These constructions of ARTs in Islam perhaps reflect wider socio-cultural-religious discourses of reproduction rooted within South-Asian-Muslim culture and religion. These problematic constructions are then associated with wider practices of asking for advice regarding the permissibility of ARTs from religious scholars, who are seen as 'experts' who make conclusions through the studying the Quran and Hadiths. Potentially, this can lead to the negative labelling of individuals as doing something prohibited. Discourses of permissibility possibly operate upon the premise that individuals should think, feel and behave in particular ways; hence, any deviation from this is considered unacceptable. This discourse of permissibility potentially promotes compliance with societal and religious regulatory practices, which regularises Muslim community and society, perhaps serving the political aims of religious institutions (Foucault, 1978a).

The next section addresses the final discursive site of this group of South-Asian-Muslim women reclaiming a sense of self and educating others, within which the women's talk created a narrative of resistance.

### 3.3 On the way to liberation from biomedical and sociocultural hegemony in the context of ART

This section aims to show the active role of women while they undergo ARTs and to consider negotiations of their problematised subject positions through their talk. By creating a story of resistance and placing themselves in a position of educating others, these women could be seen to offer a contrasting account in which they challenge those problematic constructions and resist practices of self-regulation which would protect their status as respectable South-Asian-Muslim women and as eligible patients. Foucault rejected the idea of discourse as all-powerful, suggesting instead that discourse is a site of conflict and contestation which provides opportunities for resistance. He argued that choice, opportunity, and power manage our relationships with the discourses we employ (Foucault, 1978); thus, women are not seen as passive, which supports Sawicki's (2020) portrayal of women's active role in their encounters with ART. This approach of the women's active role explores the negative and troubling aspects of ARTs, facilitating a shift away from woman-blaming or female victimhood towards a focus on the power relations within which ARTs operates (Throsby, 2004).

The talk in extracts presented here constructs how this group of South-Asian-Muslim woman position themselves as reframing and resisting the dominant subject positions of 'respectable and responsible woman', and 'eligible patient'. In the context of talking to a female outsider/insider interviewer, the participants engage in reflection on empowerment and construct alternative positions that could be considered more positive and socially desirable to inhabit.

> [21] ***Barbara:****…I asked for the referral but I said to them, 'cause I didn't want to have IVF, I just wanted someone to do the tests and see maybe...because I conceived twice by then I just wanted to see whether there's something simple where they can give a medication or something. Because I really do feel that there's a big gap in this thing where if you're experiencing issues of infertility they just refer you for IUI or IVF, they don't actually... because someone could just have something really simple where they just need something to stimulate them or something like that and they would want to conceive naturally but they never offer that to you it's either IUI or IVF…(161-173)*

In [21], Barbara constructs herself as someone who takes an active role, by asking and questioning the mainstream approach: *I asked*; *I just wanted someone to do the tests*; *there's a big gap in this thing…it's either IUI or IVF*. These constructions could be understood as an attempt to resist the powerful, expert in-group position, by identifying her own power in determining her fertility treatment. It could be argued that Barbara goes one step further and 'others' the medical staff within institutions of ARTs (*they never offer that*), undermining their system of diagnoses, referral and treatment: *there's a big gap in this thing…it's either IUI or IVF*. These constructions serve to create alternative subject positions to 'eligible patient' and might allow women to take the position of 'involved patient' whilst positioning clinicians as not all-knowing. Another example of discourse as an arena for resistance can be seen in [22] below.

> [22] ***Kendra:****…I have two...another people in my family, but that doesn't want to talk about this [IVF]. Why they won't to talk about this, I don't know why. But the oh, everybody know this...I give up, what the people say now. Now I'm living my life, simple as that, I doesn't care who wants…to know…when the people coming, I'm happy, I'm happy with my life, I have no control somebody talking this, that or saying something. Many people, when coming…when have you married? I have a little bit late married, and then after I late my daughter yeah, but my daughter is from IVF. I'm feel very prouder now…*(621-634)

Foucault (1972) argued that speech is a fundamental aspect of power, facilitating social change. In [22], Kendra uses talk as a form of understanding her experience; nonetheless, she recognises its limitations, saying that others *[don't] want to talk about this [IVF]*. She constructs the social perceptions of ARTs as something that she does not care about anymore (*I give up, what the people say now*), constructing this as liberating (*I doesn't care…I'm happy with my life*). Kendra possibly draws on feminist discourse as a way of reclaiming power and indicating her freedom from the dominant sociocultural discourse and South-Asian family hegemony; her talk perhaps constructs her sense of liberation from the dominant discourse by countering the negative view of mother by IVF with the positive view of proud mother: *I have a little bit late married, and then after I late my daughter yeah, but my daughter is from IVF. I'm feel very prouder now*. This construction may create a more tolerable account of ARTs and more tolerable subject position of proud IVF mother, extending this to her child. She describes talking to many people about her experience of IVF; by doing this, she perhaps frees herself from silencing and allows herself to feel proud about her experience of IVF, thus freeing herself from shame. In this way, perhaps her talk could be understood as liberating and resisting, which is consistent with viewing speech as a fundamental aspect of power that facilitates social change (Foucault,1972).

In [23], Chloe's talk constructs social interaction as a way to increase understanding of ARTs, positioning herself as educator increasing others' awareness of ARTs.

> [23] ***R: And do you think that by undergoing this treatment and do you challenge any stereotypes within Muslim or Asian community?***
>
> **Chloe**: *...with my in-laws I've been very hesitant in talking about it 'cause I know that my mother-in-law and my mum don't want me to talk about it. But outside I talk about it to anyone, I mean, if someone asks me...I will always refer them to my friend that I knew as an alima and her husband 'cause I always give them as an example and I would always...say look into it, if you have any questions let me know. And I think just by talking about it and using the proper technical terms to describe the process because there's IVF there's IUI, there's so many different things...But I haven't done any more than that, I mean, there are probably more things that you can do, like, even in the local mosque they do have talks about things and I've never heard them talk about [IVF]...Just talking about it in the community and just, sort of, saying that this is something that is allowed yeah but I think something like that would help...*(549-586)

Here, Chloe's talk seems to show resistance to the dominant sociocultural discourse of ARTs and she positions herself as liberated and resisting silence (*outside I talk about it to anyone*). She counters her experience of silencing (*my mother-in-law and my mum don't want me to talk about [IVF]*) with her talking *outside...to anyone*. Although this countering may create a division between the family and her other social networks, it might also represent a position on the way to liberation from silencing. Despite experiencing silencing within her family, Chloe constructs her position as a woman who is experienced in and well-informed about IVF, and who understands the importance of talking to raise awareness about IVF within the community. This is again consistent with the Foucauldian approach to power enabling social change via talk (1972). Through her talk, Chloe challenges dominant South-Asian sociocultural discourse, by talking about ARTs, and by suggesting there should be more education about ARTs in mosques. Perhaps making sense of ART-related issues in these ways could bring positive change to these women's lives, challenge dominant social constructions of ARTs, and create alternative new discourses.

The subject positions of 'involved patient' and 'liberated woman' perhaps serve to reframe this group of South-Asian-Muslim women's experience of ARTs and provide more desirable positions for these women to inhabit. The participants in this study discussed these positions in terms of by their ability to educate others, manifesting their knowledge acquired through experience and positioning themselves as more liberated. While they acknowledge that ART is a platform of many challenges, especially for women within the South-Asian community, there was also a sense of strength and empowerment in these women’s talk. Participants employed this talk as an act of resisting the silencing and problematic construction of the ‘passive patient’, helping make sense of and reframe their experience of ARTs.

This concludes the analysis and discussion chapter. The next chapter will summarise and draw conclusions about the ways in which the women in this study constructed ARTs as biomedical and sociocultural events. An evaluation of the research will be offered and the implications for therapy practice, for policy and practice surrounding how ART is approached by the NHS, and recommendations for further research of will be outlined.

# Chapter Four: Summary, Evaluation, and Implications

## 4.0 Overview

The research findings are critically evaluated in terms of the study's aims and research questions, considering influence of the researcher. The implications of the research for future research and practice, and its relevance for CoP, are also discussed.

## 4.1 Summary of the research findings

The primary intention of current research was to explore how ARTs were constructed in and through South-Asian-Muslim women's talk in the context of their sociocultural and biomedical environments, as well as its implications for subjectivity; this was guided by the three questions outlined below:

### 4.1.1 How do South-Asian-Muslim women talk about ART in the context of their socio-cultural environment?

Firstly, within the wider biomedical discourse, ART seemed to be constructed as a biomedical event; secondly, within the wider sociocultural discourse, as not normal and not natural; and thirdly, within the Islamic discourse, as not permissible. Whilst these constructions of ART were related to various degrees, they were also problematic and pervasive across these women's lives. Across all these dominant constructions, various hierarchical structures seemed present, within which these women perhaps struggled to find their own voices. Sites of disciplinary power such as NHS fertility clinics, mosques, the community and the family seemed frequent constructions in the participants' talk, demonstrating how power is exercised on this group of South-Asian-Muslim women. Sociocultural, Islamic, and biomedical discourses gave the impression of wider hierarchical discourse portraying ART as a problematic event located in women.

Within the sociocultural discourses, in the context of the family, ART perhaps emerged as *not normal* and *not natural*. Within these constructions, the approval of women's conduct and the fulfilment of the social regulatory practices seemed to be important aspects of the participants' talk, which was also present in previous research by Inhorn, et al., 2012, and Culley and

Hudson, 2009. The South-Asian-Muslim family and community could be seen as generating the normalising knowledge of *not normal* or *not natural* ART, controlling then procreation; this may be linked to ART's problematic construction in Islam as *not permissible* or within *very grey areas*. Lack of agreement, when certain aspects of life do not fall into permissible or not permissible categories within Islam, may create a third category of *not normal* or *not natural*. Arguably, then, sociocultural and Islamic discourses overlap to a great extent. Furthermore, when within Islam there is a lack of clarity about an issue such as ART, then this may reinforce its constructions within the sociocultural discourse as *not normal* or *not natural* and lead to judgement. Thus, the construction of ART as *not normal* seems to be intertwined with the constructions of *not permissible*.

These constructions of ART are possibly underpinned by the power coming from knowledge which can be accumulated by processes of defining homogeneity, creating 'desirable ways of being'. Foucault (1983) saw this as 'totalizing power' operating on people while being invisible to them, steering individuals to embrace their subjection as freedom. This could be observed in the women's talk about their social requirements to have a baby to secure their womanhood, and religious requirements to do what is permissible. Similarly, within the biomedical discourse, ART seemed to be constructed through regulatory practices such as 'right BMI' and 'fertile age' which are aligned with the Foucauldian (1978) concept of normalisation. ART also seemed to be constructed as requiring frequent and intrusive scans, measures and tests of the women's bodies; through this gaze, these women were perhaps problematised and categorised into what is acceptable and what is not, creating a 'disease' of 'infertility' for which the treatment is ART. This idea of female body being seen as a faulty machine needing medical interventions, is in in line with Greil's (2002) arguments about body objectification on context of reproduction. Again, the process of defining homogeneity seemed present in the women's talk about 'right BMI' and 'fertile in the context of being 'eligible patients'. Perhaps these constructions of ARTs as a treatment for the 'disease' of 'infertility' for which we have then a choice to 'stay ill' or seek treatment to 'be healthy', speak directly to the contemporary idea of the medicalisation of fertility. Furthermore, constructing ARTs within the medical system as a treatment for 'infertility' validates its usefulness, although about 25% of 'infertility' cases within NHS are actually unexplained (NHS, 2020). In the context of this construction, women are then classified as eligible patients who need to follow the advice and guidelines within the system. Arguably constructing ARTs as a medicalised treatment for an 'illness', could be seen as economically benefiting a growing business Spars (2006), particularly when we consider that majority of the fertility treatments in the UK are actually paid privately.

Additionally, the effects of gaze were also seen in the constructions of ART as *not normal* and *not natural.* This perhaps serves to regulate these women's practices, as seen in their talk about needing to silence the fact that they were undergoing ART. Perhaps they used silencing to shelter themselves from potential societal and medicalised punishment in the form of looks, judgement, back biting and exclusion. A potential consequence of silencing and suppressing their identities, their wishes and emotions could be recognised as different forms of somatization. Considering that there is a big gap in the medicalised approach to fertility treatments (about 25% of infertility cases are unexplained and low success rates of ART treatments), perhaps to an extend this could be contributed to somatisation.

Throughout, ART seemed to be constructed as a problematic event, problematising women: first, as a physically and emotionally draining treatment within which women's bodies may be problematised as too old or overweight; second, as *not normal* and *not natural,* such that women might be socially judged for doing something potentially unacceptable and *not permissible* in Islam. This resonates with previous research conducted in Costa Rica that discussed the injustice of social rules regarding infertility which cast childless people "as abnormal" (Jenkins et al., 2002, p.187). Additionally, it appeared that the women were constructed as predominantly responsible for conception within sociocultural and Islamic discourses, and for successful ART treatment within the biomedical discourse. Perhaps these constructions of ART—as problematic, as women's responsibility, as *not normal* and *not natural*—create possibilities for the Muslim community and medicalised fertility system in which others do not need to take responsibility or interest in sharing what these women are experiencing. Thus, discursive constructions of ART in which responsibility is shared appear to be limited, constraining what these women can or cannot do or say.

Additionally, in contrast to ARTs as events that need to be silenced within the dominant sociocultural discourse, women also appeared to construct this as an event that can be discussed with specific people. This may enable a counter-discourse that allows these women to resist the dominant discourse. Although silencing could be argued to be a form of resistance in some discourses, in this instance, it does not appear to bring any long-term difference; rather, it may maintain the dominant discourse. Potentially, it may temporarily help women to avoid the gaze of others and any immediate consequences of their treatment being known, such as back-biting or judgements. However, it should be acknowledged that participants in the current research broke the silence and spoke out about what they may have been expected to stay silent about. Similar insights were shared by Jenkins et al. (2002), who recognised how their participants broke the silence simply by participating in their research about childlessness.

### 4.1.2 How do this group of South-Asian-Muslim women undergoing ART become constituted through the available discourses?

Three main subject positions were elucidated: ‘eligible patients’ within the biomedical discourse, and ‘respectable women’ and ‘responsible women’ within the sociocultural and Islamic discourses.

Medicalised knowledge such as NICE guidelines and practices of clinicians within the NHS seemingly rendered these women as ‘eligible patients’. Within this subject position, through talk, aspects of the body (‘right BMI’, the ‘right age’) and body practices (healthy eating, scans and tests) seemed to be problematised. Furthermore, this way of positioning women seems to create a problematic reality for them, particularly when treatment fails, which is in fact very often as seen by the statistics of ARTs treatments; in this way, women seemed to be left with complicated emotions of guilt, regret, shame, rumination (i.e. I could have done things differently) and the burden of self-blame, which resembles with Thorsby’s (2004) argument.

Additionally, the ‘eligible patient’ subject position may also be used to legitimise explicit forms of hierarchical power and control, such as rendering these women’s bodies docile; this means that when they are approached as patients, they might be seen as separate from their bodies, which are then objectified. This resonates with Shildrick’s (2015) argument that objectification silences and ignores individuals, treating them with a modernist rather than holistic approach. Furthermore, Shildrick argued that there might be an assumption that as long as the medical duty of ‘do no harm' is fulfilled, there will be no ethical problems; however, this approach may potentially deny patients moral agency. Arguably, there are profound implications for women who take up the subject position of ‘eligible patient’. For instance, their decision-making during treatment may be affected, whereby they may become passive and obedient, not asking questions for fear of occupying the ‘ineligible’ subject position. This might be relevant in the context of accessing treatment through the NHS, as Culley highlights that about 80% of all ARTs in the UK are self-funded, maintaining a high demand for the free NHS cycles that have “very strict eligibility criteria” (2009, p. 23).

Within the sociocultural and Islamic discourses, participants seemed to be afforded the ‘respectable woman’ and ‘responsible woman’ subject positions; these were intertwined and interdependent in various situations.  Perhaps, to occupy the ‘respectable woman’ subject position, women seemed to first have to occupy the position of ‘responsible woman’.

