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The "Lived Pain" Experience: The Case of Women Undergoing IVF treatments

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Abstract

This research used the embodied approach to analyse the pain experiences of 25 heterosexually married Israeli-Jewish women undergoing in vitro fertilization (IVF) treatments for a first pregnancy. Semi-structured interviews were conducted to allow the women to openly discuss issues concerning their perceptions of pain. Research findings show that the women's pain perceptions dictated two distinct categories of discourse. The first category of discourse surfaced in the accounts of 14 of the interviewees. Women belonging to this category expressed their willingness to "do everything for a child". These women insisted on silencing pain and considered it to be irrelevant. They refused to locate bodily pains at the centre of their experience, fearing that this would delay their goal of reproducing. The second discourse of pain emerged from the accounts of 11 interviewees. This discourse was associated with women's motivation to maintain an active dialogue with painful experiences. They obstinately sought to direct internal attentiveness to what was happening inside their bodies. This approach enabled them to define body boundaries and form an active negotiation with the authority treating their bodies. The research findings suggest that women who share the same socio- cultural environment (Israeli pronatalism) and physical circumstances (the inability to conceive) have varied and wide-ranging interpretations of pain. It seems that medical authorities can benefit the understanding of pain by providing new support resources to women undergoing IVF treatments.

Introduction: In Vitro Fertilization worldwide

In vitro fertilization (IVF) is a procedure in which women receive ovulation stimulating drugs and egg cells are removed from the women and joined with sperm in a laboratory dish. The fertilized egg is placed in the women's uterus to grow into a pregnancy. Data presented at the 2006 annual conference of the European Society of Human Reproduction and Embryology has shown that more than three million babies have been born using IVF and other assisted reproductive technologies (ART) since the world's first IVF baby was born in 1978 (Kirsty, 2006). ART is responsible for an estimated 219,000 to 246,000 babies born each year worldwide according to the International Committee for Monitoring Assisted Reproductive Technology (De Mouson et al., 2009).

The ICMART (2009) study also found that the number of ART procedures is growing steadily. In just two years (from 2000 to 2002) ART activity increased by more than 25%. According to the study, the USA reported the largest number of aspirations, followed by Germany and France. On a regional basis, Europe had the largest contribution (56.4%). Overall, frozen embryo transfers represented 21.7% of the aspiration number (14.4% in 2000). This proportion fluctuated from >64% in Finland, Australia and Switzerland to <10% in 23 other

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countries. In 2002 56.6% of fertilization procedures were represented (47.6% in 2000), reaching 75.9% in Latin America and 92.4% in the Middle East. The availability of ART varied from two cycles per million inhabitants in Ecuador to 3688 cycles per million inhabitants in Israel. The large number of Israeli women undergoing IVF treatments led to this research's exploration of their experiences using the embodied approach to the lived body and pain.

The connection between the lived body experience and the nature of pain

Williams (2006) argues that one of the main ways in which the body is evident in medical sociology today is through the more fully embodied perspective on matters of health and illness:

> This perspective lays the Cartesian ghost of mind–body dualism to rest once and for all, and in contrast emphasizes the moving, thinking, feeling, pulsing, body; the lived body as a mindful, intentional site of on-going experience. (Williams, 2006, p.10)

In accordance with Williams (2006), Young (2005) explains the idea of the 'lived body' by arguing that it is a unified idea of physical body acting and experiencing in a specific socio-cultural context:

> It is body in situation. The woman always faces the material facts of her body and its relationship with a given environment. Her specific body lives in a specific context crowded by other people. Her bodily organs have certain feeling capacities and function in determinate ways. Her skin has a particular color, her face has determinate features. Her body is surrounded by specific social processes that make specific requirements on her to access them … her physical and social environment constitute her facticity. (Young, 2005, p. 16)

Young (2005) suggests an embodied perspective that intertwines physical elements with emotional and sensational aspects echoing socio-cultural aspects. She thus widens the definition of the body and challenges the binary classical thought regarding the body.

