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"No One Sends You Flowers": Social Norms and Patients' Emotional Journey Within Fertility Treatment

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Abstract

Patients undergoing fertility treatment, such as IVF, experience a range of emotions—hope, disappointment, grief, anxiety, jealousy, guilt, and anger. Through a sociology of emotions lens, we trace the emotional journey of patients in fertility treatment in Switzerland to understand subjects' experiences with medically assisted reproduction (MAR), and to highlight how societal and cultural norms and expectations shape the way they use and emotionally manage (failed) fertility treatments. The theoretical background is grounded in the notion of feeling rules (Hochschild, 1983) and associated concepts such as disenfranchised grief (Doka, 2002). Methodologically, the article is based on a qualitative interview study conducted with affected women in Switzerland (LoMAR) and a quantitative analysis of the first wave of CHARLS, a nationwide longitudinal study. Linking qualitative and quantitative data allows us to show the significance of occurring emotions as well as a deeper understanding of particularly strong emotions felt during (failed) treatment cycles that the research participants have disclosed in the interviews. Further, we argue that fertility treatment itself contributes to producing what we call "layers of loss," a cumulation of multiple losses experienced.

Keywords

emotion; feeling rules; grief; infertility; IVF; medically assisted reproduction; narrative interviews; reproductive failure; reproductive loss

1. Introduction

It is estimated that one in six couples are affected by involuntary childlessness worldwide (ESHRE, 2023). Other statistics estimate that 10–15% of couples have an unfulfilled desire to have children (Bispink, 2012). Thanks to in vitro fertilization (IVF) and assisted reproductive technologies (ARTs), many can be helped. According to the European Society of Human Reproduction and Embryology, the number of treatment cycles has grown by 5–10% annually (ESHRE, 2023). Around four million ART cycles are performed each year worldwide, with the number of babies born steadily increasing (ESHRE, 2023). However, the growth in successful treatments is only one side of the story. The other side can be described by a quote from Anna, one of our interviewees, about her multiple IVF cycles: "At the first attempt you think, yes, easy, that will work. And we'll do it. And I'm pregnant. It just wasn't like that."

With this study, we are interested in what is described here so succinctly and rationally with "it just wasn't like that": the multitude of experiences of loss and disappointment and emotional complexity that characterize fertility treatments such as IVF. While the social study of human reproduction "has often focused on reproductive 'success'...rather than on reproductive 'failures,' or experiences of loss" (Earle et al., 2016, p. 1), we draw on a growing body of work turning towards the drawbacks, failures, and losses within subjects' experiences of fertility treatment (Earle et al., 2016; Lo & Chan, 2017; Throsby, 2004). We use "reproductive loss" as an umbrella term that includes miscarriage, stillbirth, and perinatal and infant death, as well as all "kinds of loss relating to reproduction, including the loss of 'normal' reproductive experience" (Earle et al., 2016, p. 1). In line with a few other scholars, we argue that there is even an "extra sense of loss induced by...fertility treatment" (Lo & Chan, 2017, p. 308; see also Assaysh-Öberg et al., 2023). What's more, recent publications highlight IVF's low chances of success and its emotional and psychological consequences. They emphasize that *not* achieving a live birth is a common outcome of treatment, which is burdensome (Gameiro et al., 2024, pp. 1591–1592). As *The Economist* points out, "IVF is failing most women" since it subjects them "to cycles of dreaming and dejection" ("Making babymaking better," 2023, para. 2). Repeated and unsuccessful cycles of IVF result in loss, grief, shame, and isolation while the fertility industry is "profiting from vulnerability" (The Lancet Editorial Team, 2024, p. 215).

Our study is based in Switzerland, where access to ART is "restricted by the high cost and legislation, which is among the strictest in Europe" (Turuban, 2024, para. 1). In Switzerland, infertility—the "failure to achieve a pregnancy after 12 months or more of regular unprotected sexual intercourse" (WHO, 2024, para. 6)—affects around 15% of couples, and each year 3,000–4,000 patients start IVF/ICSI treatment (Turuban, 2024, para. 11), which involves hormone therapy to stimulate egg production, egg retrieval, and fertilization with sperm in a Petri dish, and possibly embryo transfer. Intracytoplasmic sperm injection (ICSI) is a procedure in which a single sperm is injected directly into the egg; although the fertilization procedure outside the body is different, for the patient, the treatment is the same as IVF. Ordinary health insurance does not cover IVF, making it hard for patients with low and middle incomes to access. In 2022, around 6,600 patients were receiving treatment. Figure 1 presents the success rates reported for that year from treatment to birth.

Embryo transfer occurred in 66.7% of all IVF/ICSI treatment cycles started in 2022 in Switzerland. In 24.5% of all treatment cycles, the embryo transfer resulted in a clinically confirmed pregnancy, and 18.4% of all treatment cycles resulted in a live birth. In-depth analyses showed that, in 2022, the average number of treatment cycles per woman who gave birth was 3.3. The average number of cycles for those who had not

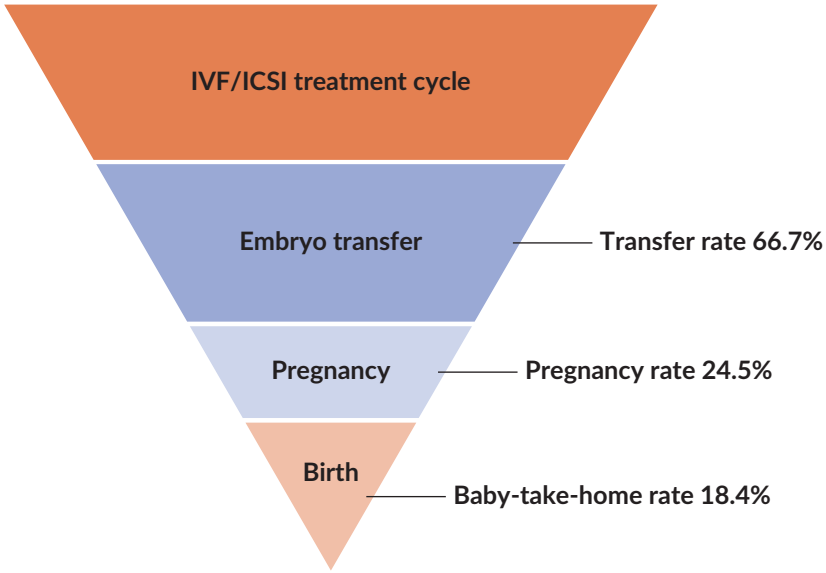

Figure 1. From treatment to birth: Success rates in Switzerland 2022. Source: FIVNAT & BFS (2022).

yet given birth by the end of 2022 is 6.3 cycles (own calculations based on FIVNAT data). Unsuccessful treatment cycles are a common experience, even if a child is eventually born.

