INTEGRATING INFERTILITY CRISIS COUNSELING INTO FEMINIST PRACTICE*

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Synopsis – Infertility is not an individual problem demanding an individual solution. It is a social problem that cannot be solved purely by medical intervention. Infertile women, pressurized both by social attitudes towards infertility and their own desire for a child find themselves in a crisis situation. In order to overcome the crisis they turn to the only available help – the medical establishment. The technodocs offer technologies that are not the best solution for infertile women. However, they are seen as such because of the social and political ramifications that lie behind them. This article claims that an alternative to reproductive technology must be found by the feminist movement. A holistic alternative suggested at this stage is the setting up of infertility crisis centers. Such centers should have four main aims. They should (1) empower infertile women by giving them all available information and realistic counselling; (2) become pressure groups to encourage research into the causes of infertility; (3) work to change the face of infertility treatment, and (4) radically alter social attitudes towards infertility.

INTRODUCTION

Five years ago I discovered I was infertile and infertility became a crisis in my life. It had never occurred to me that I might be infertile and because it does not generally occur to women that they may not be able to have a child exactly as planned, I had to cope with it alone. There was nobody within the medical establishment who helped me and the women's movement also was unaware of how to deal with this crisis.

I am not going to detail here the endlessly tiring, humiliating, invasive treatments I received; the drugs I took and took again when they didn't work; the doctor's attitude when I dared asked questions or object to treatments, ("you do *want* a baby don't you?"). Instead, I will give just a few impressions of some of the feelings I experienced.

Five years ago I was desperate for a child. I used to look in the mirror and think, "I'm not a normal woman. I may look like one, but inside I'm not." Normal women could get pregnant – I couldn't. This may sound melodramatic – but it is true. I had never thought about infertility and had certainly never read about it. So that having decided I wanted to have a baby, I went straight out and bought the mothercare catalogue, a book on pregnancy, and a book on childcare. I started reading the book on pregnancy the same evening, although I promised myself I wouldn't read the book on childcare until I was actually pregnant. It remains unread to this day.

Since I was infertile, gradually my whole life began revolving around the intense desire to get pregnant. I wanted to change my job, but assumed it wasn't worth it if I were going to become pregnant, I wanted to join an aerobics class but thought I'd soon be pregnant so it wasn't worth paying the year's membership. I also wanted to buy a bicycle to ride to work, but once again it didn't seem worth it if I were going to get pregnant. I wanted to join the tennis team at work – stupid, little things maybe, but they are what makes up our life. And when you don't do them, life becomes one big wait –years of living in limbo.

None of the women around me seemed to know more about infertility than I did. For example, when I used to tell my friends that I was apparently not ovulating they used to say, "oh, don't you have periods then?" They all assumed that women with infertility problems have always known they would have problems conceiving and it never occurred to any of them that you could have periods and not be ovulating.

In a social circle of young couples where everybody is a parent, we found ourselves the outsiders among our friends. They all had young babies, they would not want to or be able to go out when we did. Festive gatherings always revolved around the children and activities for them and, especially when the men would all go off together, I would be left with the women and children feeling useless. Although I had never been brought

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up to feel that a woman's only mission in life is to have children, when this is the atmosphere all around you, you cannot help but be influenced by it.

People sometimes think that perhaps it was because I was married to a Sephardi[1] that I felt so much pressure. Although this is true, even women from Western, educated families are under tremendous pressure to have children. I have recently met a woman who left the kibbutz she was living on because of her infertility. She is 36 and had tried to accept her childlessness but had found herself made to feel a total outcast. The kibbutz has become one of the most family–orientated institutions in Israel. The first fact a kibbutz always boasts about is how many children it has. In town, it is no different; for example, my friend Orna, a young Ashkenazi, modern "career woman" feels that even if she could accept her childlessness, her family and friends, to say nothing of society at large, would not.

I went through all those typical stages childless women go through – looking at women and wondering how they got pregnant so easily, looking at harassed women with six children dragging behind them and thinking how unfair it was. I also had (and still have) a problem hearing about my friends' abortions. I never disapproved of them in theory, but did find the practice ironic.