The rejection of dualism and the will to expand the understanding of the body are also evident in David Morris' (1991, 2001) research of pain. Morris (1991, 2001) analysed the culture of pain and argues that modern culture rests on an underlying belief or myth concerning the existence of two types of pain: mental pain and physical pain. Morris (1991, 2001) argues that this artificial division was created by western thought, which adopted the Cartesian division between mind and body.

Bendelow and Williams (1995, 1998) also suggest that the tradition of fragmentation is a result of classical physiological perceptions that began with Descartes' proposed 'specificity theory' in 1664. According to this theory:

> The specific pain system carries messages from pain receptors in the skin to a pain centre in the brain. The location of the centre is thought to be contained in the thalamus and the cortex is assumed to exert an inhibitory control over it … Although there have been modifications and refinements with the emergence of physiology as an experimental science in the nineteenth century, the proposition nonetheless remains basically unchanged. (Bendelow & Williams, 1998, p. 250)

Morris (1991) and Bendelow and Williams (1998) attempt to challenge this division by arguing that mental pain and physical pain are not separate components or aspects of pain. According to Morris (1991):

> We need to challenge our unthinking culture-wide assumption about pain because our own health is at stake … the rigid split between mental and physical pain is beginning to look like a gigantic cultural mistake, perhaps similar to the belief that the world was flat. Mistakes, we know, can prove very difficult to abandon or correct when we have invested centuries of belief in them. (p. 4)

Field studies of the sociology of pain and the sociology of body have led to the development of qualitative approaches that can circumscribe the mind/body dualism. For example, Freund (1990) uses the phenomenological approach to stress the need to understand the lived body as an expressive body. He argues that pain should be investigated from a phenomenological perspective in order to take into consideration relations of power and social control. In a similar manner to Foucault (1980), who draws attention to the shift from anatomy to psychosocial effects, Freund (1990) also sees the importance of studying pain within the context of other dimensions. Thomas and Johnson (2000) support the use of phenomenology as a preferred approach for the exploration of pain by arguing that:

> Within phenomenology … the body is viewed as a fundamental category of human existence. In fact, the world is said to exist only in and through the body. Therefore, phenomenology

> appeared particularly well suited for the exploration of pain phenomena. (p. 686)

Researchers have formulated new conceptualisations of pain in order to achieve an embodied perspective that challenges the mind/body dualism. These approaches resist quantitative medical tools for estimating levels of pain. Researchers apply the qualitative perspective offered by the concept of embodiment and argue that pain is learned as a dynamic experience and therefore calls for dynamic interpretation (Miles, 1998). These researchers identified the need for a new conceptualisation of pain aimed at creating holistic approaches that extend the definition of the lived body. The practical implications of this new perception are reflected in the transition from quantitative questionnaires to qualitative interviews. Various researchers (Bendelow & Williams, 1998; Csordas, 1994; Lyon, 1994; Miles, 1998; Morris, 1991) argue that the silenced nature of pain demands a qualitative consideration. These researchers claim that in order to understand how people experience pain or describe their bodily pains, the metaphors and narratives of pain must be studied. The researchers agree that the qualitative approach can challenge the binary division by enabling a new language of body and, more importantly, new definitions of pain.

Morris (1991, 2001) suggests that these targets can be achieved by regarding pain as an 'experience'. He quotes the International Association for the Study of Pain (IASP) definition for pain: "Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage" (Morris, 1991, p. 3). According to Morris (1991, 2001) if pain is regarded as an experience, then it needs to be connected to its meanings. He argues that pain and meaning serve an indispensable social function precisely because they cannot be easily pinned down. Morris (2001) claims that linking pain to narratives is particularly important within medicine. This is because within the developed world pain has been thoroughly medicalised, to the extent that medicine has worked out a very specific relation to pain: "there is even a new specialty known as pain medicine" (Morris, 2001, p. 57).