It is against this backdrop that we explore the emotional challenges patients face while undergoing fertility treatment. Through a sociology of emotions lens, we trace the emotional journey of women who underwent fertility treatment in Switzerland to understand their subjective experiences with medically assisted reproduction (MAR). In doing so, we highlight how societal and cultural norms and expectations shape the way they experienced and emotionally managed (failed) fertility treatments. We draw on the metaphor of the journey (see also Huang, 2022) to describe the subjects' route through fertility treatment from one (emotional) experience to another, also because our interviewees used it. Greta, for instance, marks the OB-GYN's recommendation to visit a fertility clinic as the "start of [their] journey" and the pregnancy as "the end of this round trip after three years," while Doreen is just about to start her "IVF journey" at the time of the interview. While the interviewees identified different starting points, all of them used the metaphor in the sense of a trip towards a baby as a destination that included both planning and unexpected experiences.

2. Theoretical Background

2.1. Sociology of Emotions

In this article, we draw on the idea of emotions having a signal function (Hochschild, 1983). We use the terms "emotion" and "feeling" synonymously here, even though emotion is defined as a broader concept, encompassing subjective feeling, bodily experience, cognition, and behavioural elements (Turner & Stets, 2005, p. 2). Like seeing and hearing, feeling is a medium for experiencing the world. Emotions reveal the subjective meaning of what we see, remember, or imagine, and therefore provide orientation (Hochschild, 1983). We distinguish between the internal and external signalling functions of emotions. In subjective reality, following Berger and Luckmann (1991), feelings indicate the meaning of people, situations, and objects for the perceiving subject. As objective reality, feelings are shaped by social norms, social structures,

and social inequalities (Hochschild, 2024; for grief, see Jakoby, 2012). Through emotions, social issues such as domination, competition, dependence, inequality, connectedness, and norms are processed by individuals (Illouz, 2024, p. 15). Emotions can be understood as a dialogue between us and the world, as Illouz (2024, p. 18) has described so aptly, emphasizing their social and cultural embeddedness.

Emotions are influenced and constrained by social norms, values, and emotional "vocabularies," that is, a "name provided by culture" (Turner & Stets, 2005, p. 3). Feelings are subject to evaluation and legitimization. Feeling rules are social norms that frame feelings in specific situations. They link socio-cultural context to individual emotions since they outline to individuals how they should feel in a certain situation, or which emotional expression is appropriate (Hochschild, 1983). Emotional norms vary by situation, history, culture, social class, religion, race, and gender. However, there is often a discrepancy between what individuals feel and what feelings are expected. Individuals do "emotion work" (Hochschild, 1983) to resolve this discrepancy, an "emotional deviance" as labelled by Thoits (1990), and adjust their feelings to the respective norms.

In addition to situation-specific emotional norms, some emotions are deemed more desirable in a society. Especially in Western capitalist societies, an emotion culture strives for positive emotionality and pathologizes feelings labelled as negative, such as sadness and grief (Horwitz & Wakefield, 2007). Instead, happiness is elevated to the imperative of current existence (Cabanas & Illouz, 2019; Ehrenberg, 2004). This pressure to present oneself as a successful and happy individual leads to even stronger feelings of failure. Doreen, one of the interviewees, describes these normative assumptions as follows: "We live in a society that acknowledges…being successful, productive, and resilient, but it's not so common to grieve, to be vulnerable." The values Doreen addresses correspond to the "modern paradigm" (Harris, 2009) and the capitalist economy, which promotes success, productivity, competition, functionality, efficiency, resilience, and rationality. Loss and grief contradict these values and symbolize vulnerability, weakness, and emotionality, which is often linked to femininity and devalued. Grieving norms are embedded within this emotional culture. Grief needs to be quickly overcome, controlled, or processed. The aim is to restore functionality and recover from intense emotion (Granek, 2010). In other words: "Our high-speed neoliberal society is perhaps an exact antithesis of the grieving body" (Macdonald, 2020, p. 130).

2.2. Reproductive Loss and Disenfranchised Grief

In line with Hochschild's concept of feeling rules, Doka (2002) highlights socially legitimized mourning roles leading to disenfranchised grief among those denied the right to mourn. Disenfranchised mourners are not allowed to express their grief publicly and receive no recognition for their loss or social support. Losses are therefore social phenomena, as they gain social meaning and value only within the social and cultural context of their occurrence. This conceptual framework sheds light on society's power to define the legitimacy of a loss acknowledged, for example by legal regulations (Böcker, 2024).

Pregnancy losses are often not acknowledged (Lang et al., 2011). A common response in Western societies is the claim that the embryo or foetus "wasn't really a baby" (Layne, 1997, p. 300). Whereas intended parents may mourn an unborn family member already named, outsiders may consider the embryo/foetus mere "uterine contents" (Frost et al., 2007). Such rational terms and a lack of empathy lead to feelings of disenfranchisement. There is also a long cultural history in many countries of treating pregnancy loss in the same way as infertility,

namely as individual failures or punishments for past wrongs, leading to guilt among the affected parties. These normative reproductive scripts especially affect women, who are assigned the main responsibility for successful reproduction. At the same time, men face other challenges, such as gendered role expectations to show no feelings or weaknesses or a lack of social recognition for their grief after pregnancy loss (Obst et al., 2020).

Reproductive losses within marginalized populations are especially neglected. Miscarriages or stillbirths experienced by lesbians, trans men, or surrogates (Berend, 2012; Peel & Cain, 2016; Riggs et al., 2020), for instance, are less seen because their reproduction is not the expected social norm. Craven (2019) argues that LGBTQ people's reproductive experiences with pregnancy loss, infertility, and sterility have not received appropriate attention regarding the technological opportunities that have emerged for queer people to become parents. Similarly, although they face increased risks, losses among racial and ethnic minorities are less addressed in research (Boakye et al., 2025; Paisley-Cleveland, 2013).