During that period I was tense a lot of the time. Every morning I'd be taking my temperature, waiting for the fourteenth day of the month to see if there would be that sudden drop and rise. Because there was always a slight rise, I would wait anxiously for the end of the month hoping that *it* wouldn't happen – that my period wouldn't appear. I read everything on the subject of infertility – by then the books on childbirth were relegated to the back of the bookcase and their place was taken by the only available book I could find about infertility.

Then one day after I'd done some test or other, the doctor suggested that since the results would take about two months I should just take a rest from everything: stop taking my temperature, planning intercourse, and so on. I was furious. It was like telling me to stop thinking, to stop breathing. Didn't he know that my whole life was guided by one ambition and one alone – to get pregnant? Today, my infertile friend Orna says that she finds these breaks disconcerting –"sometimes its such a pleasure I don't want to start again. But of course," she adds quickly "what choice do I have?" Orna says she'll give it one more year and then give up. But she admits that being in infertility treatment is like being on drugs: you always think, just one more time. Today I also feel this way about fertility clinics. I feel as if those fertility drugs are just like any other drug – something you get hooked on. And just like any real junkie, you're part of a whole scene. An addict can't take drugs and carry on leading a normal life, and that's what I was – an addict.

I took the two–month break –and suddenly I discovered that it was actually a pleasure not to have to "think–thermometer" first thing in the morning, to make love how and when we chose, to stop thinking about babies, and to start thinking about me. For the first time, I began to think what would happen if I did not get pregnant, at least not for the time being. I could start getting involved in many activities that I had postponed for so long. I could seriously think about changing my job. If I stopped being tied to the clinic, I could start doing interesting, exciting things – if I could make that choice.

When the two months were up, I delayed going back to the clinic. I felt disillusioned. At the beginning I'd been so sure that the treatment would be quick and easy. I had believed that when I took a drug to make me ovulate it would work. After all, when I took antibiotics they always worked. But now I knew that fertility drugs weren't antibiotics and they didn't always work, and especially not on me. I knew that the drugs themselves made me feel unhealthy. I had read about test–tube babies but all that seemed to have nothing to do with my reality – it was something that happened to other women. I distinctly remember wondering how on earth women got into such programs. I did know that it was only after years and years of infertility treatment. And I knew I'd have to go through a hell of a lot of other treatments before I ever got

[1]Sephardi Jews living in Israel tend to originate from countries such as Iran, Iraq, Syria, Morocco, and India. They are largely a poorly educated and economically depressed sector of the community and may generally adhere to traditional values. Ashkenazi Jews are predominantly white Eastern European Jews with a more "modern" attitude.

near that.

About a year after I'd started infertility treatment, I became involved with the women's movement. Even there I discovered that whenever I brought up the subject of my infertility, there would be a total lack of understanding. Often I would be told that nowadays there are so many treatments for infertility – somehow implying that if I were still infertile then I really only had myself to blame, or that it wasn't really a problem since I would soon stop being infertile. Either way, nobody seemed to be listening to what I was actually saying. I felt that my feelings and my reality were being denied. Yet I felt that a feminist approach could be helpful to myself and other women and below I have outlined how I see that approach.

ATTITUDES TO INFERTILITY

Before describing a feminist approach to infertility, I would like first to briefly look at present attitudes to infertility in the medical establishment, in Israeli society, and in feminist theory. By examining where present attitudes fall short, we can then establish a way of looking at infertility which will be most helpful to infertile women.

The medical attitude

Sophie Laws has said that in our society all to often, "the only way to deal with female experience is to put it into a category which is easy to recognise – sickness" (Laws, 1983: 20). This is what has happened to infertility.

For medical practitioners, infertility is a purely medical problem, a malfunction of a system in need of repair. Not only is the system in need of repair, it is the doctor's *duty* to repair it, since this is his* job. For proof of this mechanistic attitude we need only look at the terms used to describe infertility caused by tubal blockages or other physiological problems, at least in Hebrew, which are called mechanical causes of infertility.

Infertility is a malfunction of a system, and this is clearly seen in the way hospitals calculate their success rates on IVF programs. In my own survey of IVF clinics distributed in Israel in 1986, all clinics clearly stated that success rates are based on the number of *pregnancies* compared to the number of *laparoscopies* rather than the number of births compared to the total number of women on the program.[2] This finding supports similar findings in a survey of IVF clinics in the U.S. (Corea and Ince, 1987). Success is the repair of the malfunction – pregnancy – and not the desired effect by the patient – a child.