Throughout the analysis, the responsibility for procreation and ART was seemingly assigned to these women, perhaps via gender roles and masculinity discourses, rendering them responsible compared with the men, who inhabited the position of being *laid back*. This supports the argument that women were the ones initiating treatment, rendering them responsible for decision-making in regards to ARTs and the ‘couple’s infertility’ (Inhorn & van Balen, 2002; Throsby, 2004). Additionally, the ‘responsible woman’ subject position could also be seen within the ‘eligible patient’ position, in which ARTs plans focus on the woman, rendering her responsible for changing her diet, relaxing, and knowing the NHS guidelines.

Adding to the point, ARTs created ongoing legal, moral and ethical dilemmas, to which perhaps there is no simple answer. Thus, possibly by positioning women as ‘responsible’ within the sociocultural and Islamic discourses, this could also be seen as potentially placing the responsibility for taking the moral, ethical and legal decisions on women, which seems like a very heavy weight. Also, when women find themselves being silenced within the biomedical discourse this could have the consequence of leaving them unsure about some of these dilemmas, as it can be argued that they might not have a chance to explore such dilemmas due to silencing issues. Possibly if we were to approach the legal, moral and ethical issues openly across these discourses, women might be left with clearer choices, having more sense of control and the responsibility would be distributed more evenly. Potentially, bringing an approach that does not prioritise silencing or place responsibility on women in the context of ARTs, might decline the growth of ARTs treatments and increase statistics of childlessness as a choice.

Moreover, within the current data, the biomedical, sociocultural and Islamic discourses seemed to strengthen hierarchical power and control through the subject positions of ‘eligible patient’ and ‘respectable woman’. Arguably, for women to occupy these subject positions, they needed to adhere to the acceptable regulations of what constitutes the ‘normal and permissible conception’, which resonates with Foucault’s concept of normalisation. Also, perhaps by occupying these positions women risked losing the liberty to choose how to construct their womanhood whilst maintaining the hegemonial power of the family, society and mosque. Finally, silencing creates a ‘narrow way of being’, which means that these women do not have many choices for practices available to them, within the available wider discourses (biomedical, sociocultural and Islamic). What is more, this ‘narrow way of being’, might not be aligned with their identities, wishes or desires, which in turn can create a lack of congruence within themselves. For this reason, I believe that if we approach the legal, moral and ethical issues openly across these discourses, this would perhaps then create more choices for these women to have (more ways of being) and a greater sense of control. Yet, this proposed open approach may create a ‘new idea of womanhood’ that may not consist of or may not include motherhood in it; in short, this may create a change, that could challenge the status quo, by going against the medicalised approach to fertility and Islamic pronatalist approach, in which arguably women might have more freedom, and power might be more evenly redistributed.

### 4.1.3 What are the social practices guaranteed by these discursive constructions?

Within the biomedical discourse, women perhaps silenced their wishes, obeyed guidelines and unquestioningly followed advice; within the wider sociocultural discourse, women possibly, silenced the fact they were undergoing fertility treatment, were proactive in arranging it, and managed expectations and questions from family, friends and community about their ‘fertility status’; and within the Islamic discourse, women seemed to silence their treatment and question its permissibility, but resist the dominant discourse by questioning the lack of support for women undergoing ART.

The social practices guaranteed within these discourses may also relate to the available subject positions. Therefore, when women were positioned as ‘eligible patients’, they may have deployed silencing, obeying and unquestioningly following clinicians’ advice, perhaps demonstrating their internalisation of dominant knowledges through these self-disciplining behaviours under the regulatory power of normalisation and othering, which seem to create ‘desirable ways of being’. Yet, if these women were to voice their concerns (e.g., Chloe regarding the choice of treatment in [2]) or wishes (e.g., Catherine regarding when to begin treatment in [1]), they may have feared being placed in the position of ‘ineligible patient’, considering the very limited access to free NHS ARTs (Culley, 2009). Additionally, medicalisation of certain aspects of life such as reproduction is explained by Foucault’s concept of biopower: “techniques for achieving the subjugation of bodies and the control of populations” (1978, pp. 140). Biopower can be understood as a practice of governmentality, because the knowledge it creates acts as a tool of power to make individual bodies more efficient and thereby govern populations and support the socio-political control of people in society. Therefore, people and their bodies become part of the system of cultural regulatory practices and discourse within a society. This technology of power is arguably present in the talk about women's bodies being problematised in the context of their age or weight, and making their body most efficient to achieve pregnancy, and also in the talk about changing treatment plans without their consent and requiring these women to follow doctors' guidelines. In context of biopower, perhaps participants in current research talked about a desire to have children that potentially originates within the biomedical and sociocultural discourses and that acts as a disciplinary technology against which women than they are policing their bodies and conduct. However, this in turn creates a very narrow way of being for these women and in the case when they cannot fulfil the requirements of 'eligible patient' they can be discharged and eventually perhaps blame for infertility and lack of offspring.

Similarly, when positioned as 'respectable' within the wider sociocultural and Islamic discourses, participants appeared to practise silencing, such as disposing of used needles outside the house shared with in-laws, hiding a small fridge for IVF medication in a bedroom (Kendra, [10]), or just avoiding talking about ART with people who might disapprove of it. These silencing practices may demonstrate the internalisation of dominant knowledge through self-disciplining behaviours. Again, the regulatory power of the hegemonial family and, particularly, the Muslim society, appears to generate 'desirable ways of being' through normalisation, such as natural conception being the ultimate *normal* and *permissible* conception. Additionally, this normalisation of women's reproductive functions could be considered a form of social control that maintains the power of the patriarchal family and male-dominated institution of Islam. Furthermore, ARTs here can be seen perhaps as challenging the regulatory constructions of 'natural' or 'normal' conception within the wider sociocultural discourse; Farquhar (1996) said this can be threatening to the patriarchal reproductive hegemony and its uncritically persisting applicability of the 'normal conception'. This is, because perhaps ARTs create choices and alternative ways of being, for women, for instance women can decide to have children later in their life that is not aligned with the sociocultural norm of reproduction with the sociocultural and Islamic discourse.

What seems to bring these three subject positions and social practices together is silencing and responsibility. Within the sociocultural discourse, the women seemed to use silencing to conceal their treatment and occupy the 'respectable woman' subject position. Within the biomedical discourse, the women *just [followed] the doctors' guidance,* silencing their wishes or concerns to occupy the subject position of ‘eligible patient’. Within the wider sociocultural and masculinity discourses, women seemed to choose not to talk about *fertility issues,* perhaps to occupy the subject position of ‘responsible woman’, which seemed to involve multiple layers. The first entailed all the responsibilities women have within the biomedical discourse when obtaining treatment and ensuring its success (e.g., age, BMI). This is in line with Throsby’s (2004) argument that medicalised constructions of ARTs are also connected with funding issues, putting the entire responsibility for successful treatment onto women, and that women are held responsible when treatment then fails. Secondly, women were rendered responsible for managing expectations of partners, family and community, by assuring them that *fertility tests come back fine,* for instance. Thirdly, women seemed to take the responsibility for ‘couple infertility’, a finding which has been reported widely in the literature (Inhorn and van Balen, 2002; Reissman, 2000; Remennick, 2000; Throsby, 2004). Here again, the social practice of silence might be seen as advantageous; if nobody knows about the treatment, there can be no expectation or judgement.

## 4.2 Evaluation and Critical Review

In this section, the findings of the current analysis will be evaluated in relation to its validity, application and trustworthiness (Georgaca & Avdi, 2012; Willig, 2013; Yardley, 2008). Willig (2013) states that quality of research should be assessed based on its epistemological assumptions and methodological outline. This research follows a critical realist social constructionist epistemology (Willig, 2012). Accordingly, the evaluative criteria include: commitment and rigor; sensitivity to context; transparency and coherence; and impact and improvement (Willig, 2013; Yardley, 2008), which I will expand on below.

### 4.2.1 Sensitivity to context

Sensitivity to context can be achieved by displaying alertness to the participants’ perspectives, the socio-cultural background of the research, and how these may impact an interview’s outcomes and researcher’s interpretations (Yardley, 2008). I strived to demonstrate sensitivity to various social contexts in Chapter One by paying attention to institutional racism (1.9) and acknowledging my relationship with the participants through reflection on my position as an insider and outsider researcher and related issues of power (see 2.8.1 & Appendix I). Additionally, after reviewing the literature and conducting interviews I became more aware of the stigma attached to ‘infertility’, childlessness and ARTs within the South-Asian-Muslim culture, and consequently chose to exclude demographic details of the participants to protect their confidentiality and thus any potential stigma. Also, I did ask participants about their age, but I did not include it in this thesis, since the research aimed to understand how the participants construct their subject positions, I wanted the reader to focus on constructions such as *[I] am old, ... according to a lot of people. I don't feel old* (Catherine, [11]) rather than participants' actual ages, hoping to limit the transmission of pre-conceived ideas.

### 4.2.2 Commitment and rigor

Yardley (2008) claimed that commitment to the research is possible by immersing yourself in the subject studied; I therefore used a reflective journal and engaged in supervision, reflexive peer conversations and reading about the topic extensively, which was also recommended by Harper (2012). Though I undertook this project five years ago, I have never disconnected from it. Also, during this time I underwent IVF treatments myself, and I am now raising two toddlers whilst remaining committed to this research.

Furthermore, within qualitative research, it is possible to accomplish rigour by analysing collected data attentively, with a fine understanding of theoretical concepts and appropriate methodological skills (Yardley, 2008). I achieved this by reading about FDA extensively and asking for further support from experienced academics and peers who had embraced the same methodology. My dynamic process of engaging with this research can be seen in my reflexivity throughout the thesis and in Appendix I.

### 4.2.3 Transparency and Coherence

Transparency can be shown via 'paper trail'; this can be understood as parts of the thesis that will not be examined but are still available to view upon request (Georgaca & Avdi, 2012; Yardley, 2008). Thus, I presented a clear and coherent account with methodological and analytical transparency (see Appendixes J to M).

Moreover, research coherence is evaluated through its capability to produce a valid and clear claim from the liaison between theoretical framework, study questions, methodology and analysis (Yardley, 2008). Thus, in the current study, I readdressed the research questions and arguments in my analysis and discussion; this is demonstrated in Chapter Three, through the three discursive sites that were organised into a narrative that presents how this group of South-Asian-Muslim women in this study constructed ART.

### 4.2.4 Limitations

FDA has been criticised for lack of theoretical approach and being methodologically linear (Willig, 2013). These criticisms could result from the dissimilarities between the naïve realist architype, which constructs empirical conventions, and the more relativist epistemologies of qualitative research. Foucault developed several concepts which he wanted to act as tools to investigate the effects of discourse on social change (1974). Thus, I used FDA concepts to produce coherent narratives of ART constructions without rigidly following theoretical structures (Foucault, 1974; see 2.8). Also, as a critical realist researcher, I reflect on my own subject position's influence on the data and demonstrate awareness about alternative interpretations (Willig, 2013; see 3.0).

A key limitation was the difficulty in recruiting participants (See 2.7.1). Recruiting participants from denser South-Asian-Muslim communities outside London, such as in Luton or Bradford, might have offered different insights into ART constructions. However, I am aware that recruitment in these areas may have required more time considering my outsider and insider positioning (see 2.8).

### 4.2.5 Impact and Recommendations

#### 4.2.5.1 Implications and Recommendations for Future Research

The vast biomedical research which constructs ARTs as a medicalised event has been important in thinking about service provision for women who require these treatments; although the sociocultural literature about minorities and ARTs is growing, this area remains under-researched (Culley et al., 2004; Wade & Halligan, 2004). In line with Wade and Halligan's (2004) contextualised model of illness, it was my intention to investigate the sociocultural environment and how women construct ARTs in the context of their relationship with themselves and others, which I argue is neglected by the medicalised approach to ARTs.

For instance, most of my participants vocalised feeling shame, fear, and a need to silence themselves; this was analysed in terms of their need to perhaps preserve the status of the 'respectable woman' and 'eligible patient'. Future research could focus on a different area such as South-Asian-Muslim women's lived experiences of ARTs whilst in therapy; arguably, being in therapy might potentially help women to broaden their understandings and consequently provide new insights into their experiences, particularly if embracing a qualitative methodology that encourages the lived experiences of participants when taking up certain subject positions.

Based on the masculine discourse, also reported by Seymour (1999) and Dryden (2014), within which men seemed more withdrawn from ARTs compared to their women partners, it also seems important to perhaps consider men in ARTs research in conjunction with women. The literature would benefit from supplementary research to explore men's constructions of ARTs within the South-Asian-Muslim society. This might provide new insights into the 'silent men' position in the context of ARTs and may consequently lead to the construction of more balanced ways of distributing the responsibility for infertility in couples.

The current, novel research findings and any future research in this area could inform a more holistic approach to working with the South-Asian-Muslim women who attend fertility clinics in the UK. For instance, Yao and Mills (2016) state that there is an increasing awareness worldwide about the possible benefits of holistic approaches to male infertility, which suggests that a similar approach could be valuable when working with South-Asian-Muslim women. Similarly, Gonda et al. (2018) advocates for a more holistic approach to IVF female patients, indicating that lower stress and anxiety may increase the chances of live birth after ARTs and also could improve patients' overall experience of ARTs. Potentially, this more contextual approach could also contribute to reducing the excessive responsibility for reproduction placed on these women.

This study demonstrates the potential benefits of moving away from a predominantly medicalised approach to ART within the modernist science, and it illustrates the likely implications for women's subjectivity due to the way ARTs are constructed within biomedical and sociocultural discourses. Within psychological services and fertility clinics, this knowledge could possibly contribute to the consideration of new non-medicalised approaches focused on the contextual factors of people from minorities, perhaps centring on silencing, which seems to be a predominant theme. Similarly, valuable understanding of different meanings of ARTs could be gained through research approaches that make it possible for the voices of women and their sociocultural environments to be heard. Particularly, by focusing on women's talk about ART in the context of resistance, qualitative methodologies that elevate participants' voices (e.g. IPA, TA) could potentially offer avenue to promote marginalised discourse of ART treatments. Additionally, qualitative research on ARTs involving mosque imams might also enrich this niche, by bringing their perspectives. Additionally, FDA enables elucidation of connected processes operating to regulate subjectivity (Willig, 2013); therefore, perhaps by examining the historical and sociocultural processes of masculine, biomedical and sociocultural discourses of ART and 'infertility', their impact on women from South-Asian minorities could be better understood and resisted.

### 4.2.5.2 Implications for Clinical Practice and CoP

As already demonstrated, there is extensive research on 'infertility' and ARTs based on a modernist approach to science that contributes to their medicalisation. It could be argued that this approach marginalises a holistic approach to fertility, favouring 'objective knowledge' regarding women's body measures and age common to biomedical and economic discourses. In this research, it seems that women's wishes and concerns regarding their treatments were disregarded and following NICE guidelines and recommendations were prioritised. The reviewed literature and findings of this study thus demonstrated a potential gap in the medicalised approach to ARTs that appears to dismiss the values of women who perhaps try to fit into the system to occupy the position of 'eligible patient'. This then creates a possible conflict between their moral values or wishes and what they feel they need to do, possibly leaving them emotionally vulnerable when silencing their concerns regarding the permissibility of ARTs or when taking the full responsibility for the treatment's outcome, for instance. Furthermore, the practice of silencing has been also demonstrated within the sociocultural discourse in the current research, which may again prevent women from expressing their wishes or even from having choices regarding their fertility journey; this could be regarded as being against CoP values (Holmes, 2001). Therefore, my recommendation would be to introduce protocols, evaluative measures and assessment procedures that focus not only on medical aspects of the body but also on sociocultural aspects of these women's lives, such as their religion/beliefs, living arrangements/family relations, support network and so on, which are at the core of humanistic CoP work values (Strawbridge & Woolfe, 2003). This contextualised approach might increase awareness about the potential needs of these women and help them to foster an environment and relationships in which they might, firstly, become aware of their choices and, subsequently, make informed decisions, express their needs and wishes regarding treatments. As a CoP, I advocate for all these recommendations since they lie at the core of the discipline. Considering the findings about the subject position of 'responsible woman', it could be argued that it is predominantly women who take the blame when treatment fails, within both the biomedical and sociocultural environments. Therefore, I would recommend creating supportive spaces or therapy groups within fertility clinics, to encourage women to share their experiences with other women and resist the dominant discourses. Furthermore, initiating talks about ARTs hosted by women in mosques could potentially help to challenge dominant discourses and increase awareness about the issues women within these minorities are facing.