Pregnancy also bears social and medical normative expectations regarding maternity. Layne, in her pioneering work *Motherhood Lost*, speaks of "narratives of linear progress," which she contrasts with the disruptive event of miscarriage (Layne, 2003, p. 59). Miscarriages contradict the medical norm of linear development from fertilization to the birth of a healthy baby. It also contradicts the ideal of a joyful pregnancy and maternity, described by Faulkner as the "happy-glowing-pregnant-lady-myth" (Faulkner, 2012; see also Browne, 2023, p. 6). Experiences of reproductive loss and infertility shatter these normative orders and expectations regarding the individual's predictable, coherent, and linear life path (Becker, 1994; Cunningham, 2014). On the contrary, subjects undergoing fertility treatment experience disruptions, setbacks, and failures, facing a range of strong and sometimes opposing emotions like hope, disappointment, grief, anxiety, jealousy, guilt, anger, and frustration.

2.3. Emotions in (Failed) Fertility Treatment

Many social science scholars have highlighted the "unintended consequences" and side effects of MAR (e.g., Layne, 2006). Feminist scholars in particular have criticized the pronatalist social pressure for childless women to use ART, the physical strain on the female body caused by hormone therapy or egg collection, and the social stigma and isolation around failing to reproduce naturally (Ravn, 2016). For example, Throsby (2004) illustrates, in her pioneering book *When IVF Fails*, how much discursive effort people whose IVF treatment had failed had to make to justify their use of ART, because conceiving in a way "not natural" was considered neither normal nor reasonable.

In an early sociological study, Nave-Herz et al. (1996) revealed the emotional complexity of IVF (see also Onnen-Isemann, 2000). After the initial "shock" at the diagnosis of infertility, couples experience different feelings, such as anger and rage, guilt and shame, as well as isolation, depression, and grief. A characteristic feature of the IVF experience, which we draw upon in Section 4.1, is a cycle of hope, disappointment, and new hope for the next attempt. According to Sorg and Fränznick (2002, p. 90), the hope that each attempt may have a positive outcome creates a "treatment pull" (see also Franklin, 2022). In addition, subjects experience a loss of control over their own fertility and treatment dynamics as well as social isolation from friends and families with children (Fränznick & Wieners, 2001; Imeson & McMurray, 1996).

While we are interested in the social science perspectives in this article, the medical-psychiatric lens dominates research on infertility and the emotional impact of IVF treatment on individuals (Greil et al., 2010). Especially studies including the experience of pregnancy loss focus on psychological disorders such as depression, trauma, chronic grief or anxiety disorder, as well as despair, loss of hope, and guilt (e.g., de Castro et al., 2021; Hammarberg et al., 2001; Meier et al., 2024; Stanhiser & Steiner, 2018). Short-term effects associated with unsuccessful treatments are anxiety, low self-esteem, depressive feelings, and poor relationship quality (for a review, see Hammarberg et al., 2001). These studies focus on psychological disorders, coping strategies, and positive influence factors, but not on emotions beyond pathologies and their societal roots.

3. Data and Methods

This article is based on a qualitative interview study conducted with affected women in Switzerland and a quantitative analysis of data from CHARLS, a nationwide longitudinal study on assisted reproduction. Linking qualitative and quantitative data allows us to show the significance of occurring emotions as well as a deeper understanding of particularly strong emotions felt during (failed) treatment cycles that the research participants have disclosed in the interviews.

3.1. Qualitative Interview Study

The qualitative study on reproductive loss and bereavement in medically assisted reproduction (LoMAR) examines the biographical, social, and cultural conditions of loss experienced by intended parents before and during fertility treatment in Switzerland. Based on narrative interviews with affected women, the social conditions and meanings of loss and bereavement, as well as ways of dealing with them within the context of fertility treatment, were examined. Interviewees answered our public call for participation shared via social media and the citizens' science panel of the University Research Priority Program (URPP) "Human Reproduction Reloaded | H2R" at the University of Zurich. The call addressed people with experience of loss or bereavement within their fertility treatment in Switzerland and who were willing to talk about it. Only individuals identifying as female answered the call and they participated without partners. One woman had gone to Spain, where egg donation is permitted, after treatment with her own eggs in Switzerland failed.

Although interview research has limitations when studying emotions, because talking about emotions is not the same as feeling them, and because it is not possible to distinguish between the actual lived experiences and narrated life story, interviewing is still a social situation where emotions can be sensed and observed: they and we smile when they tell us something funny or absurd, or sigh if they have something hard to tell. To grasp these emotions, non-verbal expressions and hesitations (signalled with "(.)") were included in the transcriptions and considered in the analysis. Furthermore, the narrative approach allowed us to link emotions in fertility treatment with social norms, because the narrative accounts also represent, besides subjective experiences, the wider social and cultural expectations, norms, and values these are embedded in (Przyborski & Wohlrab-Sahr, 2014).

In 2023 and 2024 we conducted seven interviews via Zoom with affected women (see Table 1), six of whom were mothers at the time of the interview. Each lasted between 48 and 125 minutes. The interviewer, who was experienced in sensitive social research (Böcker, 2025; Delaunay et al., 2025), began with an

open-ended question asking respondents to tell the story of their fertility treatment, before asking in a flexible format about when they first realized they wanted a child; the beginning, process, and type of fertility treatments; (pregnancy) losses and the times afterwards; ways of dealing with embryos/foetuses; and farewell and remembrance practices. In closing, we asked respondents to evaluate their past experiences, voice wishes and regrets, and share their hopes for the future. All interviews were conducted in German, recorded and transcribed verbatim, and the transcripts were analysed through sequential hermeneutics (Maiwald, 2005) in an interpretation group of two to five trained social scientists. Selected sections were translated into English for this article. Ethical approval for this study was obtained from the Faculty of Arts and Social Sciences' Ethics Committee (University of Zurich).

Table 1. Sample LoMAR: participants' social characteristics and reproductive losses.