My survey also found that all IVF climes in Israel will treat a woman who already has children from a previous marriage or from her present marriage who since became infertile. Their reasoning is usually that infertility is a sickness that needs treatment. Even if this were an acceptable definition, it is clearly not true because this sickness has a social aspect. A single woman who is infertile is not "sick" – if she were it would be the doctor's duty to "cure" her. Yet "cures" for infertility are available only for married women.

According to the doctors, infertility is a medical problem. Yet, quite astoundingly, doctors are willing to treat – give hormonal injections, do laparascopies and operate – on perfectly healthy women. They do this quite openly and indeed according to the above–mentioned survey most of them saw this side of things expanding. The reason – male infertility. IVF is seen as a legitimate answer to male infertility.

Doctors claim that IVF is being done to help unfortunate women, desperate to control their reproduction. I have never heard this explanation given as a reason to grant abortion to rape victims or give artificial insemination to lesbians. It is clear that if doctors really cared about women and our health, IVF would be very low down on the scale of priorities. Instead, while the infertility clinics remain full to overflowing and have long waiting lists, every year new IVF clinics are opening up – clinics that are far more expensive, take far more "man"power, and have very low rates of success, if we consider success in real terms (i.e., the number of babies born to the number of women attending

*Throughout this article, doctors are referred to as male. This is because (1) most doctors working in IVF and the upper echelons of infertility treatment are indeed male and (2) women doctors have often absorbed the male medical mentality so that they may treat their women patients in a male (authoritative, patronizing) way.

[2]If this difference seems trivial, it should be pointed out that using such a statistic totally falsifies the real success rate of IVF clinics. For example, one hospital in Tel Aviv had 350 patients, 54 pregnancies, and 6 births. It claimed a success rate of 26%.

the clinic).

The social attitude

Despite the fact that doctors are sure that infertility is purely a medical phenomenon, in most countries the use of medical procedures is backed by social and religious attitudes. In Israel, where many aspects of daily life are ruled by religion one would think that this might have some dampening effect on the "progress" of IVF. However, this is not the case, precisely because for the dominant religion – Judaism – the attitude towards infertility arises out of the first and supreme commandment in the bible, to "be fruitful and multiply."

Despite the fact that only 30 percent of the country are orthodox in faith, secular women are just as desperate as their religious counterparts to become pregnant. Fertility is not only a religious priority but also a national one. Children take on an almost holy aura for a people who's very existence was threatened during the holocaust and for a nation who feels its survival to be in constant danger. Thus both religious politicians and secular leaders call on women to answer the religious/national need for an increased Jewish/Arab birthrate.

Increased birthrates must be within the family framework and thus there are financial disincentives for single, childless women, such as higher income tax, no rights to a joint mortgage, less sick leave, and so on. To be married and voluntarily childless is seen as the height of selfishness, and I have yet to meet a young couple who would state openly, as can be heard so often by Western "yuppies"– that "we don't want children."

I am not trying to say that infertility is *purely* a social problem. Many infertile women truly feel an overwhelming desire for a child. Yet leaving aside the question of whether there is an inherent motivation in some women to become mothers, the desperation of infertile women is undoubtedly exacerbated by social conditions and by certain life–styles. Society, for its part, is happy to perpetuate the present patriarchal social order and thus does little to relieve women who may be the victims of it.

The feminist attitude

Until recently, infertility was not particularly an issue within feminist circles. Naomi Pfeffer (1985: 50) describes the feminist reaction to infertility thus:

> Several years ago Anne and I made valiant attempts to set up workshops on infertility at women's health conferences and in our own homes. The response was nil. We had no preconceptions about how we wanted infertility discussed, we just wanted it to be put on the feminist agenda because we believed that we could find support from our sisters. Sadly our efforts failed. It has taken IVF and the more outrageous solutions to infertility such as womb–leasing to stir up feminist interest.

From personal experience and through conversations with other infertile women, we have found that the women's health groups know little about infertility and infertile women are likely to be told by feminist activists that motherhood should not be the central issue in life. All too often, our experiences are delegitimized and trivialized by women who would not dream of doing so in any other crisis situation such as rape.

