Conceiving infertility: How social class shapes infertile experiences

by

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To Tony

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Chapter One

Introduction: Conceiving Infertility

When I met Angie, a Black, homeless, 25-year-old, she was desperately yearning for a child. She told me she wanted a child so that she could "receive love," something that was missing from her own upbringing. Angie had been trying to become pregnant through unprotected intercourse for nearly eight years before realizing that something might be "wrong." Her childlessness makes her feel "abnormal" among her peers, since most of them already have several children. In fact, Angie does not know anyone who has had difficulty with childbearing. She told me that while marriage is not important to her, the lack of a commitment makes her fearful that her partners will leave her once they discover her childbearing difficulties, so she does not tell them of her troubles. She also does not seek medical care due to her lack of insurance coupled with discrimination she has previously faced from physicians. Ultimately, Angie, accustomed to not getting everything she wants in life, is forced to cope with her infertility and primarily does so through prayer.

Sarah, a white, upper-middle-class, 33-year-old, also told me about her childbearing difficulties. After completing college, establishing a career, and getting married, Sarah decided it was time to have a child. But after just six months of trying with temperature taking and ovulation kits, she began to worry about why she was not conceiving. She described her husband as her strongest support system and said talking

to her friends is her "therapy" for getting through her reproductive troubles. Several of Sarah's peers are still childless as they delayed childbearing to focus on their careers, so Sarah still feels like she "fits in." Upon recognizing her difficulties, Sarah immediately went to the doctor and began fertility treatments. She complements the medicine with weekly acupuncture and massage appointments. If her current medications fail to result in pregnancy, Sarah plans to continue medical procedures "as the doctor orders," including intrauterine inseminations (IUIs) and in vitro fertilizations (IVFs). She cannot imagine a life without children. Motherhood is something she has always wanted, and this is one of the few occasions in her life that things have not gone according to plan.

Both Sarah and Angie describe experiences of infertility, yet experience it in two very different ways. However, only Sarah's story and stories like it have previously been told. Infertility is stereotypically depicted as a white, wealthy woman's issue, shaped by media images of celebrities receiving in vitro fertilizations and reality shows highlighting the lives of families with sets of multiples. But in reality, poor women and women of color have higher rates of infertility, due to class- and race-specific trends, such as a higher prevalence of sexually transmitted infections among their populations (Chandra et al., 2005). Their stories of infertility have been silenced, however, due to our understandings of reproduction and fertility along race and class lines. Society has lauded the childbearing practices of higher-class, white women throughout history. Policies have encouraged their procreation, even at times disallowing abortions among white, affluent women. In contrast, society criticizes the fertility and reproductive practices of lower-class women and women of color; namely that they have too many

children. By focusing on their "hyperfertility," policies and popular culture have overshadowed the presence of infertility among marginalized women.

In addition to having a specific image of *who* is infertile, people also have a particular understanding of *what* infertility is. Infertility is not only stereotyped as affecting higher-class, white women, it is also conceived of as a health issue to be treated medically. The 'medicalization' of infertility, or its transformation from a natural life event into one that requires medical treatment, developed with the advent of assisted reproductive technologies (ARTs) in the late 1970s and early 1980s. Since the birth of Louise Brown, the first baby born from IVF, ARTs and other fertility treatments have proliferated, making infertility synonymous with its medical treatment. Media representations of infertility reinforce such depictions, highlighting assisted reproductive technologies as its resolution. For instance, recent *New York Times'* articles headlined, "Million Dollar Babies," "Donors, Daddies, Surrogates, Lawyers," "The Gift of Life, And Its Price" all focus on the medical treatment of infertility, primarily its financial accessibility and ethical implications.

Both of these stereotypes, depicting who and what infertility is, make infertility experiences among marginalized women, like Angie, invisible. Lower-class women cannot afford the medical treatments for infertility, and along with women of color, they do not fit the typical image of the condition. Research furthers their exclusion from our understanding of infertility. Understandably, for convenience, most infertility studies recruit participants from medical clinics. However, in doing so, the academic portrayal is also one that concentrates on the medical dimensions of infertility, and it examines those who are lucky enough to receive medical care for infertility, typically white, higher-class

women. As these stereotypes would suggest, there is virtually no research on lower-class women's experiences of infertility or the lived experience of infertility outside of the doctor's office.

My goal in this book is to center rather than marginalize the infertility experiences of lower-class women. By bringing their stories to light and comparing them to the white, higher-class women we typically associate with infertility, the book begins to break down the stereotypes of infertility and show how such depictions consequently shape infertility experiences. As other infertility researchers have noted, infertility can be thought of as a "cultural disorder" because it serves as a 'mirror' of cultural norms and a 'barometer' of cultural change (Sandelowski & DeLacey, 2002). Comparing experiences among women of different races and classes particularly reveals how race, class and gender intersect within the institutions of motherhood and medicine. As I will argue, infertility is a social process, one that is influenced by class- and race-based ideas around reproduction, motherhood, family, and health. These ideas shape our understanding of who and what infertility is.