It is also possible that the concepts of 'normal' and 'abnormal' within fertility are not exclusive to medical clinicians but also held by psychologists, who consequently might not focus on issues of context. By not challenging the medicalised regulatory practices about for instance the right BMI, clinicians might have a substantial effect on a client's therapeutic journey. This might be due to the constructive power of discourse that enables certain ways of being (Willig, 2013); thus, also psychologists may fail to challenge dominant biomedical discourses, perpetuating issues of women undergoing ART treatments by limiting alternatives such as holistic discourse. In line with the constructive power of discourse, I believe that unless doctors and psychologists use alternative discourses within which the responsibility is distributed more evenly within couple and between the clinic and the couple, the regulatory power of fertility clinics will remain unchallenged. Thus, when CoPs or any other therapists inform their practice with awareness about Islamic and sociocultural discourses in the context of ARTs, this may encourage South-Asian-Muslim women to talk about this, enabling the construction of new, liberating discourses which resist hegemonial and hierarchical power. Possibly when practitioners are not aware about the knowledge taken for granted, this might limit the conversation between them and clients, and then limit what clients can or cannot say and consequently restraining client's practices. Consequently, I would recommend the creation of an online platform such as a YouTube channel, blog or podcast, to disseminate research-based information such this research, share experiences, create discursive spaces, and potentially new discourses, strengthening the marginal discourse that are already available through our resources. Such a platform could be accessible not only to women, but also to the wider South-Asian-Muslim society and also practitioners.

Hopefully, through addressing some of these issues, it may be possible to facilitate a better overall experience of ARTs, and also thereby increase the chances of life births after ARTs, in line with Gonda et al.'s (2018) conclusion that decreasing stress and anxiety may increase the chances of successful fertility treatments.

## 4.4 Reflexivity

In this section, I reflect on how my role as a researcher has shaped the knowledge constructed (Braun & Clarke, 2013), including my relation to the epistemological stance taken here.

### 4.4.1 Epistemological Reflexivity

Willig (2013) recognised that when data is being analysed using FDA, the focus is on how language influences the constructions of social and psychological life. In line with this, the current thesis must itself be understood as a discursive construction; thus, a reflexive stance was adopted which paid attention to my impact on the research while constructing this new knowledge. Rather than discovering the 'truth', I wanted to explore how South-Asian-Muslim women construct ART. FDA allowed me to explore various constructions of reality, via the sociocultural and psychological effects of discourse, and their implications for subjectivity. I have not identified any research studying constructions of this minority in the context of only ART; My approach to this topic was therefore exploratory. Although alternative methodological approaches could have been used, they would not have matched with the aims of this research (see further 2.3).

### 4.3.2 Personal Reflexivity

In line with Willig (2013), in this section I reflect on how my clinical, researcher and personal experiences shaped the process of writing this thesis and my understanding of ART in the context of the South-Asian culture.

Throughout this research process, and especially when analysing the data, I started to adhere to scientific discourses related to needing confirmation and references for various statements. Additionally, Foucault constructs truth as a historical product; thus knowledge is not ultimate (Hollway, 1989). In this study, my need to draw on the science discourse was tempting because the 'knowledge' and science perhaps reassured me as a trainee CoP psychologist without professional experience in the field of fertility issues. It was only through peer-supervision that I was able to realise and then resist this position of unexperienced researcher by drawing upon alternative discourses. Whilst recognising numerous realities can create a sense of doubt, now I am reassured by the concept that my research comprises a new set of many possible understandings, which is in line with my epistemological position.

Additionally, working through this project has also enhanced my awareness of my own assumptions; at some points, I noticed how difficult it was to resist dominant constructions of ART as problematic and located within women, with the responsibility for not having children and dealing with all aspects of ART treatments thus falling automatically onto them. These perhaps socio-culturally inherent assumptions eventually showed themselves during the process of writing this thesis. Importantly, I wanted to explore this issue to demonstrate how deep-rooted these dominant constructions of ART could be, and how they might insidiously influence other clinicians. Even I, having researched and personally experienced ART in the context of multiple cultures, was not immune to these regulatory processes. See Appendix I for more personal reflections.

### 4.5. Summary

This research aimed to explore how South-Asian-Muslim women construct ARTs within the contexts of the NHS and their sociocultural environment. Through a social constructionist lens, a Foucauldian Discourse Analysis demonstrated that ARTs are constructed by participants as a problematised phenomenon. The data was discussed in the context of the biomedical discourse of medicalised NHS; sociocultural discourses of the hegemonial South-Asian-Muslim family, society, and romantic relationships; Islamic discourse; and Foucauldian concepts of power. The findings suggested that South-Asian-Muslim women are predominantly rendered responsible for procreation and consequently ARTs. Also, these women seemed to take responsibility for couple infertility, which resonates with previous research by van Balen (2002), Reissman (2000), Remennick (2000) and Throsby (2004); furthermore, they appeared to be responsible for the medicalised aspects of ARTs (Throsby, 2004), and they also appeared to be rendered responsible for ARTs within their Islamic and sociocultural circles (Farquhar, 1996). Additionally, finding of silencing emerged as a prevalent aspect across these women’s lives. Therefore, a broader perspective on these ‘issues’ is advocated, which may aid understandings, of the effects of context and language to promote new and de-problematising discourses within biomedical and sociocultural environments. This would entail professionals within medical and therapeutic settings firstly becoming aware about the knowledge taken for granted such as these women’s problematic subject positions, and then consequently helping these women and couples to create new de-problematised discourses within which they could make informed choices in relation to ARTs. Promoting the new discourses within the sociocultural environments could also perhaps help to shift the responsibility that predominantly lies on the women. I hope that by sharing these new insights into ARTs within the South-Asian-Muslim minority in the UK, a new more positive construction of ARTs will be possible, helping women and couples to perhaps feel less lonely when dealing with ‘infertility’.

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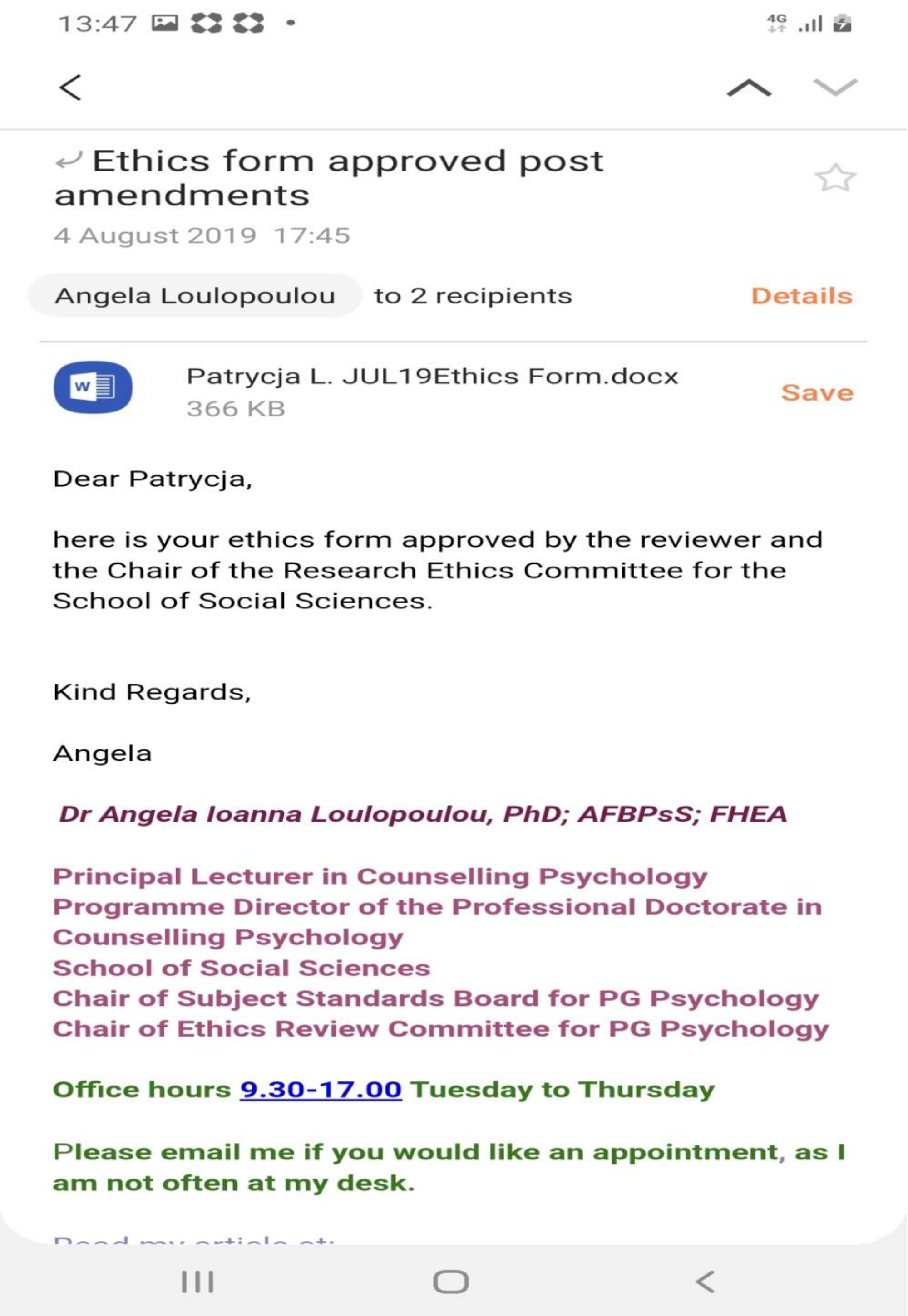
# Appendix A: Ethical Approval

An email confirmation about the Ethics Review being approved, post amendments



Ethics form approved post amendments

4 August 2019 17:45

Angela Loulopoulou to 2 recipients

Patrycja L. JUL19Ethics Form.docx
366 KB

Dear Patrycja,

here is your ethics form approved by the reviewer and the Chair of the Research Ethics Committee for the School of Social Sciences.

Kind Regards,

Angela

***Dr Angela Ioanna Loulopoulou, PhD; AFBPsS; FHEA***

**Principal Lecturer in Counselling Psychology**
**Programme Director of the Professional Doctorate in Counselling Psychology**
**School of Social Sciences**
**Chair of Subject Standards Board for PG Psychology**
**Chair of Ethics Review Committee for PG Psychology**

**Office hours 9.30-17.00 Tuesday to Thursday**

**Please email me if you would like an appointment, as I am not often at my desk.**

# Appendix B: Invitation Letter

I am inviting you to participate in a research study: How South Asian Muslim women from pro-natalist minorities in the UK construct their social networks while undergoing assisted conception treatments such as IVF or IUI: Foucauldian Discourse Analysis. Before agreeing, could you please take the time to read this information letter.

I am a postgraduate student at the London Metropolitan University, and I am studying for a Professional Doctorate in Counselling Psychology. As part of my studies, I am required to complete research, and you are being invited to participate in.

I am conducting research into how South Asian Muslim women in the UK construct their social networks while undergoing assisted conception treatments such as IVF or IUI.

My research has been approved by the Research Ethics Committee which follows the standard of research ethics set by the British Psychological Society.

You have been invited to participate in my study because I believe you represent the group of the population described in the title of my research. I emphasise you will not be judged or personally analysed in any way and you will be treated with respect.

You are free to decide whether to participate.

In case you decide to participate you will be invited to an interview; I will ask you several open-ended questions. I am planning to record the which should not last longer than 90 min. We can agree on a location of the interview (e.g. university site or private place of your choice)or we can have interview over the Skype. You will not have to answer all questions asked and you will be able to withdraw from participation at any time without explanation or consequences, up to 4 weeks after the interview.

All the information you provide will remain completely confidential, and you will be protected from any infringement of privacy. The only exception to this would be if there were concerns regarding harm to yourself or others. All interview data will be stored securely in a locked cabinet that only the researcher will have access to. The information will not be shared with anyone else. The interview will be transcribed and the data collected will be made anonymous by changing your name and identifying information. This anonymity will be kept throughout the research process. Extracts of the anonymous interview transcriptions will be accessed by the researcher's supervisor and university examiners for the research report to be marked. Brief quotes from the interview will be used but these will be fully anonymised. The audio recordings will be erased once transcribed and the electronic transcripts will be kept for 3 years, as publication of the research is a possibility. A copy of the final research project will be made available to you at your request and you will be informed should this research be published.

If you have any questions or concerns, please do not hesitate to contact me: Patrycja Laskawska-Masood. My email address is psl0025@my.londonmet.ac.uk or my research supervisor Dr Raffaello Antonino: r.antonino1@londonmet.ac.uk.

# Appendix C: Consent Form

How Muslim South Asian women from pro-natalist minorities in the UK construct their social networks while undergoing assisted conception treatments such as IVF or IUI: Foucauldian Discourse Analysis.

I have read the information letter and have been given a copy for myself. The nature and purposes of this study have been explained to me. I was also given the opportunity to discuss the details and ask questions. I understand what is being explored and procedures in which I will be involved.

I was explained that my participation in this research and data collected during interviews, will remain confidential. Only the researcher will have access to identifying data. I have been informed what will happen with data once the research study has been completed.

I fully consent to participate in the study, which has been explained to me. By signing this consent I understand that I have the right to withdraw from the study at any time, within 4 weeks since the interview, without any disadvantage. I also understand that should I not withdraw , the researcher has the right to use the interview data after analysis of the data has begun 4 weeks after the interview.

Participant's Name (BLOCK CAPITALS)

Participant's Signature

Researcher's Name (BLOCK CAPITALS)Researcher's SignatureDate:

# Appendix D: Distress protocol

## Protocol to follow if participants become distressed during interviews:

Participants are going to be informed at the start of the interview of their right to withdraw at any time within 4 weeks since the interview date and for any reasons during the interview; explaining to them that this could be as a consequence of distress. It is anticipated that sever distress will not occur; however, it is covered in the protocol, in case of circumstances when senor professionals cannot be available.

**To be mindful of:**

1) Tearfulness

2) Voice becomes choked with emotion

3) Participant becomes distracted/ restless

**Possible actions to take:**

1) Ask participant if they are happy to continue

2) Offer them time to pause and compose themselves

3) Remind them they can stop at any time they wish if they become too distressed

**To be mindful of:**

1) Uncontrolled crying/ wailing, inability to talk coherently

2) Panic attack

3) Flashbacks

**Possible actions to take:**

1) The researcher will pause the interview, debrief and suggest relaxation techniques

2) The researcher will validate participants' distress, reassure them and investigate as to whether they might have the possibility to talk to a third party once the interview is completed. The interview will be ended if causing high levels of distress.

**Additionally**

**To be mindful of:**

1) If interviewing participants in their home, phone call will be made to a third party before the interview (reminding them of the precise location) and once I have left the participant's house. However, this participant group is not recognised as "high risk".

2) If the researcher has concerns for the participant's or others' safety, he will address this with participant and infirm appropriate service regarding this.

# Appendix E: Debriefing Letter

Date:

Dear participant,

Thank you for taking interest in the study.

I will use your answers to compile a report as part of my thesis; however, I am going to use pseudonym to protect your identity. The consent form with your name on will be kept separated from the rest of the documents. All audio recordings will be erase once the study is completed and transcripts with your pseudonym will be destroyed 5 years after this interview

I hope the questions have not caused you high levels of distress but if you require any further information or if you have any comments or suggestions you can contact me by email : psl0025@my.londonmet.ac.uk or my supervisor Dr Raffaello Antonino: r.antonino1@londonmet.ac.uk.