Based on Morris' (1991, 2001) suggestion that pain be viewed as an experience, it seems that these questions are crucial to the understanding of the experience of pain in women being treated with in vitro fertilization (IVF). IVF treatments focus on the female body as, regardless of the reason for infertility, the female body is usually the body undergoing intervention. Moreover, medical intervention creates unavoidable encounters with pain (the stabbing of needles, injection pen devices, egg retrieval, ovaries enlargement and so on). Technological practice also transfers the female body from a private to a public context, entailing a 'bodily transformation' that combines the 'natural' with the 'artificial'. The female body thus objectified is exposed to a discourse that generates control and discipline mechanisms. In this context it is very important to understand how women treated with IVF conceptualise their bodily pain. We believe that the discursive examination of pain can shed light on systems of control, socio-cultural demands to reproduce, and perceptions regarding the obligations and entitlements of infertile women. The metaphors of pain produced by the women can also explore the conditions in which feminine resistance arises. These questions are particularly important within the Israeli context, which demands reproduction (Remennick, 2006). Miles (1998) expresses this tension by arguing that "bodies are not just acted upon but are themselves responsive, reactive and creative. The body is not just a reflection of culture, but a place in which culture can be created through the use of manipulation and metaphors about pain and distress" (p. 3).

Pain, infertility and the Israeli atmosphere

For Israeli women who wish to give birth but do not succeed, awareness of infertility is a boundary-crossing moment. Infertility calls for dynamic interpretations (Ha'elyon, 2006). Remennick (2000, 2006), focuses on Israel's social climate and argues that 'pronatalist ideology' has turned Israel into the 'fertility champion' among developed countries. According to Remennick (2000, 2006), the overall fertility rate of Israeli Jews is about 3 children per woman, compared to 1.4 in Western and Northern Europe and 1.9 in the USA. Religious Israeli Jews, who account for approximately 25% of the Israeli-Jewish population, average between 4.5 and 7.5 children per household, depending on their degree of orthodoxy. These statistics clearly demonstrate motherhood is much more than a simple desire for Israeli women. Instead, it is an ideological icon, a national and religious mission and the primary identity for most Israeli women regardless of their education, employment and career aspirations (Remennick, 2006). According to Kahn (2000):

> For Israeli Jews the imperative to reproduce has deep political and historical roots. Some feel they must have children to counterbalance what they believe to be a demographic threat. … Others believe they must produce soldiers to defend the fledgling state. Some feel pressure to have children in order to replace the six million Jews killed in the holocaust. Many … simply have traditional notions of family life that are very child-centered. (p. 3)

Amir and Benjamin's (1997) study explored the

socio-cultural ideologies of motherhood by analysing the discourses of the abortion committees in Israel. They found that the stereotype 'good Israeli-Jewish mother' is depicted as responsible, committed and sensible. Johnston and Swanson (2003) suggest that in order to understand the origin of motherhood ideologies researchers must focus on myths, which are the building blocks of ideologies (Barthes, 1972, cited in Johnston & Swanson, 2003). The very first myth of Israeli-Jewish motherhood appears in the Biblical text. Amit (2002) points out that the four Biblical matriarchs of the Jewish people were all infertile until God 'opened their wombs', thus allowing them to become mothers. This implies that motherhood in Jewish tradition is a sacred mission shaped by God's own intervention.

Within this Israeli-Jewish atmosphere, it seems almost impossible to refuse IVF treatments. According to Remennick (2006, p. 25) "childless (Israeli) women carry a lifetime stigma that can only be alleviated by protracted attempts to get pregnant by means of assisted reproductive technologies". In addition, the explicit pronatal Israeli legislation (Birenbaum-Carmeli, 2004; Hashiloni-Dolev 2006; Kahn 2000; Remennick, 2000; 2006) formally and openly encourages the medical management of pregnancy and IVF treatment by making prenatal care (including IVF treatments) accessible and virtually expense-free (Ivry & Teman, 2008).