Name	Born	Civil status	Children	Pregnancy losses	Duration of treatment
Anna	1976	Single/divorced	2	2	7 years (CH/Spain)
Beate	1986	Married	1	3	4 years
Chris	1990	Married	2	2	3 years
Doreen	1991	Married	None	None Unexplained infertility	Ongoing
Eva	1983	Married	1	1	2.5 years
Franziska	1974	Married	4	None Implantation failure	5 years
Greta	1989	Single	1 (+8 months pregnant)	2 (+1 ectopic pregnancy)	1.5 years

3.2. Swiss Longitudinal Study on MAR

The qualitative study is supplemented by a quantitative analysis of the first wave of CHARLS—Swiss (CH) Assisted Reproduction Longitudinal Study—conducted within the framework of the URPP H2R. CHARLS is the first Swiss panel study collecting data on attitudes, experiences, and beliefs related to assisted reproduction and family. The first wave was collected from March to August in 2023. The study employed a disproportionately stratified sampling approach, drawing a sample of 20,000 individuals from the Swiss population register. The population of interest comprised all individuals aged 18 and above with permanent residence in Switzerland. The sample was stratified according to the three language regions and, within these strata, further stratified by gender. The language regions included the three main languages: German (including Romansh), French, and Italian. Individuals were then selected at random within each stratum. The target population was contacted via postal letter and invited to complete the survey either online or in paper format. The response rate was 26%, yielding a total of 5,256 respondents. However, certain selection tendencies were apparent. For example, the participation rate of Swiss citizens was significantly higher than that of non-Swiss citizens, and participation rates were higher in urban compared to rural areas. Additionally, there appears to be an education bias, with more highly educated individuals being overrepresented in the resulting sample. The comprehensive questionnaire covered a wide range of topics, requiring an average of 40 minutes to complete.

For this study, we included survey questions on the experience of miscarriage, associated emotional and social responses, as well as mourning practices. In addition, the use and duration of ART treatment and the duration of infertility were surveyed.

4. Findings

The findings of the qualitative study show that patients experience and navigate complex emotions, also with regard to societal norms and expectations. In each of the following sections, we present fertility treatment's structural characteristics, occurring emotions, and the social norms and expectations framing them. Although we do not claim that these emotions are felt by all subjects in IVF treatment, we argue that the treatments themselves bring about these kinds of emotionally challenging journeys. Subjects enter a cycle of hope, pressure, and often disappointment (4.1) in which, if they do not get pregnant, each round adds another layer of loss and grief (4.2). Although the losses are painful and "real" for the subjects, they are invisible and intangible within their social surroundings (4.3). The losses then provoke further emotions such as anxiety in subsequent pregnancies, guilt about reproductive failure, and jealousy, but also anger about societal expectations (4.4). In support of our argument, quantitative data shows that people who have used ART report higher levels of sadness, anger, guilt, and fear of losing another pregnancy after miscarriage than those who have not (4.5).

4.1. Cycles of Hope, Pressure, and Disappointment

The emotional structure of IVF treatment is one of a recurring cycle of hope and disappointment, as summarized by Greta, one of the interviewees: "On the one hand, it was very burdensome, but on the other hand, you just could not let go." The driver of undergoing treatment procedures, the central feature of which is repeatability (Hoffmann, 2017), is the hope of next time getting pregnant. Franklin (2022, p. 9) referred to IVF as a "hope technology," thus implying the "treatment pull" (Sorg & Fränznick, 2002, p. 90), causing patients to remain in the process and opting for further cycles. While doing so, subjects are under time pressure, since their "biological clock" continuously lowers the chances of conceiving, heightens the risk of miscarriage, and, thus, does not allow for a long pause after failed cycles. Other reasons for staying in the process, for example reported by Franziska, were the feeling of agency through each new treatment cycle as well as the motivation to not have to reproach oneself later—and to not let oneself be reproached. Hope is a central coping mechanism (Bernet et al., 2025, p. 5) for dealing with the uncertainty, grief, and stress of IVF treatment. It is both the cause and effect of every new attempt.

Reaching certain stages—such as an embryo transfer or a positive pregnancy test—are framed as small successes, even when implantation eventually fails. They are seen as indicating potential and being "almost there" (Throsby, 2004, p. 62). This hope is also encouraged by clinicians, as Beate emphasizes: "They also say, you just have to try, try, try….If you can get pregnant, you have such, such a big chance for a child." Once in the process and having had initial successes, patients tend to push their personal limits regarding how far they would go. Chris, for instance, reflects on her decision to continue: "I've always said that, for me, it [IVF] is the cut-off point. But when the time came, I threw that overboard and said, no, somehow, I can't let it go." In this context, a miscarriage can also be a driver to continue: "Up to that point we had always said: would be nice if it works, then we do have children. If not, then we don't. After the miscarriage it was clear to me, I want to try everything possible" (Anna). This echoes the findings of the quantitative study by Beringer and

Milewski (2024), showing that the intention to have a child increases after miscarriage. Pregnancy losses can actually restore hope and let intended parents carry on because they are a sign of the ability to become pregnant in the first instance. Due to its cyclical form, the fertility treatment itself contributes to producing a series of losses that pile up to what we call "layers of loss," a cumulation of multiple losses experienced.

4.2. Layers of Loss and Grief

4.2.1. Before Treatment: Loss of Reproductive Normality

Before eventually receiving fertility treatment, people frequently have a long history of trying to conceive. The starting point of the journey is an often long-term phase of involuntary childlessness. CHARLS data shows that almost 50% of ART users report a period of two to five years of trying before the treatment, and 12% report a period of more than five years. This means that even before starting medical treatment, there are experiences of loss, possibly even miscarriages. For some, the fact that they have not conceived naturally is the first crack in the wall of what is perceived as reproductive "normality." Doreen, for example, starts her story by saying she had an unthinking, normal expectation and wish to have children:

> Doreen: I know that as a young woman, as I was growing up, I thought, yeah, I want four kids too, just like my mum….We tried for six months, and I would say with lots of energy and fun and, you know, it was really a good time. And I think after about six months, eight months, uh, I was like, "uh," I know that from looking at statistics…most couples fall pregnant and 80% of couples fall pregnant naturally in the first year….I think for me, one of the…distressing moments was hitting one year. Because that was in my mind,…the fork that meant, uh, we're no longer in the 80%, and that was hard. Like: uh, REALLY? At the time, I was 30 when we started trying….I expected: Yeah, by 31 I'll be pregnant, and I wasn't. You can hear it in my voice. I'm like, that was the first uh [19 seconds pause], uh. [voice breaks, cries].
>
> Interviewer: Just take a moment.
>
> Doreen: Yeah, sure-sure. [19 seconds pause] That was one of the first, uh, moments when we realized that it wouldn't necessarily be (.) such a straightforward journey.