If you feel that you would like to talk about your experience of taking part in the interview then the researcher will be available for a one off session at a later date over the phone. Alternatively, if you should need further support or advice then the following organisations may be helpful:

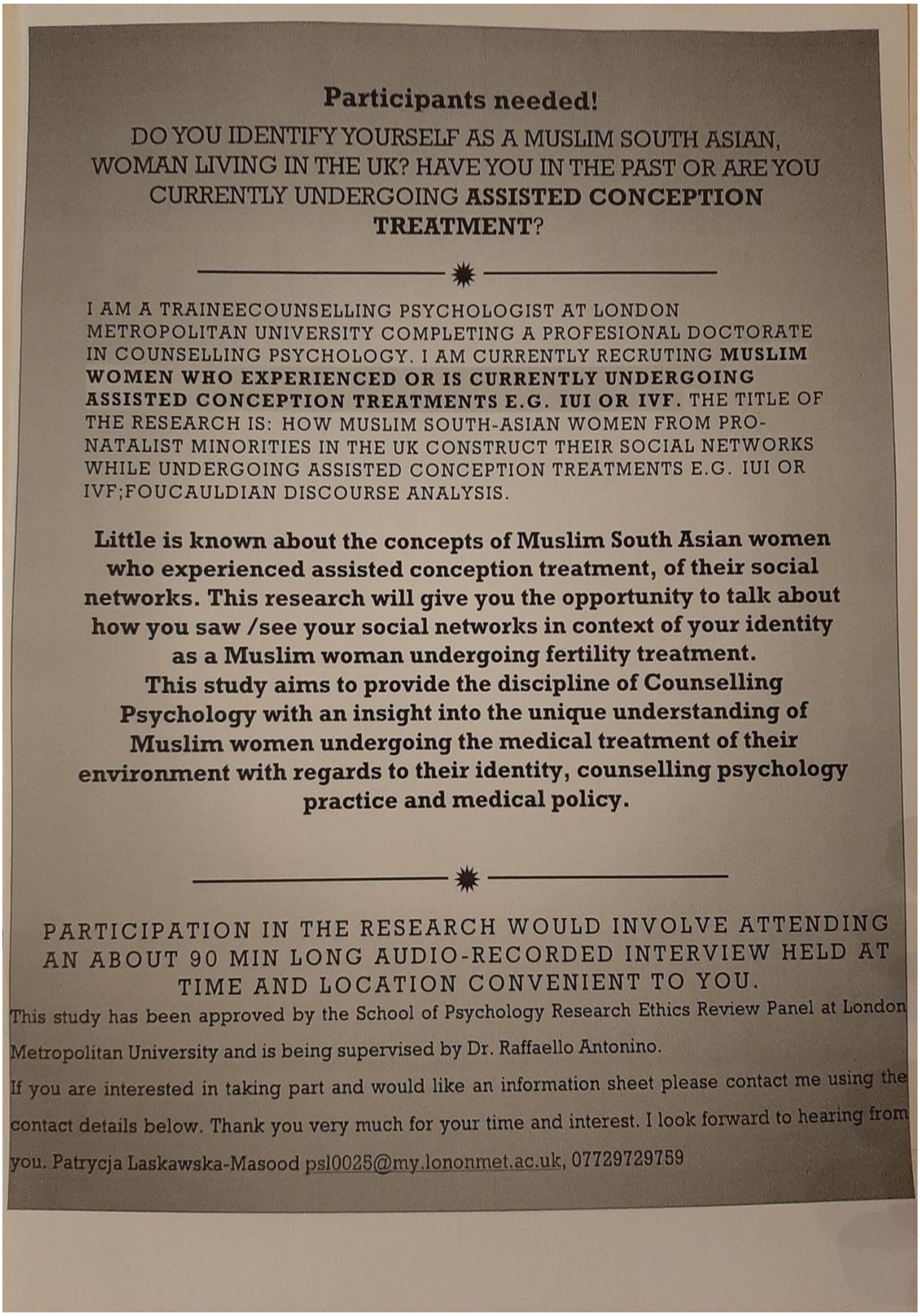
-Fertility Network UK provides free and impartial support, advice, information and understanding for anyone affected by fertility issues. https://fertilitynetworkuk.org/ , tell: 01213235025

A copy of the completed study will be available to all participants.

Yours sincerely,

Patrycja

# Appendix F: Poster



## Participants needed!

DO YOU IDENTIFY YOURSELF AS A MUSLIM SOUTH ASIAN, WOMAN LIVING IN THE UK? HAVE YOU IN THE PAST OR ARE YOU CURRENTLY UNDERGOING **ASSISTED CONCEPTION TREATMENT**?

* * *

I AM A TRAINEECOUNSELLING PSYCHOLOGIST AT LONDON METROPOLITAN UNIVERSITY COMPLETING A PROFESIONAL DOCTORATE IN COUNSELLING PSYCHOLOGY. I AM CURRENTLY RECRUTING **MUSLIM WOMEN WHO EXPERIENCED OR IS CURRENTLY UNDERGOING ASSISTED CONCEPTION TREATMENTS E.G. IUI OR IVF.** THE TITLE OF THE RESEARCH IS: HOW MUSLIM SOUTH-ASIAN WOMEN FROM PRO-NATALIST MINORITIES IN THE UK CONSTRUCT THEIR SOCIAL NETWORKS WHILE UNDERGOING ASSISTED CONCEPTION TREATMENTS E.G. IUI OR IVF;FOUCAULDIAN DISCOURSE ANALYSIS.

**Little is known about the concepts of Muslim South Asian women who experienced assisted conception treatment, of their social networks. This research will give you the opportunity to talk about how you saw /see your social networks in context of your identity as a Muslim woman undergoing fertility treatment.**
**This study aims to provide the discipline of Counselling Psychology with an insight into the unique understanding of Muslim women undergoing the medical treatment of their environment with regards to their identity, counselling psychology practice and medical policy.**

* * *

PARTICIPATION IN THE RESEARCH WOULD INVOLVE ATTENDING AN ABOUT 90 MIN LONG AUDIO-RECORDED INTERVIEW HELD AT TIME AND LOCATION CONVENIENT TO YOU.

This study has been approved by the School of Psychology Research Ethics Review Panel at London Metropolitan University and is being supervised by Dr. Raffaello Antonino.

If you are interested in taking part and would like an information sheet please contact me using the contact details below. Thank you very much for your time and interest. I look forward to hearing from you. Patrycja Laskawska-Masood psl0025@my.lononmet.ac.uk, 07729729759

# Appendix G: Interview Schedule

This draft interview schedule has been based on interview questions used in research on gay people, parenting and social networks (Clarke, 2006; Clarke, 2007).

**-So why don't we start by you telling me something about yourself and your family?**

**-Can you tell me what it is like for you to undergoing** assisted conception treatments such as IVF or IUI**?** What, emotional impact has on you the process of undergoing IFV/ IUI? Where do you go for support? What advice would you give to a Muslim woman considering fertility treatment?

**-How did you come to decide to undergo IVF/ IUI; was it mutual decision between you and your partner?** If you chose it, why? Is your choice related to your socio-cultural environment?

**-Does your family or friends know about you undergoing IVF/ IUI and if yes how they reacted to this?** If you have not disclosed this to your family what stopped, you from doing this? Who is the most supportive to you while undergoing IVF/IUI from within your social network? How they express they support? How, your relatives, partner and friends feel about you undergoing IVF/ IUI?

**-Do you think that by using IVF/ IUI do you challenge any stereotypes within Muslim or Asian community?** Why? Which one? Can, you tell me about any challenges that you have faced as a Muslim South-Asian woman undergoing IFV/ IUI within the medical system?

Have you resolve them? Have you encountered prejudice as an 'infertile' Muslim and South-Asian women undergoing fertility treatment? How, you dealt with it? Did, you have any concerns relating to your religion or culture when deciding on IVF/ IUI? How, you dealt with these concerns?

**-I think that is everything I had to ask you to talk about. Have you got anything else you would like to say or any kind of thoughts that you would like to follow up that I haven't asked you.**

# Appendix H: Examples of extracts from the interviews

**Interview with Abigail:**

R: Maybe if you could tell me just a bit more about the friend?

P: I mean she's one of my closest friends, and you know, she was going through something very difficult at the same time. It was just, we kind of supported each other through it. I mean my second and third cycles, my third cycle was probably my best cycle, because I actually had counselling throughout then, before. And after my second cycle, after my second cycle, so second cycle was just what embryos I had left. Third cycle was a complete new cycle. And prior to that, because I had really struggled emotionally, and I was just drained out, and I was really struggling with my husband I thought I need to access some help.

R: And what do you mean when you say that you were struggling with your husband?

P: I think it was just, we were both so, with the medication and things, we were just sort of like, we were like, "Oh, this is tough, and it's hard," And, you know, it was putting a lot of pressure on our relationship. And I think by the third time I was like, "No, I need." And I went for counselling, which I think was the best thing I did, 'cause before, you know, and we spent a lot of time, even both of us, between the second and third cycle, just not thinking about doing the third one. We were like, "Okay, we're just gonna take a break, just do what we need to do." And we just spent a lot of time on us. Like, you know, and that was really helpful, because it all became about the baby, and having the baby, as opposed to, if we have it we have it, if we don't we don't. And by the third cycle I had counselling pre-cycle and throughout the whole, I mean, I had that all the way until I had him. Which was, I think, the best thing I did.

R: And was that through NHS, or…?

P: No, it was a completely, it was private company. Yeah. But I thought I need to, I just thought I need to find a counsellor I'm happy with.

R: So, what was it about the counselling that you've received that, what was helpful?

P: I think because it was my safe space. So, I could say what I wanted about everything and not feel like I'm being judged, or, not feel like, oh, this is gonna go back to someone. Which was, you know, I think that was what it was. And it was also kind of like, having that professional support to make me sort of question why I was doing this. And looked, instead of just think, you know everyone's telling me, “This is the best thing possible, and you’ve got three cycles on the NHS that are free, why don’t you just take the third cycle?” But I think I was emotionally drained to be able to do that third cycle. So, yeah, I think that’s why the counselling really helped me.

R: And then you mentioned that the judgement, did you come across any judge…?

P: I don’t think anybody, sort of, ever said anything, I think it’s more a case of you build it up in your, I think you kind of like build it up in your brain. And sometimes you do get, like, you used to get, “Oh, when are you gonna have kids?” You know, especially when I was working, it was like, “Oh.” “But now you’ve got this far in your career, are you gonna start a family?” And I was like, “Well, I never said I didn’t want children, it's just never happened.” And for me it was always, I think I’ve always been like, if I have children I have children. But my life is very sort of, my life was very busy without children. I used to work a lot with children anyway, like on a voluntary basis. And I was doing a lot of voluntary work and I was studying Arabic and things like that. So, for me it was like, having a child Alhamdullila (thanks to God) but not sort of the means of my life. And I think, that people have struggled with that, ‘cause they say, “Well, she's carrying on.” I think because in our communities, children are the most

**Interview with Chloe:**

And do you think that by undergoing this treatment and do you challenge any stereotypes within Muslim or Asian community?

P: Yeah, I mean, with my in-laws I’ve been very hesitant in talking about it ‘cause I know that my mother-in-law and my mum don’t want me to talk about it. But outside I talk about it to anyone, I mean, if someone asks me if someone is just talking about children how they haven’t had children for a long time I will always refer them to my friend that I knew as an alima and her husband ‘cause I always give them as an example and I would always sort of say look into it, if you have any questions let me know.

And I think just by talking about it and using the proper technical terms to describe the process because there’s IVF there’s IXI, there’s so many different things, so yeah, so just by talking to them about it I think. But I haven’t done any more than that, I mean, there are probably more things that you can do, like, even in the local mosque they do have talks about things and I’ve never heard them talk about… I don’t know if you know…which area do you live in?

R: X

P: X oh okay, well there’s a community in Y that’s quite good community, like, they’re talking about lots of new things I’ve noticed. They’re talking about things like drug abuse and knife crime and porn and things like that but… and they’re talking about domestic abuse and even women abusing men and lots of topics are talked about at that mosque. It’s a mosque at X Road and there’s lots of, like, monthly women’s groups and mental health issues in women but I’ve never heard them talking about IVF and things like that so it would be interesting to see if, like, if that could be encouraged yeah. Just talking about it in the community and just, sort of, saying that this is something that is allowed yeah but I think something like that would help.

R: ‘Cause I haven’t heard myself, I never actually thought about it.

P: Yeah. Exactly and I know there’s an issue in terms of the fact that if you go for public funded treatment you’ve, I mean, I don’t know about your experience but there were times when there would be men and it would be impossible for them although you request it they would try but there were times when it was impossible for them to get you a female.

In the same way, I mean, we know when people like you, very you, at that point of crisis they don’t say “no we have to have a female and a male for male” so you just go. Sometimes you have to, sort of, relax a little bit, isn’t it? And they don’t talk about these things, they don’t talk about the difficulties and how we can even… Not even try to have an input at the hospitals to request these things, like, there’s a big community in Y maybe the Muslim community could put pressure on the hospital to say “oh can you always make sure that there's a woman present?" Yeah but they don't put that pressure on them, the chaplain probably there never mentions it, yeah.

R: So how's your experience as a Muslim South Asian woman undergoing the treatment within the medical system?

P: Within the medical system was fine, yeah, I felt very comfortable with the nurses. I mean, there was that aspect where most of them I think wore…some of the doctors wore…they did look South Asian themselves. I remember there were two or three Indu, they looked Indu anyway, they were from India, I think, or something and I don't…

**Interview with Sabrina:**

R: What advice would you give to a Muslim woman who is maybe preparing to go through fertility treatment?

P: I think what I would and I'm going on personal, is never be too shy to talk about it. Everyone has journeys. I feel if you're going to undergo this sort of treatment do a lot of research, mentally prepare yourself. I would say your dignity goes when you're in that room. The amount of checks and internals and this check and that check, your dignity goes and you have to be prepared for that. If you're not mentally prepared for that, then it's a shock to your system, but talk, it's okay. And never feel like what you're doing is wrong.

Because sometimes I feel like sometimes some Asian communities, some Asian ladies think is this unnatural? Yes it is natural, there's nothing wrong with it. But I feel you have to talk about it, there's nothing wrong to say, yes I had my baby and yes, it was through IVF, there's nothing wrong with it. I think anyone who is undergoing it or will be undergoing it, should first of all do their research. Mentally prepare themselves.

R: When you say mentally prepare, what do you mean by that?

P: Don't go in there with your eyes closed. Be aware of what you're going to be undergoing. So accept that you're going to have internal scans done, accept that you're going to be asked questions that are really personal. Because that's what they do, don't they? They ask you all those personal questions about timings and how and this. And if you haven't told yourself you’re going to be asked these questions and go in there being none the wiser, you cage away from it, you get embarrassed or you’re shy because someone is asking these really personal questions.

But it’s okay. So that’s what I mean, mentally prepare yourself, read up a lot. Do some research, speak to other people who have been through it.

R: Have you had a chance actually to talk to other women who underwent?

P: No, no I haven’t really anyone that’s close enough or been through this IVF journey for us to exchange words, no I haven’t.

R: What do you think that might be, about maybe people within your community not talking about it? Because I’m guessing they do undergo it?

P: I’m sure there are people out there, but I’m none the wiser aware of. I’m sure there’s probably people out there in the Asian community that have gone through it, or people that maybe I know or someone else knows, through different people, that have probably been through it. But nobody that I’ve ever come across have said, oh we had our baby through IVF. I’ve never spoken to anybody. Obviously when you go to these hospital appointments there are other women there so you tend to have a chat here and there.

But even then, I found that nobody really wanted to be open about it. So, when you’re going into your appointments and waiting in the waiting room, obviously there’s women there but everybody kind of kept themselves to themselves and not really forthcoming in talking about it.

R: What do you think that might be about?

P: I don’t know if it was due to privacy. They wanted to just keep it private. Or just didn’t feel they were confident, or comfortable enough, to be having that conversation with somebody else.

# Appendix I: Reflexive Journal

Following different stages of this research, I referred to my reflexive journal; a number of these were in note form, and I used them during the write up stage. Here I am presenting just a few extracts from the journal.