IVF treatments involve pain and discomfort. Sometimes the amount of pain a woman is able or willing to undergo becomes an important aspect in the decision making process. In light of the Israeli-Jewish context, understanding how Israeli women conceptualise their bodily pain while undergoing IVF treatments is a very interesting topic. Moreover, Morris (1991) suggests that pain serves as an agency between the subjective experience and the outside world. It is thus important to understand what meanings women relate to their bodily pain during treatments. Finally, if pain becomes a way of delimiting body boundaries – for example, the pain might cause a woman to cease treatments (Benjamin & Ha'elyon, 2002) - understanding how women negotiate pain in front of doctors and other medical authorities becomes very important.

Method

Following the unified lived body conceptualisation of the physical body acting and experiencing in a specific socio-cultural context, the current study aimed to review definitions of pain expressed by women undergoing IVF treatments. The study was conducted using qualitative research methods. Semi-structured interviews were designed to explore women's perceptions of pain. The first part of the interview consisted of socio-demographic questions aimed at establishing the women's biographical profiles. Subsequent questions centred on the women's reproductive histories. The women were asked to explain their decision to undergo IVF treatments and to explore their attitudes towards pain. The interviewing strategy involved a cooperative approach and active listening (Marshall, 1996) .The women were recruited from fertility clinics, internet forums, newspaper ads and through the use of the snowball effect. The final sampling was a socio-demographically heterogeneous group of 25 women, with a mean age of 31 years (ranging from 25 to 42). All the participants were heterosexually married and undergoing IVF treatments at the time of the study. The interviews were held at the women's homes or at 'neutral' locations chosen by the interviewees. The findings were analysed in six distinct stems, based on Sacks' (1974) categorical thematic approach. The narratives were read and reread and then sameness and common patterns that might point to shared concepts and behaviours were traced and identified in the terminology and formulations used by different women. In the third phase these patterns were analysed and found to fall into two distinct categories. The fourth phase consisted of rereading the texts while focusing separately on each category. During the fifth phase, the relationships between the different themes were traced to make a text corpus consistent and intelligible, thus allowing the identification of patterns within and between categories. In the sixth and final phase the themes and categories that emerged were used to explain the findings and interpret the women's narratives. The two categories identified in this study do not represent essential psychological differences between women, but rather indicate different perceptions of pain. The findings are indicative of the multiple dynamic natures in the conceptualisation of bodily pains. The informants were assured of anonymity and are mentioned under fictive names in this article. This study was approved by Bar Ilan University (a competent authority) and forms part of a doctoral dissertation. The subjects all provided written consent for participation in the study.

Findings

The analysis of the 25 interviews was conducted by tracing the same interpretations in different interviews and coding them into categories. The first category included 14 interviewees who shared the same interpretations of pain. These interpretations were organised into 3 themes. The second category included 11 interviewees who shared other conceptualisations of pain. These interpretations were organised into 3 different themes. The themes and categories are described below.

Marginalisation of pain

1) Marginalising sensations of pain

The first category of women consisted of 14 interviewees who expressed their willingness to 'do everything for a child'. They insisted on silencing pain and considered it to be irrelevant:

> I had an inner oedema. My whole body was filled with liquids. I felt like I was choking. I didn't know what it was but I couldn't breathe. I felt pain with every breathe I took. When I was hospitalised, they (the treating authorities) insulted me … one nurse said it was complete stupidity to come (to the hospital) in this condition … but I only tried to keep what I thought to be a pregnancy. . . I had no energy to behave sweetly … I didn't want to make a big deal of it.

These women prefer to marginalise pain in order to enable the treatment routine. They refused to locate bodily pains at the centre of their experience, fearing that this might delay their goal of reproducing. An interviewee noted:

> In one of my embryo retrieval treatments, they did a surgical procedure, opening something inside my body … they inserted a slender bar with a needle. It hurt me so much … but I controlled myself … I try to overcome pain.

The narratives above illustrate the degree of discomfort experienced by women who do not wish to draw attention to their private pain in public. They believe that voicing pain might breach social taboos, and might even interfere with medical procedures. This managing strategy soon turns them into external observers both of the medical procedure and of their bodies within that procedure.