The first distinct moment of "reality hitting" was when she and her husband did not conceive naturally within one year of trying, and Doreen realized she did not belong to the majority ("the 80%") that follows the "normative life-course trajectory" (Earle, 2014, p. 151). This marked the beginning of an arduous journey. In the quote, Doreen also mentions "lots of energy and fun" she and her husband had while trying to get pregnant, presenting herself as initially light-hearted, which contrasts all the more with her growing distress.

People who identify as future parents suffer a "loss of self" (Charmaz, 1980; Marris, 1986) through infertility. Not only people, objects, or past circumstances can be mourned, but also previous expectations regarding the future. Thus, infertility or early pregnancy loss are associated with the "loss of possibility" (Frost et al., 2007), "loss of promise" (Ironside, 1996), or an "unlived life" (Scott, 2019) which refer to the disruption of the perceived identity as a mother or parent. As Doreen herself summarizes in the following interview sequence:

> We have not lost a baby, but there is a feeling of loss connected to maybe a vision that you had for your life, a vision you had for yourself as mother, a vision you had for your husband….I started to realize, we can also grieve for versions of ourselves, like the version of me as a mum, the version of us as parents.

At the same time, our interviewees are aware of the feeling rules, as Doreen points out: "It is not the kind of grief that is maybe so socially accepted, understood, empathized with, because no one sends you flowers…when you don't get pregnant." In other words, in social everyday life, the grief over infertility is hidden.

4.2.2. Non-Developing Blastocysts and Implantation Failure

Before IVF is performed many patients receive less invasive treatment to support fertility, such as hormone therapy or insemination, which, of course, can be unsuccessful as in the case of two interviewees who almost used the same phrasing: "We had three inseminations in total, all of them did not work" (Greta); "we did seven inseminations, all of them unsuccessful" (Franziska). The next possible step of treatment is IVF. Starting a more invasive or costly treatment can be seen as reaching another unplanned yet necessary stage in the reproductive journey. Contrary to the perception of the IVF process as continuous, each treatment stage represents an observable "hurdle" that must be overcome to move forward (Franklin, 2022, p. 129): Each stage can fail and evoke loss and accompanying emotions, which makes IVF a "serial failure to progress" (Franklin, 2022, p. 25). There may not be enough or good egg cells, or no "good" embryos develop. Even if the embryo transfer was successful, it may not implant (in medical terms: implantation failure; see Meier et al., 2024). Chris describes the prolonged loss beginning from egg retrieval:

> Of course, that was accompanied by frustration and sadness. We had nine eggs. In the end, one was left which was half-developed. However, by the day it should have been used, it was no longer functional. Then I went home crying.

The embryos in Eva's case were transferred but did not implant: "Just in October we made a transfer, with one of the *good ones*. It didn't work. Then we did a second transfer…. Again, that also didn't work." These near successes intensify the emotional experience: Because they bring patients very close to pregnancy, the disappointment, frustration, and sadness are all the greater when a treatment is not successful. As Franklin 2022, p. 176) points out: "Nearly succeeding can be even worse than never coming close to success, as the hope has come even closer to becoming a reality, and the resulting loss is that much more devastating."

Visualization techniques reinforce the early attachment to embryos even before implantation (de Lacey, 2017; Millbank, 2017). Some fertility clinics provide photos and videos of the IVF embryos to the woman or the couple. Anna, for instance, watched such a video of her most "promising" pre-implantation embryos (called blastocysts) and "kind of fell in love with [embryo] eleven. I know it sounds kind of weird. And not that I see it as a child, but for me it was somehow clear that eleven belongs to me, too." The interviews further suggest that the embryo transfer is sometimes already perceived as "being pregnant" (Franziska).

4.2.3. Recurrent (Biochemical) Pregnancy Loss

After embryo transfer, patients wait for ten days before having a pregnancy test. During this time, even a slightly increased level of the pregnancy hormone HCG raises hopes. Anna speaks of having gotten

"a half-positive pregnancy test, as such a biochemical pregnancy" on her third attempt, only to see it vanish shortly after. Similarly, Beate's account reveals how much hope, anxiety, and uncertainty early pregnancy testing involves (see also Ross, 2018): "The test somehow showed a very faint [positive result] but it was nothing, it was still very uncertain…and then I did a test every day with these cheap [pregnancy] tests." This pregnancy testing and reporting of early positive results within the routine of frequent daily medical monitoring creates a new form of reproductive loss which, historically—and otherwise—would not be perceived as such.

Furthermore, pregnancy losses can occur in later weeks of gestation. Miscarriages are very physical and invisible forms of reproductive loss (see also Section 4.3). Of course, even later losses such as stillbirth, perinatal, or neonatal death may occur, which together with the experience of infertility may become a "reproductive trauma" (Bhat & Byatt, 2016), leading to symptoms of depression, anxiety, and post-traumatic stress disorder. In our study, however, no respondent suffered any of these late-term bereavements. Beate, who at the time of the interview had had three miscarriages, describes her recurrent losses as "really painful," just like Greta, who also states it had been "unimaginable that it wouldn't work this time. When it happened again, it really completely devastated me. Because I had thought, that just wouldn't happen so soon after another." In contrast to Greta's shock of "it" having happened again, others, as we will show in the following section, fear exactly that.