The only branch of feminism that has dealt with infertility is that dealing with reproductive technology. However, this aspect of feminist theory deals with infertility only very indirectly since it is aware that reproductive technology is a far broader issue than just infertility treatment. FINRRAGE–the Feminist International Network of Resistance to Reproductive and Genetic Engineering – believes that the "externalisation of conception and gestation facilitates manipulation and eugenic control," that reproductive technology uses biology to solve social and political problems created by exploitative conditions. IVF is seen as "the division, fragmentation and separation of the female body into distinct parts for its scientific recombination," which leads to "the take–over of our bodies for male use, for profit–making, population control, medical experimentation and misogynous science" to bring about "a rascist or fascist division of women into "valuable women . . . who should have children" and "inferior women . . . who are forbidden to have children" (FINRRAGE resolution, 1985). FINRRAGE has exposed the fact that the use of reproductive technologies exploits women's suffering, but the feminist movement has not yet found a viable way to deal with that suffering. Some feminists say that

in exposing the harm done by the reproductive technologies we do not ourselves have to find a viable alternative to them. For example, Pat Hynes (1987) deplored the fact that whenever we try to raise our voices against reproductive technology we have thrown back at us the question, "but what is the alternative?" This line of argument then lays the responsibility on the dissenter and blames us for the situation that would exist without the technology. She suggested that in order for a problem to be recognized, an alternative solution does not have to be given. If society recognized that reproductive technology is *not* the best solution for infertile women, then it would be forced to look for better alternatives.[3]

Lene Koch and Janine Morgall (1987) have taken this one step further and given guidelines towards a feminist assessment of reproductive technology. They suggest that we should first ask basic questions such as, "do we need this technology?" What happens when "marvellous results in one area have negative effects in another?" "What are the causes of infertility?" "Do (the technologies) affect all women in the same way or do they benefit some and harm others?" (p. 179.) The answers to these questions lead clearly to the conclusion that reproductive technology is *not* addressing the needs of infertile women. "The costs and benefits are calculated from the point of view of the scientist, sometimes articulated as the interests of the embryo" (p. 180).

Reproductive technology is clearly more than a treatment for infertility. It is actually providing "wombs with a view," opening the door for advancement of genetic engineering as well as becoming a form of social control. Thus it is in society's interest *not* to examine reproductive technology in a certain way and *not* to come up with alternatives. This is why we must come up with the alternatives. Feminist theory is most viable when it is put into practice. The setting up of rape crisis centers did not lead to an end to rape. However, it has led to the fact that today the feminist assessment of rape is now taught – to social workers, the police, and in certain schools of psychology – as if it were the obvious, "objective" assessment of rape. This is an incredible achievement and was brought about solely by the implementation of feminist theory into practice. We must bear this in mind when dealing with reproductive technology and infertility.

[3]These points came up in discussion following the paper presented by Pat Hynes at the 1985 FINRRAGE emergency conference in Vällinge, Sweden in 1985.

INFERTILITY AS CRISIS

While exposing the problems of the technologies, feminists often fail to differentiate between suffering caused by infertility and suffering caused by infertility treatment. Infertility is not a state that only becomes traumatic through its treatment, but is in itself a crisis that needs dealing with.

In using the phrase "crisis," I intentionally bring to mind other crises such as rape crisis. As a rape crisis counselor, I have found many similarities in attitudes towards infertility and rape. These similarities can be broadly seen in the following categories: (1) ignorance of the general population towards the crisis the victim goes through ("best to try and put it out of your mind dear"), (2) the stigma attached to the victim ("well I don't like to ask her about it, its not really something you talk about"), (3) feelings experienced in the aftermath or realization of the crisis (shock, denial, guilt, anger, depression, vulnerability, loss of (sexual) identity), (4) stereotyping of the victims of the crisis (see below), (5) reactions of women to a crisis situation (see below).