2) Expressing the sense of disappointment and body fragmentation

Repressing bodily pains positions women as external observers. Women express disappointment with their bodies and describe their bodies as malfunctioning: "I slept in the treatment bed and felt disappointment. I told my body: 'you disappointed me'". Another interview stated that she felt "like a strainer, like a hole in which they insert cold metal instruments. They inject it and suction it through . . . like a rag doll".

Subjecting the body to medical treatment creates a feeling of fragmentation between the inner agency and the material body. This fragmentation is further exacerbated when women do not express their pain. If they did express pain in this treatment context, it might expand their sense of control and enable them to define their bodily boundaries. One interviewee expressed her inability to "be there" and connected to her body. She claimed that: "I sleep in the treatment bed but I am not really there … I detach myself". This sense of detachment was also present in another interesting description:

> Since treatments began, all my experiences are 'filed' in compartments. I count days of ovulating, I count days of periods, I count the weeks before embryo transplant. Every occasion is noted in some file … I have the feeling that everything is separated, and in the middle, there is the will to become pregnant.

3) Bodily sensation magnetise feelings

These 14 interviewees tended to turn pain into an irrelevant entity. Referring to pain seems to prevent them from cooperating with IVF procedures. However, these women's descriptions show that despite their attempts to ignore it, the pain batters their insides and shapes their emotional condition, which becomes characterized by negative feelings of uselessness. This can be linked to Layon's (1997) theory on the body-emotions link. According to Layon (1997) the body is both material and social. However, to understand bodily existence in relation to social order we must explore the area of emotions. Layon (1997) argues that emotions are the point where the material and the social interact and create interpretations of the bodily existence. The descriptions provided by the women demonstrate how negative emotions soon shape their daily routine.

> Since treatment, my body is neglected. I have no desire to treat it nicely … for me, it's not natural to neglect my body, for example not to dye my hair. But I have no energy to treat my body well. Everything became useless. So even if I dye my hair or put lipstick on, it won't change the hole I feel inside.

Applying Layon's (1997) reasoning to the descriptions conveyed by these women, it seems that bodily existence during IVF treatments is characterized by denial of what Grosz (1999) calls 'positive force'. A positive force challenges the canonical order to reproduce. These women are defined by the pronatal order that shapes their emotional existence.

> These days my femininity is really vulnerable … in general, my whole way of relating to femininity is influenced by the way the environment sees me. At first, Yogev's family was very supportive but over time, there was

> this sense that his parents would have preferred he marry some other woman. I don't know, there's this myth that a pregnant woman becomes prettier, after the last time I returned, I put on blusher and a new lipstick, to make this illusion of being pregnant … it's really a miserable situation, you feel in some way that you've got to justify your existence.

Another interviewee claimed:

> I don't understand what femininity is. I barely feel like a human … femininity seems like a privilege, you can work yourself around it when you have everything …I'm waiting to become a mother, to be … that's all I ever wanted. As for femininity, I'll feel feminine enough when I walk around with a baby pram.

Beyond the pronatal context, the avoidance of expressing pain that redefines the boundaries of the body is connected with negative emotions:

> The pain causes me discomfort … and there's this message that your body's out of order, and that's why everyone's touching you, trying to fix the breakdown, and that influences what I feel.

In summary, it seems that the exclusion of pain erases the ability to regain control and redefine body boundaries. Separation becomes the main motif in women's lives, followed by negative feelings:

> Look, (she stretches her arms out), I'm completely covered in blue marks. Every day they suck my blood, and I'm not showing you what they did to my behind. Everything's covered in bumps. I feel like a strainer … but during treatments, I try to ignore all these physical phenomena, I concentrate only on the pregnancy.

Although in this situation pain could define the body's boundaries and help women find the entry and exit points in and out of the process, these women choose to ignore the pain for the sake of the medical treatment's success. This disregard for the pain positions them as observers looking in on what happens to their bodies. They do not challenge the power that penetrates their body. It seems that this non-repelled force leaves them with negative emotions, directed at preserving the proper and good social order. However, an interpretative exploration of pain demonstrates Merleau-Ponty's (1968) claims that the human body embodies many and varied meanings. The second group of women demonstrate how pain serves as a tool for undermining the social order and ramming at it full force.