**Notes in relation to anonymity and recruitment:**

I really struggle with recruitment of the participants; however, once I readjusted the recruitment criteria, I managed to employ 6 women using the snowball method. On reflection, it is possible that due to the silencing issues, these women specifically, are concerned about confidentiality and have trust issues, possibly worried about potential consequences if the confidentially was to be compromised. This in turn perhaps made me also more conscientious about the confidentiality of the participants. For instance, selecting an extract from transcript for the appendix was a struggle. I went back and forward a few times to select the right extract, worrying about confidentiality. Although everything in transcripts was anonymised, I still had the worry that my participants might be recognised by the very specific stories they described. Resulting from this worry I did include limited extracts in Appendix H and did not include participants' specific demographic information. On reflection, Foucault's (1977) idea about how people become 'docile bodies' while under constant surveillance can represent the extent of 'the gaze' that perhaps my participants were under. Perhaps as an insider/outsider researcher to the South-Asin community, I may have shared my participants' concerns about confidentiality and perhaps this resulted in me choosing non-Asian pseudonyms for participants and being indecisive about the right extract for Appendix H. On a positive note, possibly, women participating in this research can be linked with the Foucault idea of resistance to 'the gaze' and power by going against it, "in our Asian society we don't talk about this" (ART, IVF, infertility) and speaking out.

**Notes regarding impact of my personal experience of IVF on the data analysis**

This interview was long and felt intense too. I found it very difficult to finish as the participant was elaborating about very difficult and painful experiences that seemed important to her. I felt emotionally exhausted, perhaps reflecting how my participant experiences her journey of ART. On one hand, I was worried about needing to transcribe long interviews, but on the other hand I was worried about not giving the space to the participant to talk. Possibly this was their only chance to voice what they could not do with their families or friends. I wondered at this point if I needed to be clearer about the time and topics with my participants. Possibly this would position me as more powerful. At the same time, it felt that whatever she talked about was relevant in context of this research. And she has given me the real sense of how important it was for her to be heard. This made me think about 'the silencing' and 'the gaze' that possibly she was experiencing outside of the interview environment. Saying this, having the recording device in the room made me now realise the intrinsic element of surveillance that potentially could have been seen by participants as a form of 'the gaze'?

After I left the interview, I had the sense of her being powerless within the biomedical discourse and silenced within the socio-cultural environment. Additionally, I felt that the choice of whether to have or not have children was just not there and the participant seemed unaware of this.

At this point I reminded myself how I felt before my fertility treatments started in regard to having the choice to stay childless. Perhaps as an insider of two very different cultures I had some sense of the need to have a child that came from the sociocultural environment, although I left Poland when I turned 18 and, in a way, at this point I removed myself from the Polish culture to a great extent. Therefore, perhaps my experience of ART and reproduction in the context of the Polish sociocultural environment was very minimal. On the other hand, my Asian part of the family seemed more concerned about the lack of a child and sometimes this was a new experience for me. What I really struggled to understand was the fact that both my families were happy to have grandchildren, but no one really wanted me to talk about IVF. I was also confused about the fact that I needed to silence something that presumably is allowed in Islam; however, at this point I still perhaps did not grasp the extent to which silencing is affecting South-Asian-Muslim communities.

**Notes regarding struggles following initial reading of all transcripts:**

How I am supposed to do this? It seems like everything is so interesting but what is really relevant? There are so many issues to think about when identifying the object, I could identify different objects such as pregnancy, religion, miscarriage, medical staff, friends, husbands, family and in-laws. They do talk a lot about the IVF and IUI and other reproductive issues too. They do talk about the support network but is it really a support network? It seems more like an unsupportive network. I do feel overwhelmed with the amount of data/information and now I need to organise it into some coherent story.

At this point I realised that I struggle to hold in my mind all the participants at the same time. It seems that I sat with transcripts and tried to work with them the way I would do with process reports, looking and analysing one individual at the time. However, now I will need to develop a different way of analysing data that can deconstruct all six talks and then put them back together into coherent narratives. Another issue that came out for me at this point was the fact that, after highlighting different discursive objects, I could clearly see that most of the talk was spent on talking about IVF and IUI. Additionally, it was clear to me that they talked about this in a problematic way and at the same time almost they were explaining themselves to me why they decided to undergo this treatment that was the “last resort” for them and undesirable.

After looking at the data with my supervisor I decided that at this point it will be best if I change the title of my research to focus on the talk about ART rather than support network. However, the support network/socio-cultural environment will be still covered within the new title.

### Reflections after having written chapter 3

Writing now that chapter 3 is completed, I can reflect that my personal experience contributed to perhaps my expectation to find ARTs to be something unwanted and consequently then silenced. Therefore, during analysis, when I started to recognise some of my experiences in participant’s talk, this perhaps triggered some frustration regarding the power relations within the sociocultural and biomedical discourses. Consequently, this perhaps reflected then in deterministic language I used in the initial draft of the analysis; only when my supervisor pointed this out was I then able to take step back, gaining some distance from the data, and reflect on what was happening for me as a researcher, insider and outsider. Additionally, during the process of stepping back and looking at the analysis with a more critical eye, I asked myself the question, how my participants would feel or think after reading this, and consequently this triggered a fear of perhaps me becoming a part of the oppressive discourse. Therefore, gaining distance from the data and reflecting on the deterministic language helped me to perhaps continue with a more tentative analysis that I hope is now more relatable.

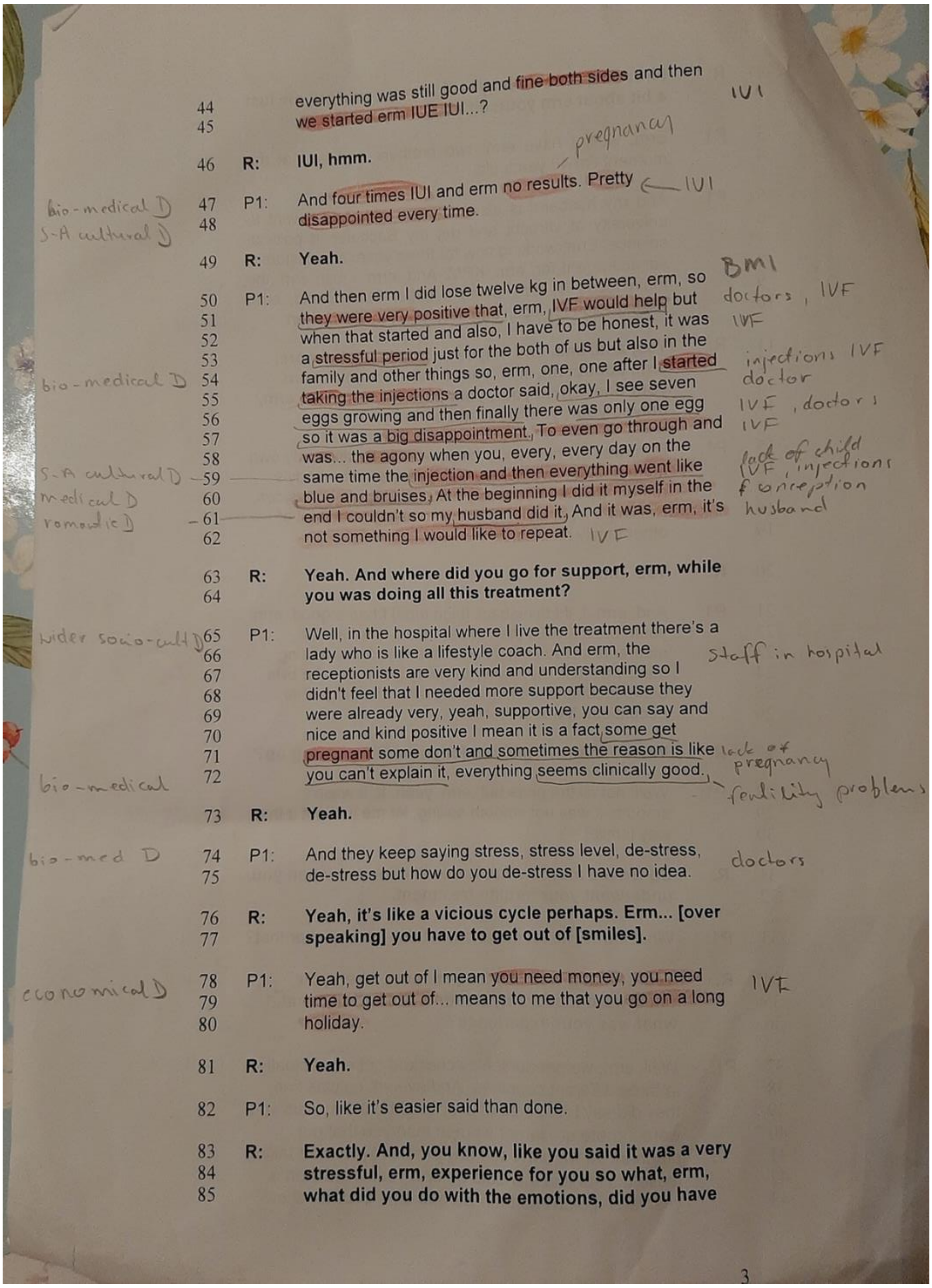
### How my personal life experiences set my assumptions about potential finding

It has been suggested by Harper (2012) that it is crucial to develop a critical and reflexive position while conducting discourse analysis. He also proposes that to ensure this, the criticality has to be applied to my practices as a researcher, by which I construct knowledge in context to my own circumstances, background and environments. Additionally, Harper also said that as a researcher, I must be transparent about these and about the effects of power on this research. My position is influenced by the fact that I am a mother and that I have my two children as a result of IVF. Also, it seems important to add that the first three cycles of IVF were done via NHS and only the last one was conducted in a private clinic. Perhaps as a result of having the experience of these two, I am able to make some comparisons, and this already perhaps sets my agenda in a specific way. For instance, my initial reaction after leaving the first appointment in the private clinic was of surprise and delight. I felt I was listened to and I felt good that the consultant took time to explain things to us that I should perhaps have known at the point of fourth cycle and she also gave us options in terms of how we wanted to proceed with this cycle. I was surprised, naively thinking that there is only one standard way of implementing IVF. Perhaps based on this personal experience I already had the idea of the NHS following the efficiency agenda that might not always consider the feelings or wishes of patients. Additionally, the fact that I ended up with successful treatment also perhaps influenced my positive view and positive feeling about the fertility institutions.

As I became aware of how my own experience may be bringing certain feelings and/or expectations into my topic of research, I searched for reflective spaces with peers and supervisors to ensure I kept an active awareness of my own assumptions and maintain the maximum rigour in the research process. I found this a particular challenging process, yet my evolving skills as a trainee CoP, by which I have learnt to stay with uncertainty, observe and understand myself in relation to others and ideas, helped me immensely.

# Appendix J: Examples of how I engaged with the data

Looking for all different discursive constructions



everything was still good and fine both sides and then we started erm IUE IUI...?

IUI

**R:** **IUI, hmm.**

bio-medical D
S-A cultural D

P1: And four times IUI and erm no results. Pretty disappointed every time.

pregnancy
← IUI

**R:** **Yeah.**

bio-medical D
S-A cultural D
medical D
romantic D

P1: And then erm I did lose twelve kg in between, erm, so they were very positive that, erm, IVF would help but when that started and also, I have to be honest, it was a stressful period just for the both of us but also in the family and other things so, erm, one, one after I started taking the injections a doctor said, okay, I see seven eggs growing and then finally there was only one egg so it was a big disappointment. To even go through and was... the agony when you, every, every day on the same time the injection and then everything went like blue and bruises. At the beginning I did it myself in the end I couldn't so my husband did it. And it was, erm, it's not something I would like to repeat.

BMI
doctors, IVF
IVF
injections IVF
doctor
IVF, doctors
IVF
lack of child
IVF, injections
& conception
husband
IVF

**R:** **Yeah. And where did you go for support, erm, while you was doing all this treatment?**

wider socio-cult D
bio-medical

P1: Well, in the hospital where I live the treatment there's a lady who is like a lifestyle coach. And erm, the receptionists are very kind and understanding so I didn't feel that I needed more support because they were already very, yeah, supportive, you can say and nice and kind positive I mean it is a fact some get pregnant some don't and sometimes the reason is like you can't explain it, everything seems clinically good.

staff in hospital
lack of pregnancy
fertility problems

**R:** **Yeah.**

bio-med D

P1: And they keep saying stress, stress level, de-stress, de-stress but how do you de-stress I have no idea.

doctors

**R:** **Yeah, it's like a vicious cycle perhaps. Erm... [over speaking] you have to get out of [smiles].**

economical D

P1: Yeah, get out of I mean you need money, you need time to get out of... means to me that you go on a long holiday.

IVF

**R:** **Yeah.**

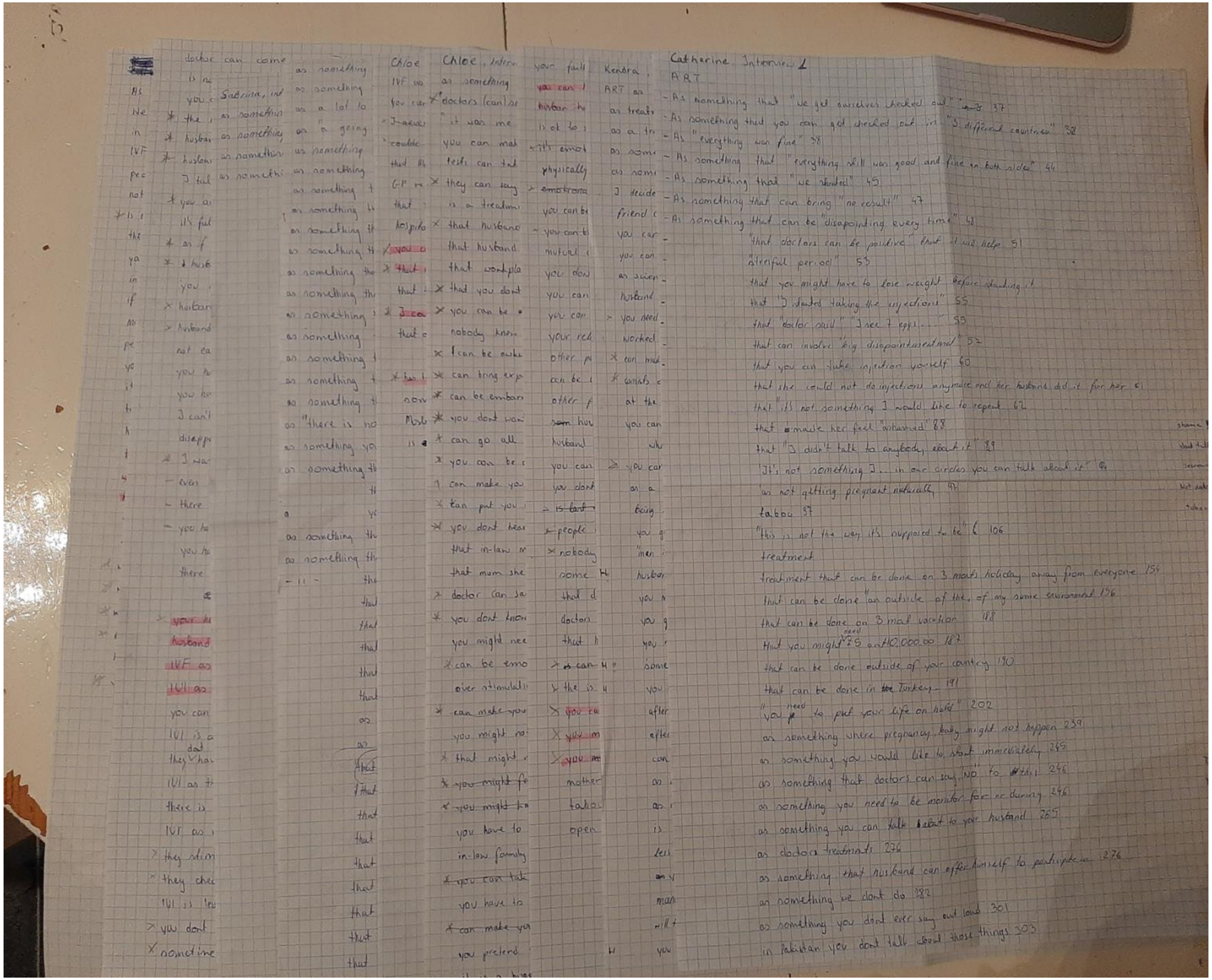
P1: So, like it's easier said than done.