I am not here drawing an analogy between rape and infertility. The two are both major crises and any comparison is meaningless.[4] Yet the feelings and emotions that arise out of these crises are very similar. This is because both crises are directly related to "womanliness," to the essence of what being female may mean. Women are raped because they are women. Women's infertility relates to one of the most basic aspects of being a woman – the ability to reproduce. If it is claimed that the only difference between men and women is that women have the unique ability to bear children, we have to think about what this means to a woman who is unable to bear children.

Rachel Levy – Shiff (1986) states that in Israel the infertile woman is seen as physically disabled, a woman in mourning, a tragic figure. Pfeffer has also pointed out that the stereotype of the infertile woman is one so "desperate" that she "loses all personal control." This stereotyping of the victim

of infertility is very similar to the stereotype of the rape victim. Either she herself is guilty – infertile women are blamed for their infertility, either because they put off getting pregnant for so long, or they had previous abortions, or they have psychological problems that lead to unexplained infertility. Rape victims are blamed for provocative behavior, getting into dangerous situations or subconsciously wanting to be raped. If they are not guilty, they are the tragic victims of circumstance and will probably never recover from this trauma. So too, it is assumed that infertile women can never lead truly happy lives without children. In fact, as Naomi Pfeffer (1985: 50) points out,

> this common feature (infertility) does not mean that all women who experience infertility respond to it in the same way … Ignoring these very real differences between women serves further to alienate infertile women who are struggling to take control of a very negative experience and denies the mixed feelings, the pain and grief involved.

Although there are some situations that may be considered crisis inducing for any individuals who experience them, an event that may be of crisis proportions for one person may have less effect on another. Crisis may be experienced differently and reactions to it may vary. However, it is generally accepted that a "stressful life experience … (seriously) affecting the ability to cope" which often is or leads to a "turning point" should certainly be treated as a crisis (Bard and Ellison, 1974: 166) and this is surely so for infertility. Characteristics of a crisis situation such as the suddenness of its occurrence, its unpredictability, and arbitrariness are clearly present in infertility crisis. We tend to assume that we are fertile and, while the discovery of infertility may be gradual, the realization of its implications are usually sudden. The concept of "family planning" becomes a mockery when you discover that you cannot after all plan your family. And, all too often, it seems to the infertile woman that she is the only one who is infertile – everyone has children don't they? Just as there is a rape trauma syndrome, so too Rachel Levy–Shiff describes an infertility crisis syndrome with six stages from denial through acceptance.

[4]Renate Duelli Klein has pointed out, however, that a woman who undergoes sterilization or a hysterectomy without her previous consent may well be compared to a rape victim.

REACTIONS TO THE CRISIS SITUATION

It is the infertile woman's reaction to the crisis situation of infertility that makes it important that she meets with a counselor – a feminist–oriented one, rather than a member of the medical establishment. This is because in a crisis very often we become helpless and dependent on others and thus "an otherwise mature and effective person behaves almost like a child in seeking support and nurturance, guidance and direction from those regarded as strong and dependable" (Bard and Ellison, 1974: 167). In the case of infertility, that "strong and dependable" person is all too often the doctor, who instead of giving complete information, suggesting alternatives, or giving counseling of any kind, assures the patient that he or she can solve all her problems if she just puts herself in his hands.

In instructing police on the treatment of rape victims, Bard and Ellison have the following to say: "Individuals in crisis are extraordinarily open and suggestible. This provides a unique opportunity to affect long–term outcomes." What a perfect situation for the technodoc who finds himself sitting opposite a vulnerable and temporarily helpless patient! By the time the woman has come to grips with her infertility, the road forward is obvious. "Being on the scene early allows us to take advantage of the period when the victim's defenses are down, when she is open and accessible to authoritative and knowledgeable intervention". Furthermore, "because professionals are expected to be competent, those seeking their services act in ways that will facilitate this competency; for example, people listen and follow directions."

I am not here suggesting that women are weak and helpless, the eternal victim. What I am suggesting is that if we recognize the infertile woman, about to embark on treatment, as a woman *in crisis,* it will be easy to see that she can more easily be manipulated because of her vulnerability. At some stage she will begin to come to terms with her infertility and then may begin to set limits on the treatments she is willing to undergo, but by then it is probably too late for her to make an

objective assessment of her situation. I remember when I was in treatment talking with another patient who had undergone treatment for the last seven years. "Why on earth don't you give up?" I asked her. She looked at me as if I were mad. It was not a question she could ask herself at that stage. Similarly, an IVF counselor may help a woman in certain respects, but in order to get that far along the road of infertility treatment the woman must already be convinced that these forms of treatment are what she wants.