Centring pain and expanding control

1) Situating pain in the centre of their experience

Eleven of the participants in the study expressed a different relationship to pain in their bodies. They obstinately sought to direct internal attentiveness to what was happening inside their bodies. Thus, one interviewee noted that:

> I feel my body … I really feel it. Everything is felt. The treatments taught me to feel every part of my body. My breasts, ovulation, body temperature. I feel my stomach, the pains in my side. I think that if I wasn't obsessively preoccupied with the feelings inside my body, I wouldn't be bothered by how my stomach or breasts ache. These days I concentrate on pain all the time. What is it indicating? Is this the signal for ovulation, of implantation, or not? It's not preoccupation with pain of the "poor me" kind. It's more constantly taking note of what's happening in my body. It's a reality that I never knew before the treatments.

Another interviewee stated:

> I'm able to feel my body, inside and outside. Every needle that penetrates. . . . I feel like I am constantly hurting. Inside, there are new sensations. After I return, there's this feeling … of fermentation. I can't explain, but it's as though someone's opened a bottle of coke inside my womb.

From the moment these women become recipients of fertility treatments, they are busy learning their bodies' new states. They familiarise themselves with what Linda Birke (1999) called "the inner body" (p. 45) and especially with that body's pains. It seems that these women's resistance to the experience of losing control during treatments is connected to an active attempt to organise their information concerning their bodies. This attempt manifests in learning about pain. The inner body thus becomes a reality existing in the sphere of definitions. The presence of pain quickly enables each woman to define body boundaries and form an active negotiation with the authority treating her body.

2) Negotiating the medical routine through the experience of pain

The ability to define, conceptualise and make use of the physical reality of pain as a guide to mapping the inner body (Birke, 1999) also connects with the possibility of expressing pain publicly. One of the interviewees described the experience as follows: "I

have no problem saying out loud that I'm in pain, and I don't spare anyone knowing that". The vocal presence of pain was also described by another interviewee:

> I get really angry that the doctors don't tell you the truth. And I, I don't have a high pain threshold, every time it hurts, I yell. Before the scan, I asked him (the doctor) to tell the truth. He tried to fob me off with "take a pill and it'll be fine", I didn't agree, and I did the scan under full anaesthetic.

This refusal to turn pain into a marginal experience assists in organising the body's procedures. In this way pain does not simply occur in the body but also serves to bring about experience. One interviewee expressed this as follows:

> After the first fertilization, a pain started that I'd never felt before. I felt pain in my side. The doctor said it's probably from the treatments. I didn't agree with him. I detailed to Nir what I was feeling. I firmly understood that I was experiencing unbelievable pain. I asked for an ultrasound … the examiner told me that there were … large circles. She confirmed that I was indeed feeling what I felt, and that I have huge cysts.

This description demonstrates the existential value of the presence of pain. The interviewee quoted above describes how directing her attention inward to the pain saved her from ovarian overstimulation.

In summary, based on the interviewees' descriptions it appears that reflective processes (Giddens, 1991) are noticeable alongside conscious expressions of bodily sensations that form a female language which causes pain to be present. Making the pain public allows these women to influence their body processes and shape them through the treatments. In this way, they expand their struggle for control and rely on private, independent knowledge toward understanding their body experiences (Marshall, 1996). The way in which these women manage their pain and their body boundaries testifies to the external power activated against their bodies. These bodies constantly encounter the reverse subjective direction activated from the inside toward the outside (Grosz, 1994).

3) Expanding the sense of control and expressing positive feelings.