**R:** **Exactly. And, you know, like you said it was a very stressful, erm, experience for you so what, erm, what did you do with the emotions, did you have**

3

# Appendix K

Lists of how each woman constructed ART in different ways

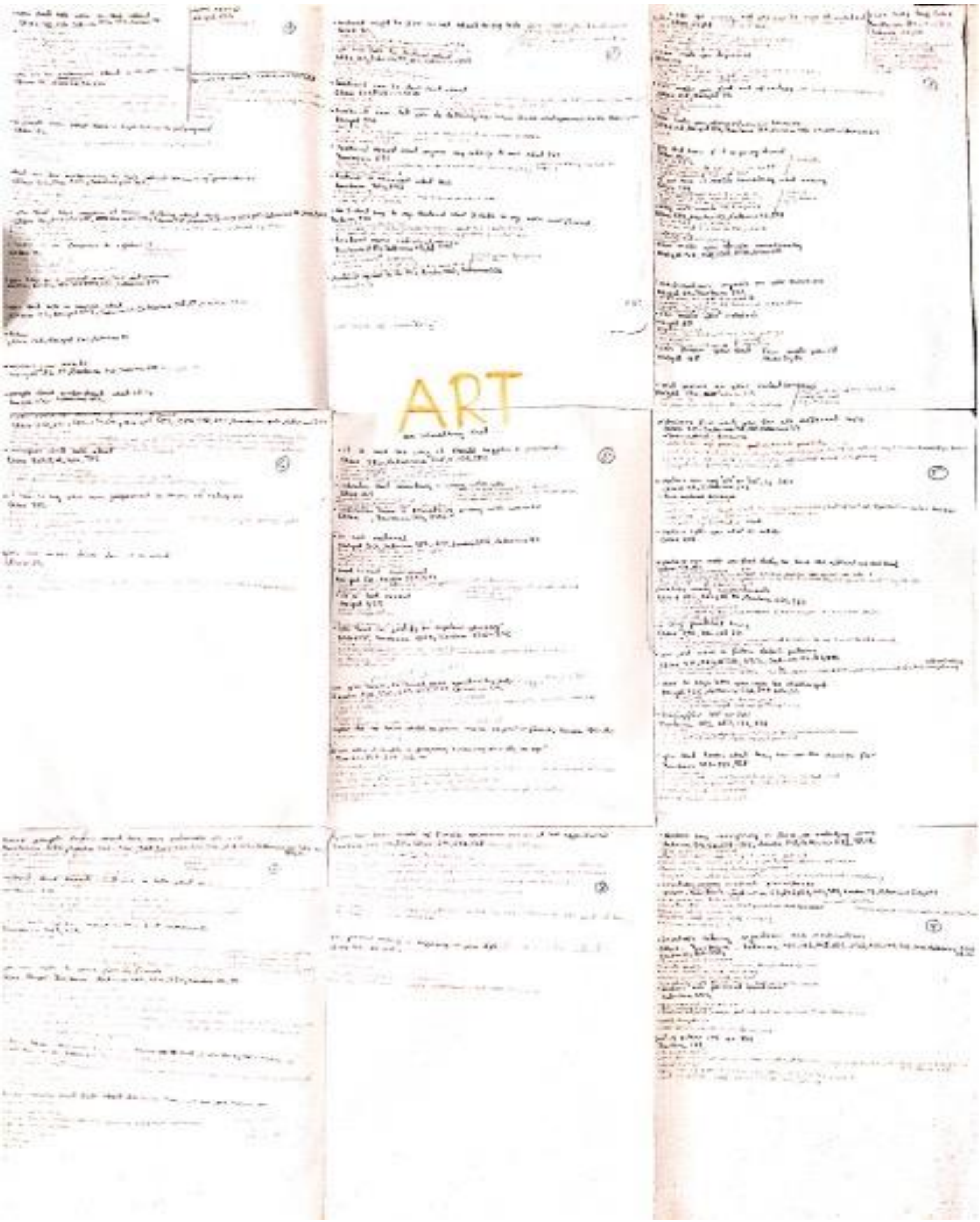


Catherine Interview 2
ART
- As something that "we got ourselves checked out" ~~and~~ 37
- As something that you can get checked out in "3 different countries" 38
- As "everything was fine" 38
- As something that "everything still was good and fine in both sides" 44
- As something that "we started" 45
- As something that can bring "no result" 47
- As something that can be "disapointing every time" 48

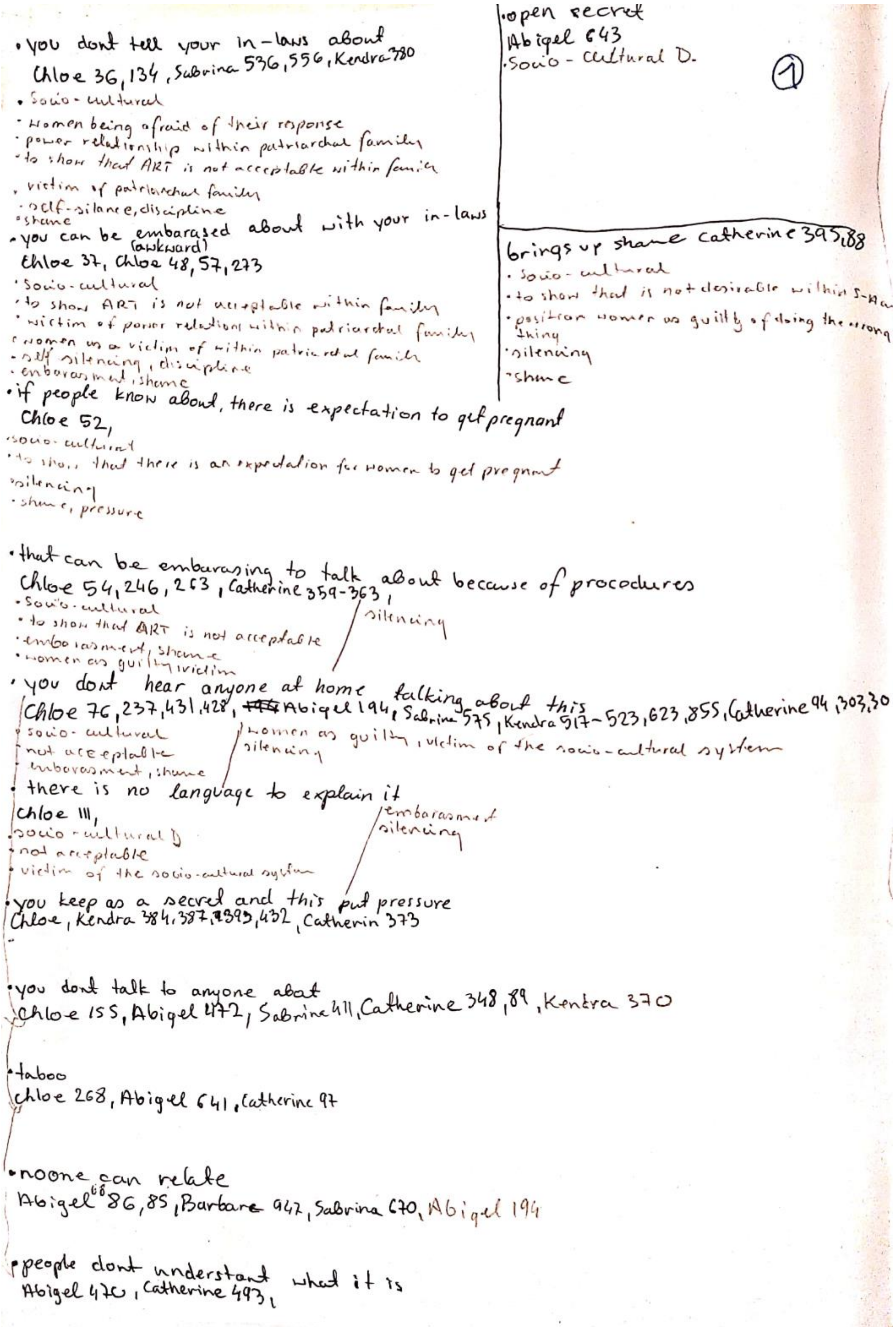
"that doctors can be positive" that it will help 51
"stressful period" 53
that you might have to lose weight before starting it
that "I started taking the injections" 55
that "doctor said" "I see 7 eggs..." 55
that can involve "big disappointment and" 57
that you can take injection yourself 60
that she could not do injections anymore and her husband did it for her 61
that "it's not something I would like to repeat 62
that made her feel "ashamed" 88
that "I didn't talk to anybody about it" 89
"It's not something I... in our circles you can talk about it" 94
"as not getting pregnant naturally 97
taboo 97
"this is not the way it's supposed to be" 106
treatment
treatment that can be done on 3 months holiday away from everyone 154
that can be done "an outside of the, of my same environment 156
that can be done on 3 month vacation 188
that you might need 25 and 10,000.00 187
that can be done outside of your country 190
that can be done in ~~the~~ Turkey 191
"you need to put your life on hold" 202
as something where pregnancy, baby might not happen 239
as something you would like to start immediately 245
as something that doctors can say "NO" to this 246
as something you need to be monitor for or during 246
as something you can talk about to your husband 265
as doctors treatments 276
as something that husband can offer himself to participate in 276
as something we dont do 282
as something you dont ever say out loud 301
in Pakistan you dont talk about those things 303

# Appendix L

All constructions of ART summarised into the most repeated



ART



- you dont tell your in-laws about
  Chloe 36,134, Sabrina 536,556, Kendra 380
  - Socio-cultural
  - women being afraid of their response
  - power relationship within patriarchal family
  - to show that ART is not acceptable within family
  - victim of patriarchal family
  - self-silance, discipline
  - shame
- you can be embarased (awkward) about with your in-laws
  Chloe 37, Chloe 48, 57, 273
  - Socio-cultural
  - to show ART is not acceptable within family
  - victim of power relations within patriarchal family
  - women as a victim of within patriarchal family
  - self silencing, discipline
  - embarasment, shame
- if people know about, there is expectation to get pregnant
  Chloe 52,
  - socio-cultural
  - to show that there is an expectation for women to get pregnant
  - silencing
  - shame, pressure

- open secret
  Abigel 643
  - Socio-cultural D.

①

brings up shame Catherine 395, 88
- Socio-cultural
- to show that is not desirable within S-Ha
- position women as guilty of doing the wrong thing
- silencing
- shame

- that can be embarasing to talk about because of procodures
  Chloe 54, 246, 263, Catherine 359-363,
  - Socio-cultural
  - to show that ART is not acceptable
  - embarasment, shame
  - women as guilty, victim

  silencing
- you dont hear anyone at home talking about this
  Chloe 76, 237, 431, 428, Abigel 194, Sabrina 575, Kendra 517-523, 623, 855, Catherine 94, 303, 30
  - socio-cultural
  - not acceptable
  - embarasment, shame

  women as guilty, victim of the socio-cultural system
  silencing
- there is no language to explain it
  Chloe 111,
  - socio-cultural D
  - not acceptable
  - victim of the socio-cultural system

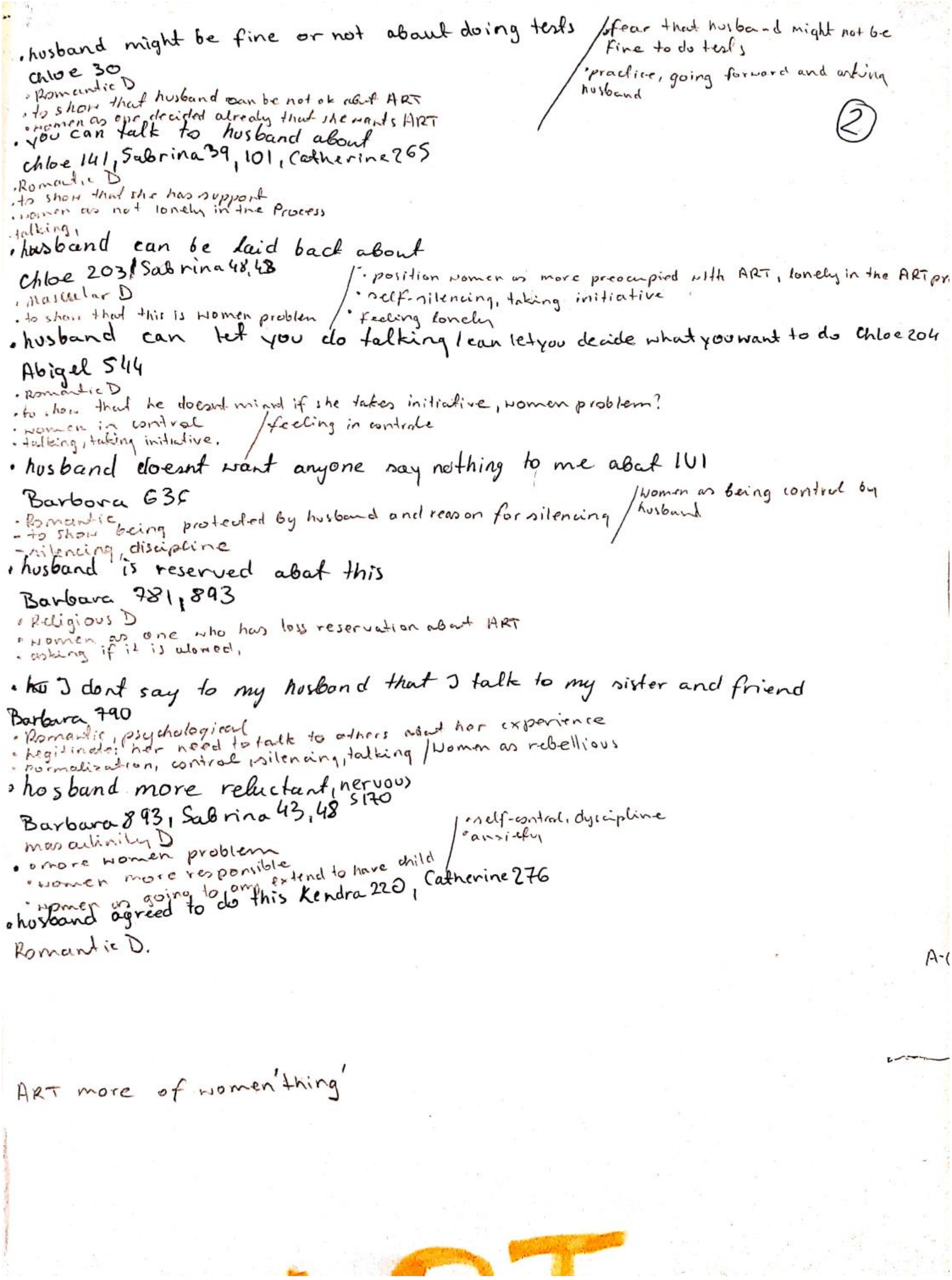
  embarasment
  silencing
- you keep as a secret and this put pressure
  Chloe, Kendra 384, 387, 393, 432, Catherin 373

- you dont talk to anyone abaut
  Chloe 155, Abigel 472, Sabrina 411, Catherine 348, 89, Kendra 370

- taboo
  chloe 268, Abigel 641, Catherine 97

- noone can relate
  Abigel 68 86, 85, Barbara 947, Sabrina 670, Abigel 194

- people dont understand what it is
  Abigel 470, Catherine 493,



- husband might be fine or not about doing tests

Chloe 30
- Romantic D
- to show that husband can be not ok about ART
- women as one decided already that she wants ART

/ fear that husband might not be fine to do tests
- practice, going forward and asking husband

②

- you can talk to husband about

Chloe 141, Sabrina 39, 101, Catherine 265
- Romantic D
- to show that she has support
- women as not lonely in the Process
- talking,

- husband can be laid back about

Chloe 203/ Sabrina 48, 48
- Mascular D
- to show that this is women problem

/ position women as more preocupied with ART, lonely in the ARTpr
- self-silencing, taking initiative
- feeling lonely

- husband can let you do talking / can let you decide what you want to do Chloe 204

Abigel 544
- Romantic D
- to show that he doesnt mind if she takes initiative, women problem?
- women in control
- talking, taking initiative.