A FEMINIST MODEL FOR INFERTILITY CRISIS COUNSELLING

It would not have helped rape victims if the women's movement had listened to them and then repeated their stories without actually helping them and this is why we must start with infertility crisis counseling. Infertility is a crisis and must be dealt with by the feminist movement on two levels. The first is the personal level, to be with the woman where she is now, to accept her feelings and help her deal with them. The second level is the social level, to work towards a society where infertility is not a stigma and an infertile woman is not socially ostracized.

On the first level, we must recognize that infertility is a crisis to which every woman will have a unique reaction. However, if we recognize infertility as a crisis that may have a syndrome with clearly identifiable stages, we will be in a better situation to know how to help the counselee. If she is at the denial stage, for example, telling a woman that "you're not really infertile, we can fix you" or "you're not a failure till you stop trying" (motto of the Tel Aviv Sheba hospital IVF clinic, quoted in Anbal, 1984: 16) is not the right way to help her. Instead, we can help her first of all to come to terms with the fact that she is, in fact, infertile. This is a very big step and is the main one in overcoming the crisis. Most women I have met have told me that they do not try to come to terms with their infertility because they believe it is only temporary. Denial is a natural reaction in crises such as rape and infertility. But it should be only a first stage and in order to come to terms with the crisis, a victim must face the fact that she is infertile. Doctors who concentrate on "curing" and "fixing" do not help the large percentage of women who even after treatment will remain infertile.

If we recognize the social implications of being an infertile woman as well as the psychological ones, we will understand better the sources of infertile women's feelings of confusion and guilt, low self–esteem, anger, and distress. A feminist counselor must always accept the very real suffering of an infertile woman, however sure she may be that it is possible to live a full life without children. It is only by helping a woman where she is now that we can help her to move on from there. In rape counseling we listen to a woman, and deal with the problem as she sees it. We do not give her psychoanalytical explanations, nor do we tell her that while she may see the problem one way, in fact the source of her problem is really something quite different. We listen to her, and we explore with her all the facets of her present situation and her present conflicts. In this way, we best help her to help herself in analyzing her emotions and feelings. In doing this we empower the woman so that she makes her own decisions, instead of having to rely on the "professionals" to do this for her.

Eventually we hope that the counselee will be in a position to ask herself how she can use this crisis experience to actually benefit her in her life. For example, women find that the knowledge that they were utterly helpless and managed to overcome that helplessness gives them tremendous belief in their own strength. Women who never questioned many aspects of their lives as women find themselves with a new understanding of themselves. Women may feel better able to deal with challenges and difficulties that may bring them to wish to change many aspects of their lives – sometimes even their whole lifestyle (Ben–Zvi and Solomon, 1986: 4). Rachel Levy–Shiff believes that the last stage of infertility crisis is learning to live with infertility. However, she says, this is not the same as accepting it, which she believes cannot happen. I disagree with her in the belief that infertile woman can accept their infertility and can use their experience to achieve not only a better understanding of themselves but also an increased motivation to advance and progress in their lives.

In addition to counseling, an infertility crisis center must be a source for information. In our rape crisis center, we have found that one of the primary reasons for turning to us is the lack of information concerning rape. The lack of complete

information for the infertile woman is just as great. In both cases, women find themselves in a situation they never expected to be in and are thus not equipped to deal with it. Everywhere where there are infertility clinics there should be a crisis counselor on hand. This is because infertile women are powerless against their doctors – if they "misbehave" they are out of the program/clinic. They are uninformed, or misinformed, and are thus unable to make real choices. I believe that in this social climate women still have very little choice, but the information must be made available. At the moment, there is nowhere for infertile women to get the real facts and figures as well as meaningful explanations about everything they are going through. Someone has to be there to tell the doctors what infertile women really want and how we feel; to explain to women what the full procedures are likely to be, what the risks are, and what the possible outcomes might be. We need all the facts and figures to give women at infertility clinics real choices.