4.2.4. Beyond and After IVF: Post-Treatment Emotions

Despite happiness at the birth of their child following successful treatment—as Anna puts it: "[child's name] was there, I was totally happy"—for our interviewees the strain did not end there. For example, they felt anxious and worried during subsequent pregnancies. Against the backdrop of previous experiences, they could not enjoy being pregnant, they were afraid of bleeding (which reminded them of menstruation or the threat of pregnancy loss), or anxious about losing the foetus. Anna, for instance, says she "just got through it" and "panicked the whole pregnancy that something would go wrong." Similarly, Chris reveals: "I wasn't such a happy pregnant woman….I just hoped it would last. Yes, I was happy. [But mainly] I've been upset, I've been sad. It wasn't so enjoyable for me. It's just been like survival." Given this damning overall judgement ("like survival"), including "happy" in her list of feelings during pregnancy could be seen as emotion work: She is still trying to meet the feeling rule of being "a happy pregnant woman." Similarly, Greta, who is eight months pregnant at the time of the interview, admits feeling the "wrong" way: "Great joy never came, to be honest. I *am* happy, but this is also always mixed with fear. I have always been terribly afraid of the [medical] appointments." These statements illuminate the normative assumptions and the ideal of a happy "glowing" pregnancy (Browne, 2023; Faulkner, 2012; Layne, 2003).

Studies confirm the concern and anxiety about the survival of the foetus and the health of the child after ART treatment (e.g., Hammarberg et al., 2008). The narrative interviews further showed that some are still troubled by memories of loss, even when they have children at the time of the interview. Beate, whose child also attends the interview, for instance, says about the lost embryo: "I still think of it. Some of the feelings are still there…a stab in the heart, just like that." And Anna, who has two children, evaluates: "I wouldn't say: If the baby is here, everything is good. You can deceive yourself for a while but, I think, you really have to work through certain things."

All in all, the interviewed women went through a very long and exhausting phase of recurring disappointments, losses, and strain. Their fertility treatments meant enduring years of hardship, as Eva simply states: "It took four years before we were able to take our child home with us."

4.3. The (Im)Materiality and Invisibility of Pain and Loss

The losses described above are painful and "real" for the subjects and have a dual characteristic. Beate, for example, describes the void after a miscarriage as both physical and emotional: "It was like such a huge void in my belly, as if I had such a big wound. And apart from that, it was really painful, too," and she also refers to another aspect of loss, "the hope that you might lose." Similarly, Greta, who suffered an ectopic pregnancy and subsequently two miscarriages, refers to this double characteristic:

> During the second miscarriage…I really bled and had contractions, and it was already very painful. It took me quite a while to deal with that, I would say. Or this *feeling of grief* over…the prospect of a child.

At the same time, Greta emphasizes that she primarily mourned that "it still hadn't worked" rather than the pregnancies themselves:

> This might sound a bit stupid, maybe, but the pregnancies in themselves, maybe let us call it "the babies," I could always close that [chapter] relatively quickly. Instead, there really was grief about the fact that it still hadn't worked, that was the most burdensome [—more] than thinking that these two, erm, pregnancies are gone.

Thus, unlike the emotional loss of a significant other like a family member or friend, a miscarriage is also a *physical* loss: accompanied by bleeding, cramps, severe pain, or invasive medical procedures such as a curettage.

Despite this emotional and material reality, pregnancy losses are socially invisible in at least two ways. Firstly, others in the social environment might not have heard of the pregnancy, let alone have started a relationship with the unborn. Anna, who had followed the cultural three-month rule of not communicating a pregnancy, recalls the awkwardness of informing her boss about her miscarriage: "I lost the child you didn't even know I was pregnant with." Another reason for the invisibility is that there is no baby, no material manifestation of the bereavement felt. Some interviewees struggle with the absence of a foetal body because it could represent their bereavement. There is literally no*body* to make the loss "tangible" for third parties such as partners, or people in the wider social surroundings.

The status of the blastocysts or embryo is unclear, something between "human tissue," an object, and a wished-for "person" (de Lacey, 2017, p. 398). The end of an early pregnancy is shaped by this ambivalence, illustrated by Chris's powerful account of her first reaction: "Out of reflex, I simply threw it into the toilet and flushed it. Where I thought afterwards, oh, actually I could have buried it." Often, though, there is no perceivable embryo and no material to deal with. Anna, for instance, refers to the procedure in the clinic after the loss of her early pregnancy: "No one ever asked me if I wanted the material." This absence was also confirmed by the CHARLS data: 45% of respondents do not know what happened to their miscarried embryo and 39% say they lost it in the toilet (multiple answers possible).

While the embryo does not count morally, legally, or socially as a human person, the intended parents already have a relationship with them (Lupton, 2013). Beate defines her miscarried embryos as children ("it was simply my child from the very beginning") and cites things other people said, such as "you'll get pregnant again," which disenfranchised her grief. This shows a discrepancy between her own definition of having lost a "child" and the reactions in her social environment. Her grief over early miscarriages is therefore "disenfranchised" (Doka, 2002) and delegitimized in comparison to "real deaths" (Lupton, 2013). Doka's concept raises awareness of the diversity of social validation and support for bereaved people, which can vary depending on the category of loss (Jakoby, 2015). Not all losses are considered grievable (Butler, 2010); instead, they depend on the normative recognition of life as a prerequisite for the social recognition of a loss of a person. The discrepancy of meanings and feelings attached to the object of loss also exists between partners; Anna described how her ex-partner, who did not attend the clinic with her, said: "Don't be silly. This was no child. This was just a 'blob.'"

The material reality of pregnancy losses also highlights the bodily experience and burden of IVF treatment for the women concerned. They go through hormone therapies (tablets, injections) and their side effects, ultrasound examinations, uteroscopy, invasive procedures such as egg retrieval, blood testing, or other gynaecological tests, and surgery. Doreen describes a particularly painful experience:

> The insemination…was very emotionally triggering because I didn't expect my physical reaction…she injects it and my body just has this really intense reaction, like instant cramping, obviously trying to get this *liquid* that shouldn't be there out. I remember feeling hot and cold and sweaty. I almost fainted….That was the worst experience I had, because my body reacted in a way that I didn't expect, and you feel very vulnerable in that moment.