/ feeling in controle

- husband doesnt want anyone say nothing to me abot IUI

Barbora 635
- Romantic
- to show being protected by husband and reason for silencing
- silencing, discipline

/ Women as being control by husband

- husband is reserved abot this

Barbara 781, 893
- Religious D
- Women as one who has less reservation about ART
- asking if it is alowed,

- ~~ku~~ I dont say to my husband that I talk to my sister and friend

Barbara 790
- Romantic, psychological
- Legitinate: her need to talk to others about her experience
- normalization, control, silencing, talking / Women as rebellious

- husband more reluctant, nervous

Barbara 893, Sabrina 43, 48 S170
masculinity D
- more women problem
- women more responsible extend to have child
- women as going to among

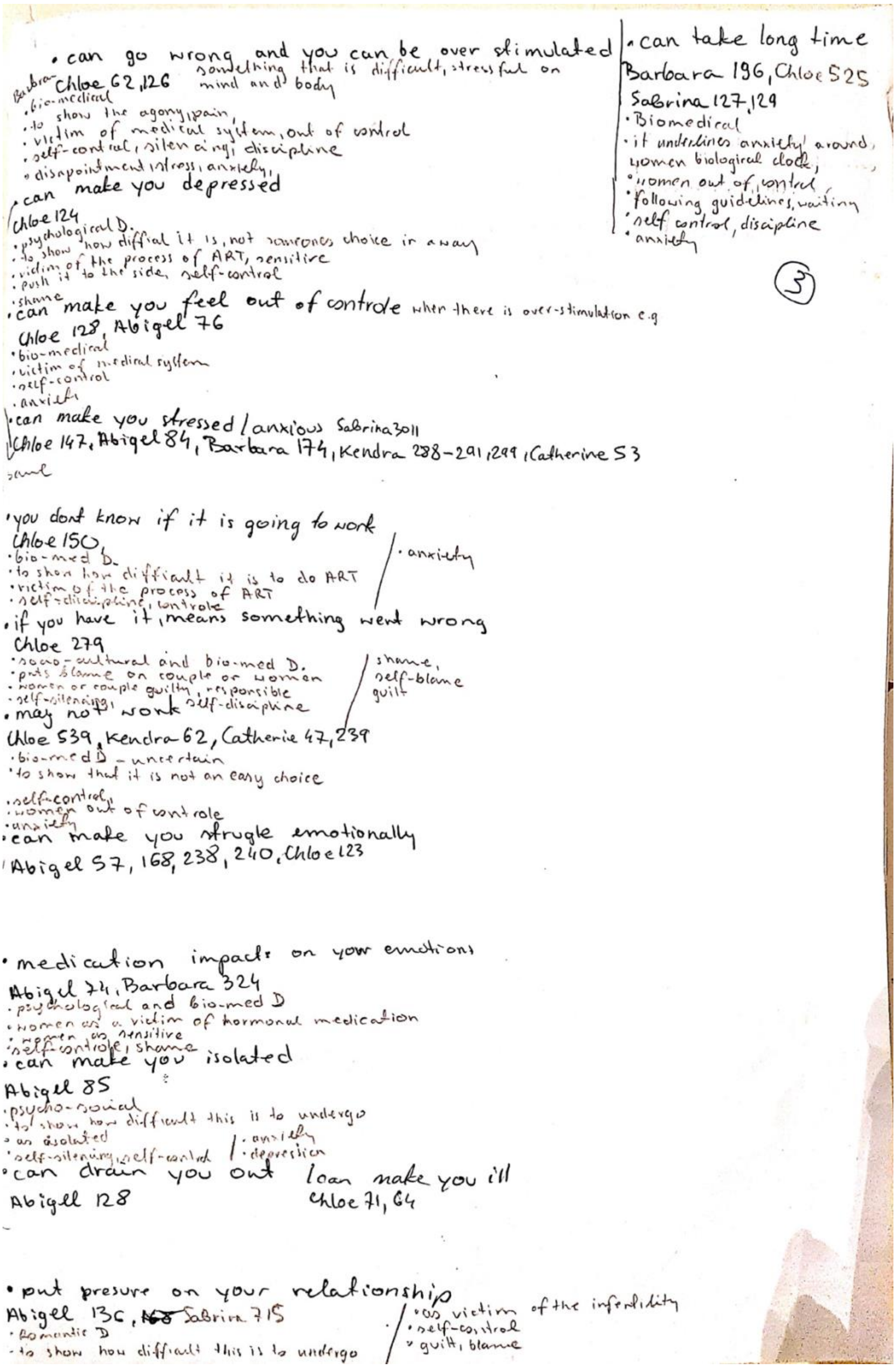
/ self-control, dyscipline
- anxiety

- husband agreed to do this Kendra 220, Catherine 276

Romantic D.

A-(

ART more of women'thing'



• can go wrong and you can be over stimulated something that is difficult, stressful on mind and body
Barbra Chloe 62,126
• bio-medical
• to show the agony, pain,
• victim of medical system, out of control
• self-control, silencing, discipline
• disapointment, stress, anxiety,

• can make you depressed
Chloe 124
• psychological D.
• to show how diffial it is, not someones choice in a way
• victim of the process of ART, sensitive
• push it to the side, self-control
• shame

• can make you feel out of controle when there is over-stimulation e.g
Chloe 128, Abigel 76
• bio-medical
• victim of medical system
• self-control
• anxiety

• can make you stressed / anxious Sabrina 3011
Chloe 147, Abigel 84, Barbara 174, Kendra 288–291, 299, Catherine 53
same

• you dont know if it is going to work
Chloe 150,
• bio-med D.
• to show how difficult it is to do ART
• victim of the process of ART
• self-discipline, controle
/ • anxiety

• if you have it, means something went wrong
Chloe 279
• socio-cultural and bio-med D.
• puts blame on couple or women
• women or couple guilty, responsible
• self-silencing, self-discipline
/ shame, self-blame guilt

• may not work
Chloe 539, Kendra 62, Catherie 47, 239
• bio-med D – uncertain
• to show that it is not an easy choice
• self-control,
• women out of controle
• anxiety

• can make you strugle emotionally
Abigel 57, 168, 238, 240, Chloe 123

• medication impacts on your emotions
Abigel 74, Barbara 324
• psychological and bio-med D
• women as a victim of hormonal medication
• women as sensitive
• self-controle, shame

• can make you isolated
Abigel 85
• psycho-social
• to show how difficult this is to undergo
• as isolated
• self-silencing, self-control
/ • anxiety • depression

• can drain you out
Abigel 128

• can make you ill
Chloe 71, 64

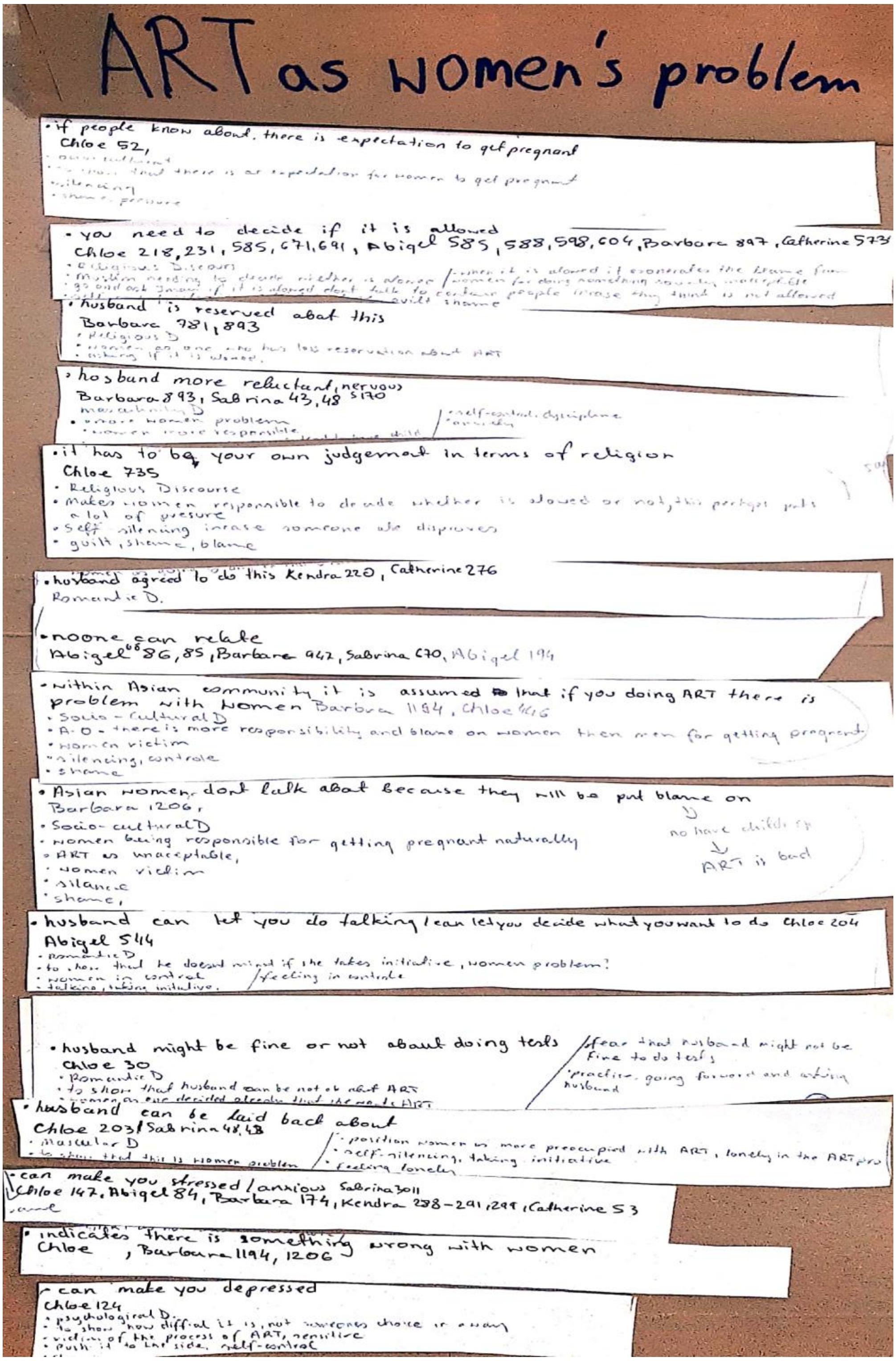
• put presure on your relationship
Abigel 136, ~~168~~ Sabrina 715
• Romantic D
• to show how difficult this is to undergo
/ • as victim of the infertility • self-control • guilt, blame

• can take long time
Barbara 196, Chloe 525
Sabrina 127, 129
• Biomedical
• it underlines anxiety around women biological clock,
• women out of control
• following guidelines, waiting
• self control, disicpline
• anxiety

③

# Appendix M

Some elements of the discursive sites before choosing those that formed the final narrative



ART as women's problem

- if people know abont. there is expectation to get pregnant
Chloe 52,
· [illegible]
· to show that there is an expectation for women to get pregnant
· silencing
· shame, pressure

- you need to decide if it is allowed
Chloe 218, 231, 585, 671, 691, Abigel 585, 588, 598, 604, Barbore 897, Catherine 573
· Religious Discours
· Muslim needing to decide whether is alowed / when it is alowed it exonerates the blame from women for doing something socially unacceptable
· go and ask Imam if it is alowed dont talk to certain people incase they think is not allowed
· [illegible] guilt shame

- husband is reserved abat this
Barbara 781, 893
· Religious D
· women as one who has less reservation about ART
· asking if it is alowed.

- hosband more reluctant, nervous
Barbara 893, Sabrina 43, 48 S170
masculinity D
· more women problem
· women more responsible [illegible] child / · self-control, discipline · anxiety

- it has to be your own judgement in terms of religion
Chloe 735
· Religious Discourse
· Makes women responsible to decide whether is alowed or not, this perhaps puts a lot of presure
· Self silencing incase someone who disproves
· guilt, shame, blame

- husband agreed to do this Kendra 220, Catherine 276
Romantic D.

- noone can relate
Abigel 68 86, 85, Barbara 942, Sabrina 670, Abigel 194

- within Asian community it is assumed ~~to~~ that if you doing ART there is problem with women Barbra 1194, Chloe 416
· Socio-Cultural D
· A.O. - there is more responsibility and blame on women then men for getting pregnant
· women victim
· silencing, controle
· shame

- Asian women dont talk abat because they will be put blame on
Barbara 1206,
· Socio-cultural D
· women being responsible for getting pregnant naturally
· ART as unacceptable,
· women victim
· silance
· shame,
↓ no have children
↓ ART is bad

- husband can let you do talking / can let you decide what you want to do Chloe 204 Abigel 544
· Romantic D
· to show that he doesnt mind if she takes initiative, women problem?
· women in control / feeling in controle
· talking, taking initiative.

- husband might be fine or not about doing tests
Chloe 30
· Romantic D
· to show that husband can be not ok about ART
· women as one decided already that she wants ART
/ fear that husband might not be fine to do tests
· practice, going forward and asking husband

- husband can be laid back about
Chloe 203 / Sabrina 48, 48
· Masculur D
· to show that this is women problem
/ · position women as more preocupied with ART, lonely in the ART pro
· self-silencing, taking initiative
· feeling lonely

- can make you stressed / anxious Sabrina 3011
Chloe 147, Abigel 84, Barbara 174, Kendra 288-291, 299, Catherine 53
same

- indicates there is something wrong with women
Chloe , Barbara 1194, 1206

- can make you depressed
Chloe 124
· psychological D.
· to show how diffical it is, not someones choice in a way
· victim of the process of ART, sensitive
· push it to the side, self-control

# ART as biomedical event

- involves many appointments

you can have male of fimale doctors or nurses at the appointment
Barbra 202, 213, 221, Chloe 691, 670, 668, Abigel 598, 604
- Gender D, Religion D, Biomedical D

* doctors can say "yes" or "no", to this
Chloe 29, Catherine 246
- Bio-medical discourse
- position patient
- [illegible] doctors decision, out of control, dependent on doctors decision

* doctors first send you for all different tests
Chloe 20, Sabrina 38, 40, Catherine 37
- Bio-medical discourse
- position of passive ~~and~~ obiedient patient,
- [illegible] not perhaps having much choice to what will they do to her, depended on do
- practice - do what she was told, self-control, or self-disciplining
- Subjectivity - feeling [illegible], no choice

- doctors ask personal questions
Sabrina 397,
- Bio-medical Discourse
- ART causing distress
- Doctor-expert, women patient, out of controle, things done to her
- self disciplining
- self-blame subjectivity, embarassment

* if is either IVF or IUI
Barbra 173,
- Biomedical D
- she has not much choice in her treatment, possibly says that doctor is not telling her [illegible] She should k
- feel restrain
- position of patient, doctor who offers very limited support,
- out of control, self-control, self-discipline

- you just need to follow doctor's guidance
Chloe 211, Abigel 511, 533, Sabrina 64, 167, 209,
resistance discourse
self-controlin
- bio-med D, Subjectivity, shame, ART doc, doctor is expert, she is patient, she is out of control, disciplining
- take the blame of women locates within doc,

- involves taking injections and medication
Chloe, Barbara, Sabrina 132, 135, 149, 155, 235, 237, 275, 302, 308, Catherine 5 55,
Kendra 61, 241-259,
- Bio-medical Discourse

- doctor tells you what he will do
Chloe 205

* doctors can make you feel lucky to have this offered via NHS (free)
Chloe 179, 181
- bio medical discourse
- position of [illegible] one to access ART, doctor as powerful [illegible] control who gets it
- A.O. she should be thankful, appreciative to have it offered, obedient, go with what they ask for
- self-control
- [illegible] guilt

- due to high BMI you can be discharged
Abigel 266, Catherine 566, 599-610, 53
- bio-medical
- she is out of control, doctor has the power,
- she is trying to lose weight, self-control, self-disciplining

- involves many medical procedures
Chloe, Barbara, Sabrina 63, 142, 157, 209, 395, Kendra 75, Catherine 571, 246
- Bio-medical Discourse
- locates ART within body, most procedures done to women, this women problem, causes physical distress, expensive, pain, monitoring
- Women out of control, as patient,
- Practice: self-control, self-silencing
- Shame, lost of dignity

⑨

- doctors say everything is fine, no underlying issues
Sabrina 54, 56, 224-225, Kendra 218, (Catherine 575, 38, 44,)
- Bio-medical Discourse
- Position - doctor as an expert, women patient
- A-O women cannot question expert, takes blame of women
- Practice - self-[illegible] following guidance
- Subjectivity - out of controle, not knowing what is happening not understanding