From the moment women position pain centrally and use it to wield social order, a new kind of affective experience is created. This affective experience is characterised by positive emotions despite the women being physically present in the gynaecological treatment space:

> Some women think that because they're not pregnant, they're not feminine. I completely negate such views, you're a woman because G-d created you that way, you can accentuate your femininity, through clothes, and other things. Everything you are, to yourself. You can also dress in a very non-typical way for women and still feel the most feminine in the world. Because, all in all, it's something you decide on. Each woman has her own way of being feminine.

Other interviewees even expressed direct resistance to defining femininity as being tightly linked to pregnancy:

> They try to have us believe that pregnancy makes you feminine, I want to remain me … for me, femininity is my me-ness.

Subversion against silencing the experience of pain also connects to subversion against structuring an identity that is stereotypically gendered:

> For us as women, it's far better than for men, we can use our femininity in so many ways, men don't have that opportunity. As a woman, I can choose what I want … femininity for me is so many things, even being able to cry without feeling that it's unacceptable, or to sigh when I'm at the physician's clinic, and know that he has no clue what I'm feeling because I'm a woman.

One of the interviews described how "positive force" is ultimately used to direct pain profitably:

> The treatments strengthened my sense of femininity. I always had a positive outlook on my femininity. I always felt my femininity was very strong. I'm a woman and love being one. If I don't feel like something, I can say that I'm in pain even when I'm not really in such pain. I turned the negative into the positive. These days, with the treatments, my femininity is even more expanded, it's not only the appearance but motherhood, but the fact that I don't have it (motherhood) right now doesn't mean I don't feel feminine.

Another interviewee claimed:

> Especially now, with these treatments, I don't have to establish my femininity, because treatments means working constantly on it, for example, I now know that my ovule count is limited, that is, the woman represents quality, the man represents quantity.

Grosz (1999) coined the term 'active force' in response to Foucalt's (1980) concept of 'negative force'. Foucault (1980) views the body as an entity servant to supervision, normalisation and obedience and attributes a negative force experience to the subject. In contrast, Grosz (1994) describes "active becoming" (p. 123), which suggests that experiences that allow the subject to exist in dialogue with hegemonic order may actually allow the experience of positive force. A woman's ability to connect to her body's sensory experiences and position pain centrally appears to contribute to the process of becoming an active body. Expanding the ability to experience 'positive force' connects further to positive emotions.

Summary and Clinical Implications

The article sought to trace the qualitative nature of pain as apparent in the narratives of 25 women receiving fertility treatments in Israel. The research findings indicate two norms of coping central to understanding the female experience of pain. One group consisting of 14 women demonstrated that the intense desire for a child at any cost creates a reality that silences pain. These women numb the physical pain in order to avoid disrupting order and to ensure that the routine of treatments is preserved. In contrast, another group of 11 women also receiving fertility treatment demonstrated a different approach that challenges the obviousness of receiving treatment. These women used pain to familiarise themselves with their bodies' reactions and expand their control over the medical situation. From this position of power, they were able to negotiate the social and medical space rather than simply accept various decisions implemented by the medical staff on their bodies. Moreover, the research findings indicate that understanding pain through qualitative research contributes to several dimensions of the theoretical discourse in the field. First, qualitative learning about pain, which uses language and body images, sheds light on the different loci of power among women undergoing fertility treatment. The different types of control applied are especially important to feminist body studies, which in recent years have investigated the conditions under which women create resistance.

Second, a qualitative understanding of pain also contributes to theoretical knowledge by showing how women manage their bodies in the therapeutic space, an issue of great relevance to policies that encourage childbirth. Countries that encourage childbirth place importance on parenthood to biological children. This approach promotes willingness among women to receive consecutive (often uninterrupted) treatments. These women are thus exposed frequently to experiences of pain that must be understood and heard. Those spheres of the medical establishment interacting with these women could therefore contribute much to our understanding of the ways in which women receiving fertility treatment manage physical pain.

Finally, the current study was related to research of the living body and indicates the inseparable link between the material experience of the body and the affinity it maintains with sensations and feelings. In this respect, the research supports the claim made by Williams (2006) and Lyon (1997) that it is not possible to learn about the living body without taking into account the feelings and sensations which that living body produces.

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