It can be argued that "emotions are intimately connected to the body" (Turner & Stets, 2005, p. 3), and thus intensified by the bodily experience, the loss of control over the body, and the physical materiality of loss. Emotions and bodily processes are linked, for example, the feeling of disappointment, anger, or sadness some people experience when menstruation returns. Again, it must be noted that these are not one-off events but are experienced several times. Franziska, for instance, reports a total of seven unsuccessful inseminations, each adding to the layers of loss. Extreme experiences that cannot be controlled also mean a loss of agency for the reproductive subject. One way to regain it, for Doreen, is to retreat from the physical and mental burdens of the treatments for a moment: "My body needed a break. I needed a break. We needed a break to not just talk about trying to get pregnant." In contrast, Anna avoided taking a break because, until she had a baby, she felt she would not have the emotional capacity to deeply engage with the accumulated trauma and pain.

4.4. Still Feeling Reproductive "Failure": Guilt, Anger, Jealousy

Infertility and miscarriages often evoke guilt in the women affected (Adolfsson et al., 2004; Taebi et al., 2021). In our study, pregnancy loss brought a doubled guilt of reproductive failure. As Chris puts it: "I just blamed myself that I *also* managed to, I don't know, kill or lose our child." The linguistic marker "also" refers to both a guilt at not being able to get pregnant naturally, first, and not being able to keep a pregnancy even after IVF. Studies document internalized guilt about pregnancy loss and treatment failure, which is perceived as "body failure" (Browne, 2023; Carson et al., 2021; Meier et al., 2024). Affected women blame themselves and search for reasons, including transcendental punishment. Greta, for instance, after three pregnancy losses in a row, wonders if she is being "punished for something" and feels "the universe wants to say to them, they should

just leave it at one child." Beate asks: "What is wrong with me, what's wrong with my body?" These notions of self-blame reveal societal expectations about childbearing and (biological) motherhood, forming the core of women's determination (Neyer & Bernardi, 2011, p. 165) and the equation of womanhood with reproduction and nature. These examples show how social and cultural values and supposedly individual feelings of guilt are interwoven.

A frequent but underemphasized emotion in the interviews was anger. Subjects were angry about the medical treatments, the sense of helplessness, and loss of control, and retrospectively looked back at missed chances. Anger is not an emotion with female connotations (Simon & Nath, 2004) and is neglected in the grieving and bereavement process (Ironside, 1996). After a curettage, Greta developed a condition that inhibited the build-up of endometrium (thus preventing conception):

> It was very difficult for me….After all these treatments I was often very, very angry, because I somehow had the feeling, erm, now they [laughs], as stupid as it sounds, broke me in the hospital and now they've left me to it. Because, in Switzerland, you have to bear all the costs yourself for all these treatments…which is incredibly expensive.

Greta blames the medical and social health care system, but her laughter and apologies reveal that she is still vulnerable and hesitates to publicly express her anger as it could be considered somehow inappropriate. Anna reveals the patient's inability to complain and powerlessness in the face of clinicians: "You are angry, but you must act carefully, since you are afraid; otherwise they will judge you and…not optimize [your treatment]….You are completely at their mercy." With hindsight, there is anger about missed opportunities and regret for (supposedly) wrong decisions, as Chris puts it: "I should have gotten pregnant earlier. Why did I do this doctorate? But unfortunately, you can't change that." These regrets and associated feelings are tenacious.

Jealousy is a common feeling when friends, family members, or acquaintances communicate their pregnancies. Beate admits: "It's sometimes still difficult to be happy, even though I have a child, too." Her statement reveals the challenge of meeting the normative expectations of being happy for everybody who is pregnant. It also shows that jealousy is not just felt towards others who are having a child, but also towards mothers who were able to conceive naturally or who already have another child. She also refers to another feeling rule, to act authentically within personal relationships: "You should be happy no matter what, and then you don't fulfil it because you don't feel it. You're not happy in the moment." To avoid this dilemma and emotional deviance, in Thoits' (1990) terms, and because they cannot or do not want to invest the emotional work necessary to overcome jealousy, they instead withdraw from these social contacts. At the same time, while Beate states "even if you think: Oh, I don't want to have this feeling," she appreciates the signalling function of jealousy, which, for her, "is a strong feeling" that "conveys what's important" and of "value" and keeps the connection with her lost embryo.

4.5. The Impact of ART Use on Emotions After Miscarriage

The CHARLS data shows that people who used ART have different miscarriage experiences than those who did not. Multiple linear regression was used to examine the association between the use of ART and emotional distress for those who have suffered a miscarriage. Coding of the independent variables was

accomplished as follows: ART use was coded as a binary variable (1 = at least one method used, 0 = no use). Technologies included: insemination, IVF/ICSI, sperm/egg cell donation, PGD (pre-implantation genetic diagnosis), cryopreservation/egg freezing (multiple answers possible). Control variables were age and the existence of children: age was transformed into decades (Age/10). Having children was a binary variable (yes/no). The surveyed items for the dependent variables are shown in Figure 2.

> The following list contains statements from people who have also had to deal with pregnancy loss. Please indicate how well these statements describe your thoughts and feelings. There are no right or wrong answers. Likert scale: (1) *strongly disagree*; (2) *disagree*; (3) *neither disagree nor agree*; (4) *agree*; (5) *strongly agree*
>
> *I am sad. / I feel the need to talk about the loss. / I feel alone. / I think I have got over the loss well. / I feel guilty. / I feel anger. / I am afraid of losing another child.*

Figure 2. CHARLS survey question and items on emotions after pregnancy loss. Notes: For reasons of sensitivity, the last item asked about the fear of losing another child, not another pregnancy; this probably influenced the responses of those who did not imagine miscarriage as the loss of a child.

Table 2 shows that the use of ART is correlated with more intense feelings of sadness, guilt, and anger as well as a greater fear of losing another child after experiencing a miscarriage.

Table 2. Multiple regressions of ART use on emotions after pregnancy loss.

Variables	Sad	Lonely	Got over it well	Guilty	Angry	Afraid of another loss
Used ART	0.250*	0.212	−0.129	0.208*	0.387***	0.361**
	(0.132)	(0.151)	(0.108)	(0.121)	(0.138)	(0.180)
Age/10	0.00244	−0.0466	−0.0498	−0.0893**	−0.118***	−0.296***
	(0.0402)	(0.0457)	(0.0327)	(0.0368)	(0.0418)	(0.0533)
Has Children	−0.191	0.271	−0.317**	0.489***	0.282	0.126
	(0.173)	(0.197)	(0.143)	(0.157)	(0.180)	(0.227)
Constant	4.325***	2.398***	4.890***	1.554***	2.155***	4.294***
	(0.306)	(0.350)	(0.251)	(0.279)	(0.318)	(0.403)
R^2	0.008	0.013	0.016	0.046	0.043	0.076
n	537	522	535	529	526	495

Notes: *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$. Source: Own calculations based on CHARLS 2023.