The aims of infertility crisis counseling are twofold. The first, as I have said, is individual counseling. The second is educating society. This is done by speaking out. Rape as a subject was surrounded by a web of silence. The myths that were generated about it encouraged women to think that it couldn't happen to them and if it did, they were at fault. Rape victims remained anonymous, isolated, and uninformed. In a similar way, infertile women are alone. Infertility, however, is an everyday reality for at least 10 percent of women and is on the increase. This fact must be broadcast, spoken about, and worked on.

There is a resistance to infertility education. In Israel, it has been claimed that if we educate young people about infertility they will not take contraception seriously.[5] It is this same distorted thinking that does not allow children to be taught about sexual abuse and it is clearly an attitude that can be changed.

Infertility crisis counseling centers should also act as pressure groups. They should expose the inhuman and misogynous aspects of current infertility treatment and demand a more holistic and caring approach. They should expose for whose benefit current treatments are being developed and they should help find more viable alternatives for infertility treatment. In addition, they should pressurize for more research to be done on the causes of infertility. If it is known that certain substances or certain environments may lead to infertility, infertility crisis centers should call for legislation leading to prevention of such substances. Preventative measures against infertility should deal with the problem before it exists, not after the damage is already done.

Finally, we must explode the myths surrounding infertility. Why, like rape victims, must infertile women remain anonymous? Why do our friends treat us with fear? Why is there such a tremendous stigma about being infertile? Why do people look upon us with such pity when they hear we cannot have children (but immediately comment that "its quite lucky really" on hearing we are divorced/single/lesbian/disabled …)? These are attitudes that have no basis other than a social one and they are ones it is possible to change. Infertility is a central issue in an increasing number of women's lives. The time has come for it to become a central issue in feminist theory and feminist practice too.

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REFERENCES

Anbal, Leah. 1984. Who do you belong to, child. *Koteret Rashit* 28.11.84 (Hebrew): 16–18.

Bard, Morton and Ellison, Katherine. 1974. Crisis Intervention & investigation of forcible rape. *The Police Chief,* May 1974: 166–171.

Ben–Zvi, Rina and Solomon, Alison. 1986. *Tel Aviv Centre for Victims of Sexual Assault, Annual Report* (Hebrew).

Burgess, A. W. and Holmstrom, L. 1974. Rape trauma syndrome. *American Journal of Psychology* 131: 981–986.

Corea, G. and Ince, Susan. 1987. Survey of IVF Clinics in the U.S. Paper given at FINRRAGE emergency conference, Vällinge, 1985. In Spallone, Patricia and Steinberg, Deborah Lynn (eds.). *Made to Order: The Myth of Reproductive and Genetic Progress.* Pergamon, Oxford.

[5]Dr. R. Sharkshall made this comment at the 6th National Conference of the Israel Family Planning Association in 1986.

Hynes, Patricia. 1987. The road not taken. Environmental Protection in the U.S.: A Paradigm for Regulation of the Biomedical Industry. Paper given at FINRRAGE emergency conference, Vällinge, 1985. In Spallone, Patricia and Steinberg, Deborah Lynn (eds.). *Made to Order: The Myth of Reproductive and Genetic Progress.* Pergamon, Oxford.

Koch, Lene and Morgall, Janine. 1987. Towards a feminist assessment of reproductive technology. *Acta Sociologica* **2**(30): 173–191.

Laws, Sophie. 1983. The sexual politics of PMT. *Women's Studies International Forum* **6**(1): 19–31.

Levy–Shiff, Rachel. 1986. Psychological and social aspects of infertility. Paper given at the 6th National Conference of the Israel Family Planning Association (Hebrew). At the same conference, comments by Dr. R. Sharkshall.

Pfeffer, Naomi. 1985. Not so new technologies. *Trouble and Strife* **5**: 46–50.

Solomon, Alison. 1986. Survey of IVF clinics in Israel, undertaken under the auspices of Tel–Aviv University. Unpublished manuscript.

FINRRAGE Resolution. 1985. Women's Emergency Conference on the New Reproductive Technologies, Vällinge, Sweden. In Spallone, Patricia and Steinberg, Deborah Lynn (eds.). 1987. *Made to Order: The Myth of Reproductive and Genetic Progress.* Pergamon, Oxford.