- a very practical thing
Chloe 190, Abigel 62
- bio-med D.
- practical thing, distancing from socio-cultural D. easier to see it as acceptable, control
- avoids talking [illegible]

- medication impacts on your emotions
Abigel 74, Barbara 324
- psychological and biomed D
- women as a victim of hormonal medication
- [illegible] sensitive
- self [illegible]

- you dont know what they can use the sampe f
Barbara 923-927, 928
- Bio-medical,
- By locating ART within biomed D gives reason to don't trust
- she is trying to gain control by making choice of IUI
- make choice of IUI over IVF
- fear of system, lack of trust,

- can go wrong and you can be over stimulat
Barbra Chloe 62, 126
something that is difficult, stressful on mind and body
- bio-medical
- to show the agony, pain,
- victim of medical system, out of control
- self-control, silencing, discipline
- disappointment, stress, anxiety,

- may not work
Chloe 539, Kendra 62, Catherie 47, 239
- bio-med D - uncertain
- to show that it is not an easy choice
- self-control,
- women out of controle
- anxiety

- they offer IVF or IUI
Barbara 182, 187, 173, 276
- Biomed
- as not having many choices of treatment, being controled what's offered,
- women out of control, doctor expert, powerful
- frustration

- can take long time
Barbara 196, Chloe 525
Sabrina 127, 129
- Biomedical
- it underlines anxiety around women biological clock,
- women out of control
- following guidelines, waiting
- self control, discipline
- anxiety

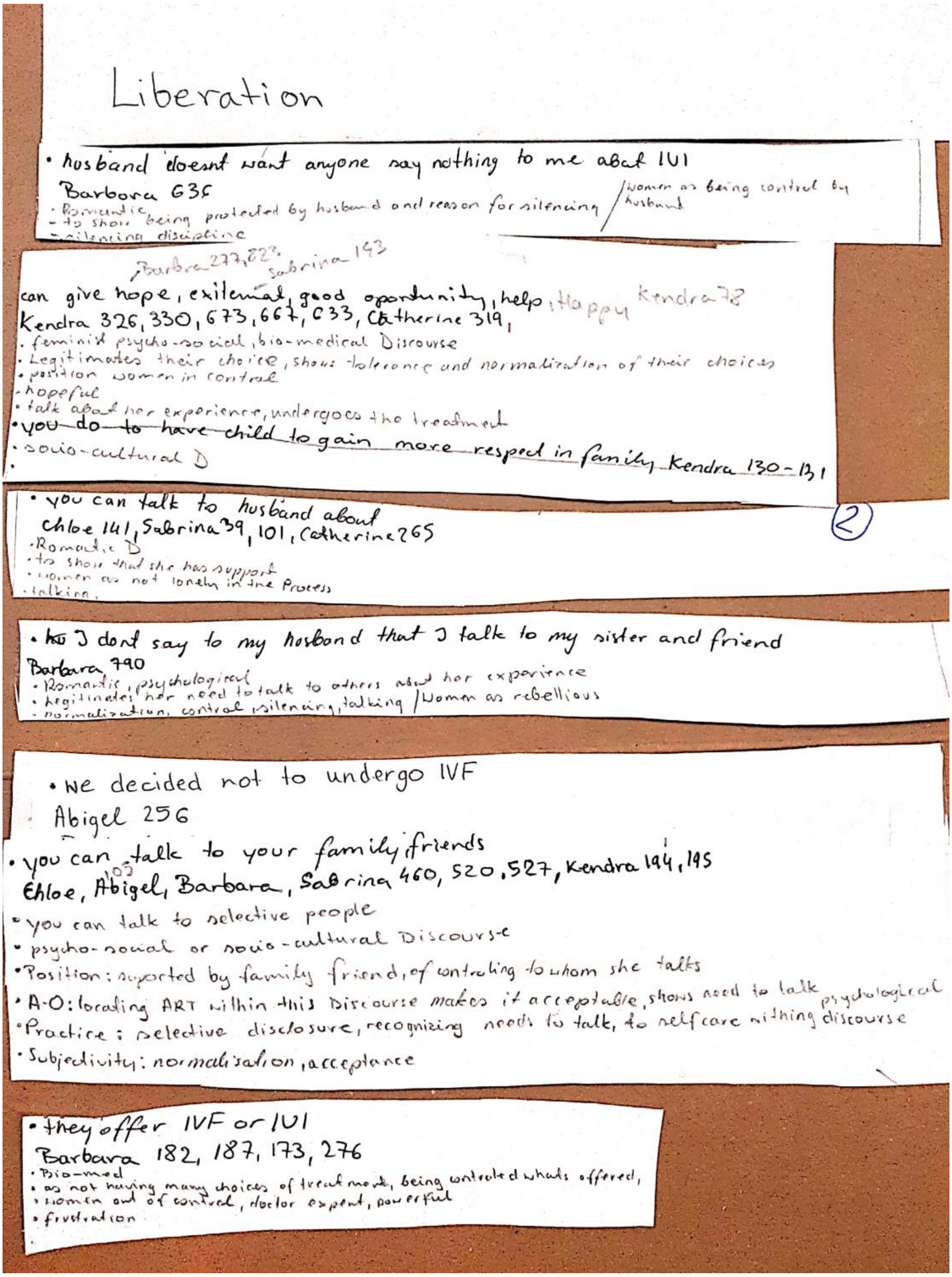
③

- can drain you out
Abigel 128

can make you
Chloe 71, 64

- can make you feel out of controle when there is overestim
Chloe 128, Abigel 76
- bio-medical
- victim of medical system
- self-control
- anxiety

- you dont know if it is going to work
Chloe 150,
- bio-med D.
- to show how difficult it is to do ART
- victim of the process of ART
- self-discipline, control
- anxiety



# Liberation

- husband doesnt want anyone say nothing to me abat IUI

Barbora 635

- Romantic
- to show being protected by husband and reason for silencing / Women as being control by husband
- silencing discipline

Barbra 277, 823, Sabrina 143

can give hope, exitemat, good oportunity, help, Happy Kendra 78

Kendra 326, 330, 673, 667, 633, Catherine 319,

- feminist psycho-social, bio-medical Discourse
- Legitimates their choice, shows tolerance and normalization of their choices
- position women in control
- hopeful
- talk abat her experience, undergoes the treatment
- ~~you do to have~~ child to gain more respect in family Kendra 130-131
- socio-cultural D
-

- you can talk to husband about

Chloe 141, Sabrina 39, 101, Catherine 265

- Romantic D
- to show that she has support
- women as not lonely in the Process
- talking,

②

- so I dont say to my husband that I talk to my sister and friend

Barbara 790

- Romantic, psychological
- Legitimates her need to talk to others about her experience
- normalization, control, silencing, talking / Women as rebellious

- we decided not to undergo IVF

Abigel 256

- you can talk to your family, friends

Chloe, Abigel 103, Barbara, Sabrina 460, 520, 527, Kendra 194, 195

- you can talk to selective people
- psycho-social or socio-cultural Discourse
- Position: suported by family friend, of controling to whom she talks
- A-O: locating ART within this Discourse makes it acceptable, shows need to talk psychological
- Practice: selective disclosure, recognizing needs to talk, to selfcare withing discourse
- Subjectivity: normalisation, acceptance

- they offer IVF or IUI

Barbara 182, 187, 173, 276

- Bio-med
- as not having many choices of treatment, being controled whats offered,
- women out of control, doctor expert, powerful
- frustration
-

# ART as sociocultural event

Even when it results in pregnancy it causing anxiety "on age"
- Barbra 827-829, Sabrina
- Biomedical D
- ART as causing distres even when pregnant due to higher risk of miscarriages after ART
- to say how difficult and not ideal this is
- women as out of control, not having many choices
- self-discipline/control "you have to be ready and you might miscarry"
- anxiety

- people dont understand what it is
Abigel 470, Catherine 493,

- that can be embarassing to talk about because of procedures
Chloe 54, 246, 263, Catherine 359-363,
- Socio-cultural
- to show that ART is not acceptable
- embarrasment, shame
- women as guilty victim
/ silencing

- husband doest doesnt want me to talk abut this, forbiden by husband to talk abt.
- Romantic Relationship Discourse
Barbara 639
- Position: protected by husband, inferior to husband
- A-O: Talk about ART makes women vulnerable
- Practice: obidience to husband and resistance still talking to selective people
- Subjectivity: not being fully understood by husband dangerous environment, shame

- put presure on your relationship
Abigel 136, ~~160~~ Sabrina 715
- Romantic D
- to show how difficult this is to undergo
/ as victim of the infertility
- self-control
- guilt, blame

- more people knows about this, more vulnerable you are
Barbara 634, Kendra 370-376, 391, 563, 570, 571, 596, 618, 620, Catherine 391, 784, 771, 794, 113
- Socio-cultural or S-A Discourse
- Position - vulnerable, inferior, victime
- A-O: opressed
- Practice: Secrecy, resistence - selective disclosure
/ Subjectivity: world - dangerous place
people - untrustworthy
shame
⑦

- there is no language to explain it
Chloe 111,
- Socio-cultural D
/ embarasment
/ silencing

- you have to justify or explain yourself
Chloe 132

you can make dua for it to work

- is not natural
Abigel 50, Sabrina 384, 480, Kendra 359, Catherine 97
- bio-med D, ART as not desirable

- you dont talk to anyone abut
Chloe 155, Abigel 472, Sabrina 411, Catherine 348, 89, Kendra 370
- mosques dont talk about
Chloe 569, 599, 784, 795
- Religios Discourse alone
- Muslim women unsuported within
- To take blame from herself
/ self-silencing
- women goes against social norms to have child
- self-silencing
④

- is a last resort
Abigel 455

- it is not the way it should happen as problematic
Chloe 280, Catherine 748, 111, 106, 282
- Socio-cultural South-Asian culture

- you dont hear anyone at home talking about this
Chloe 76, 237, 431, 428, ~~[illegible]~~ Abigel 194, Sabrina 575, Kendra 517-523, 623, 855, Catherine 94, 303, 30
- Socio-cultural
/ women as guilty, victim [illegible] system

- ~~not~~ is not normal
Abigel 58, Kendra 359, 597
- Socio-cultural / abnormal, unacceptable
- desperation to have child

- indicates that something is wrong with you
Chloe 445
- bio-medical, Socio-Cultural
- as women problem
- shows ART as not ideal, not desirable
/ A-O - to give reason for silence
- position women as a victim of social gaze,
- self-control, silencing

- you keep as a secret and this put pressure
Chloe, Kendra 384, 387, 393, 432, Catherin 373

- if you have it, means something went wrong
Chloe 279
- Socio-cultural and bio-med D.
- puts blame on couple or women
- women or couple guilty, responsible
- self-silencing
- self discipline
/ shame,
self-blame
guilt

- you can be embarased (awkward) about with your in-law
Chloe 37, Chloe 48, 57, 273
- Socio-cultural
- to show ART is not acceptable within family
- victim of power relation within family
- women as a victim of within patriarchal family
- self silencing, discipline
- embarasment, shame

- can make you struggle emotionally
Abigel 57, 168, 238, 240, Chloe 123

- taboo
Chloe 268, Abigel 641, Catherine 97

- you dont tell your in-laws about
Chloe 36, 134, Sabrina 536, 556, Kendra 780
- Socio-cultural
- women being afraid of their response
- power relationship within patriarchal family
- to show that ART is not acceptable within family
- victim of patriarchal family
- self-silence, discipline
- shame

- open secret
Abigel 643
- Socio-Cultural D.
①

- can make you isolated
Abigel 85
- psycho-social
- to show how difficult this is to undergo
- as isolated
- self-silencing, self-isolated
/ - anxiety
- depression

brings up shame Catherine 395, 88
- Socio-cultural
- to show that is not desirable within S-A
- position women as guilty of doing the wrong thing
- silencing
- shame

# Appendix N: Example of how I did the analysis

This is an example of how I did the analysis, following Willig's (2013) six stages of analysis and Arribas-Ayllon and Walkerdine (2008), but without following them too rigidly. I used one of Catherine's' extracts to illustrate the analytic process of constructing my understanding of their talk.

Catherine: *I have lost again ten kg. And, erm, after the summer I'll go back to the hospital and show them that, look, I've lost, erm, ten kg. So because that's their concern. I lost it, I gained it back and they say you have to lose it again because the pregnancy chances are going down because of your overweight. So, so those are the challenges for me. Catherine (544-550,)*

**Discursive Construction**

Here Catherine constructs IVF as something problematic (*so those are the challenges for me*) and something that you need to lose weight in order to start. Catherine constructs her experience of IVF in the context of her being overweight. There is also the construction of IVF as having a higher success rate when the woman has the right BMI (*pregnancy chances are going down because of your overweight*).

Doctors are constructed as people who can give advice to lose weight, saying that this will enhance pregnancy chances.

**Wider Discourses**

It seems that this talk is done within the biomedical discourse.

**Positioning**

In this extract Catherine described losing weight as a *challenge* and she describes that her weight it is a *concern* for doctors who said to her that her *pregnancy chances are going down* because she is overweight. By saying all these doctors are perhaps setting up a certain judgement about her being overweight while trying to start the IVF, in the context of desirable ways of being, she is seemingly positioned as the one whose fault it is for not getting pregnant and why her IVF treatment is being delayed: *you have to lose it again (weight)*. ‘docile bodies’

### Action Orientation

Here the fertility clinic is placing the responsibility on women for losing weight, to increase her chances of pregnancy via IVF and even be accepted to have the IVF.

### Practice

Catherine is perhaps taking up the role of patient, is following the guidelines, losing weight and reporting this in the fertility clinic. Ideas about the right BMI to be eligible for IVF have been informed by fertility clinics and supported by clinicians, in this example Catherine’s fertility doctors. Possibly, the constructions of clinicians as knowledgeable and powerful guarantees that women follow the most efficient way of getting pregnant via ART, thus a woman is seemingly rendered to self-discipline (Foucault, 1988) to losing weight,  ensuring perhaps her status as the ‘eligible patient’.

The construction of ART as having the higher success rate when the women has the right BMI is reflected in the NICE guidelines and literature made available for the candidates in the fertility clinic. In discussing her problematic experience of losing and gaining weight during the process of doing IVF, Catherine possibly talks into being an explicit ‘technology of power’. Seemingly, the advice and sanctions given to women who want to start IFV treatment within NHS by doctors is possibly enacted to regulate the behaviour of these women, promoting the right BMI as one of the essential objectives needed to increase chances of pregnancy.

### Subjectivity

Catherine talks about losing weight being one of her challenges and this could indicate aspects of her subjectivity in relation to the discursive construction of the responsibility the medical staff places on her. We can only speculate how difficult and lonely this must have been for her when she came for help with getting pregnant but she was only told that they cannot do anything for her until she loses weight.

# Appendix O: Stages of Analysis

**Stage of looking for what is being constructed:** This involves looking for all different constructions of ART (explicit and implicit) and this is achieved through re-reading transcripts and listening to the audio.

**Stage of looking at how the discursive object is being constructed and problematised:** This involves locating the discursive constructions within wider discourses and looking how they are problematised, made visible and knowable. These problematised discursive constructions normally reveal knowledge/power connotations.

**Stage of looking for functionality of the discursive construction:** This stage looks at how the discursive object is being problematised and what actions, gains and motivations can be possible through various constructions of the object. This stage also implies functions of problematisation within discourses.

**Stage of identifying discursive subjects:** This stage considers the subject positions available for participants and others resulting from the different constructions of the discursive object. Each subject position has a structure of rights, obligations and possibilities of action.

**Stage of exploring the process of subjectification:** This involves looking at what can be experienced within different subject positions. This stage is interested in the relationship between discourse and subjectivity; this is in line with the notion that discourses make specific ways of seeing and being in the world, constructing social and psychological realities. Once a person subscribes to a position, then he/she is limited to see the world through the lens of that specific position.

**Stage of recognizing technologies of power and implications for social practices:** For the reason that discourse warrant social actions, what can be said, gained and done from within various discourses, this stage identifies what can be felt, thought and experienced within the identified subject positions. This stage searches for various technologies of power and technologies of the self in the text and how they are used.