5. Conclusion

In medical and psychological studies, the ART process is predominantly framed as an individual and private experience. A therapeutic language is used to describe the psychological and emotional consequences of treatment for the affected women, often assessed in terms of "depression" or "anxiety disorder." This perspective reinforces a medicalization of loss and grief within IVF treatment, with medical categories obscuring social and structural causes, namely the modes and emotional consequences of fertility treatment. Technical solutions in the form of medical-pharmaceutical interventions dominate, focusing on the pathological problem and "personal responsibility" (Browne, 2023, p. 31) of individuals (Conrad, 2007). Contrary to the assumption of a "unique emotional trajectory of each woman" (Meier et al., 2024, p. 1), our

results highlight how infertility treatment is characterized by features that amount to *typical* emotional trajectories and experiences on the journey towards a baby. These are shaped by social norms and cultural values regarding expected emotions and expressions, (female or maternal) identities, and ways of dealing with (pregnancy) loss.

At the end of the treatment, the outcome and experiences of IVF are then reflected on and communicated, as Eva points out: "If it hadn't worked out with [name of child], then you'd think, what have I done? What have I done just to have a child?" Greta likewise concludes: "It was crazy what we did." Critical judgements can frequently be found on social media, where the negative aspects of IVF are openly discussed under rubrics like "IVF survivorship" (Tsigdinos, 2022) and "IVF ruined my life" (Abdou, 2024). During periods of treatment, there is rarely time for a break or reflection; instead, all our interviewees refer to the "pressure" to act and to continue with further treatments: "You just try to function, every month" (Eva). The idea or actual situation of *not being successful* provokes deep reflection, and the influence of social norms on our behaviour and attitudes becomes most apparent when we fail to meet them. Eribon (2016, p. 45) has aptly described it: "To escape the logic of the self-evident…one must…cross the line of demarcation and move from one side to the other." Experiencing years of unsuccessful attempts seems to be such a demarcation line leading to a critical reflection on one's own desire to have children and the burden of ART treatment. After years of trying and unsuccessful inseminations, Doreen tries to weigh up the burdens of IVF to come against the possible outcome: "You take a hard look at it. Is this mine? Is this my wish? Is this my story, my life course?" She critically reflects on societal expectations—"having children is…not all [as] shiny as we paint it to be"—yet decides on trying IVF so as not to regret any missed chances. The possibility of regretting IVF treatment is not considered.

The study has some limitations. In Switzerland, access to reproductive medicine is socially selective, and the costs per treatment IVF/ICSI cycle (estimated at around CHF 10,000) are high and must be paid by patients themselves. This is reflected in the qualitative sample, as all interviewees have a university degree or higher qualifications. The CHARLS study also shows an education bias. Nonetheless, this bias also reflects the fact that access to and use of reproductive technologies are socially unequally distributed. Thus, we must assume that the experiences of more marginalized individuals, whose perspectives are underrepresented in the sample and in this article, will differ.

A limitation of our qualitative sample is the small sample size ($N = 7$). A possible bias could be that only those who were particularly affected by fertility treatment participated. However, we assume, besides the limited time and emotional resources of affected parties and especially mothers to participate in a one-hour interview, that it was rather the feeling rules and social norms—to be strong, happy, and forward-looking—that hindered others from participating. Our study focused on some typical emotions experienced and reported during and after treatment, many especially linked to pregnancy loss. However, these emotions should not be considered exclusively; others, such as empathy, or—as mothers—guilt towards others who are still undergoing fertility treatment, were also mentioned but not further followed up for this article.

Another desideratum is the partners' influence on women's emotional experiences of fertility treatment. In our interviews, while partners were implicitly included in the context of a "we" deciding to start a family, in the loss and grief narratives they either played no prominent role (Chris: "In those moments I need my mommy and not the husband") or were characterized a source of extra strain (e.g., lack of support or insensitivity) as in the case of Anna. These absences may have fostered the feelings of disenfranchisement present in our data,

leading to a specific sample, yet we believe it is more likely that they are typical for a gendered experience of fertility treatment. This is mirrored in the many research gaps regarding men and reproductive experiences (Inhorn, 2025).

Further, with one exception, all the women in the sample already had at least one child. So, it could be argued that this leads to an underestimation of the emotions of women whose treatment has yet to be successful and/or who are less willing to participate in research (Hammarberg et al., 2001). These perspectives remain unheard of and future research should focus on those.

Undergoing IVF treatment demands physical, emotional, and financial commitment. Despite their low success rates, ARTs are presented by fertility clinics and in the media and popular culture as an effective treatment for infertility and thus as offering a great chance of getting pregnant. Ambivalent experiences and feelings of reproductive failure on the part of intended parents are less recognized in medicine and science, although the most common experience of fertility treatment might be loss and failure. Our results illustrate the potential for loss through reproductive technology, creating layers of multiple loss experiences and cumulative grief, which can also be described as the "mounting emotional effect" (Bradow, 2012) of fertility treatment.

One key finding of our qualitative study was that interviewees experienced surprisingly long-lasting grieving reproductive journeys within fertility treatment. Even if their treatment was eventually "successful," that is, they gave birth to a living baby, they still remember and mourn their unseen losses and burdens. This finding complicates the common-sense assumption that medically successful fertility treatment leads to happy mothers who forget the sorrows of the treatment process.

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Conflict of Interests

The authors declare no conflict of interests.

Data Availability

The data from the Swiss Assisted Reproduction Longitudinal Study (CHARLS) will be provided upon reasonable request by the URPP "Human Reproduction Reloaded" at the University of Zurich (please contact the corresponding author). Due to confidentiality agreements and ethical considerations, the qualitative data of the LoMAR-Study will remain with the authors and are not available for further use.

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