Who is infertile: The construction of the 'good' and 'bad' mother

Social conceptions of motherhood have long constructed the role of mother as universal, stable, and natural among women, amounting to a "motherhood mandate" (Russo, 1976). In other words, motherhood is expected among all women, as womanhood is equated with motherhood. In turn, childlessness is viewed as unnatural or abnormal. The current ideology around mothering, however, known as "intensive mothering," complicates the motherhood mandate (Hays, 1996). It outlines *who* should mother as well as *how* one should mother according to idealized family norms. Intensive

mothering is based upon a white, middle-class, heterosexual gold standard to which 'other' mothers are compared. According to this ideology, 'good' mothers are those who are self-sacrificing, child-centered, and can afford to stay home with their children. Women unable to fulfill this ideal are marginalized and systematically devalued (Connolly, 2000; McCormack, 2005).

The intersection of intensive mothering with the motherhood mandate provides a conflict for women who cannot adhere to one or both of the ideals. Lower-class women experiencing infertility are one such group. Not only are they childless, and therefore unable to fulfill the motherhood mandate, but they are also unable to attain the physical, emotional, and financial demands of intensive mothering. Instead of uniting women around motherhood, mainstream notions of the role divide women along various dimensions (Dunlap, Sturzenhofecker, & Johnson, 2006).

One such dimension is social class. Unlike their wealthier counterparts, lower-class women are constructed as 'bad' mothers. They are expected to fulfill middle-class standards of motherhood even though they lack the social and economic resources to do so (Baker & Carson, 1999; McCormack, 2005). These contradictions of class and motherhood are exemplified by the case of the welfare mother. As poor women, welfare recipients are expected (and forced) to prioritize work to overcome their impoverished state. However, as mothers, the notion of intensive mothering expects them to focus exclusively on mothering (Hays, 1996). As a result, not only are increased demands placed upon lower-class women, but they are also set up for failure according to social expectations of 'good' mothering.

This conundrum is overlooked due to the political and popular tendency to ignore context and instead focus on the individual woman when examining her ability to mother. Women deemed 'bad' mothers are criticized according to individual characteristics, thereby shifting focus away from how such a label is situated in notions of race and class. 'Bad' mothers are blamed for irresponsibility, lack of control, and poor decision making, while structural factors such as poverty, lack of resources, and limited support are ignored. For instance, the image of the 'crack baby' portrayed poor, Black women as irresponsible and uncaring, furthering the race and class divides of motherhood. Focusing on the individual drug behaviors of these women overlooked their 'need' for drugs to cope with the many stresses that accompany poverty in contemporary America. Yet, many women in this population took drugs as a mechanism to be better parents (Baker & Carson, 1999; Douglas & Michaels, 2004). They strove to achieve 'good' mothering, but used drugs to temporarily escape from parental pressures. Failing to recognize the social context of mothering experiences, dominant narratives condemn poor women for not being fit mothers rather than understand how poverty and disadvantage pose formidable barriers to conforming to the motherhood ideal.

The idea of the 'good' and 'bad' mother, based on a "stratified system of reproduction" in which fertility is differently valued according to an individual's race and class, plays out in policies and practices around infertility (Colen, 1986; Ginsburg & Rapp, 1991; McCormack, 2005; Roberts, 1997). For instance, the eugenics movement in the first half of the century (Steinberg, 1997), followed by the forced sterilization abuses of the 1960s and 1970s, and federally funded family planning programs that began in the 1970s, all reinforced the binary understanding of the 'good' versus 'bad' mother (King &

Meyer, 1997). All of these programs attempted to reduce the reproduction of those

deemed "unfit" or "abnormal"—often members of marginalized groups, such as poor

women and women of color. These programs are fundamental to poor women's present

representation as highly fertile and unfit to mother. Higher-class white women were also

affected by these movements in that they were subject to pronatalist policies, and

therefore unable to access ways to limit their reproduction (Glenn, 1994). For instance,

after the Supreme Court decision in *Roe v. Wade*, abortion came under the control of

medicine rather than individual women. In turn, access to abortions ironically became

more difficult for higher-class women once abortion was legalized (Gordon, 2002).

Such class- and race-based ideas are reflected in current reproductive benefits

around infertility. For example, insurance coverage of infertility treatments is implicitly

grounded in the logic developed in the eugenic period: treating the infertility of the

affluent and controlling the fertility of the poor (King & Meyer, 1997; Steinberg, 1997).

In 2001, four states had laws mandating complete coverage of treatment, five states

required partial coverage, five states did not provide ART services, and the remaining 36

states had clinics on a fee-for-service basis (Jain, Harlow, & Hornstein, 2002; Katz,

Nachtigall, & Showstack, 2002). However, there is an unequal distribution of

reproductive benefits according to social class. In Illinois, for example, the state

mandates that employer-based insurers provide coverage of infertility treatment, typically

to middle-class women, yet poor women on Medicaid do not receive such benefits.

Additionally, Medicaid recipients have mandated coverage of contraception, yet the same

is not true for private, employer-based insurance policies. This "dualistic natalist policy"

discourages births among lower-class women and encourages them among women of

higher classes (King & Meyer, 1997). Despite these blatant differences in fertility coverage, health consumers, particularly women, rarely question or acknowledge issues of equitable access. In other words, within the distribution of reproductive benefits is a class bias that has become "naturalized"—that is, unquestioned, taken-for-granted, and seemingly natural.

In addition to inequalities in insurance coverage, disparities also exist in the provision of medical treatment even within states that have mandated comprehensive insurance coverage, which is insurance for infertility treatments that everyone receives regardless of economic means. For instance, in Massachusetts, a state with mandated comprehensive insurance coverage, the use of services increased when comprehensive coverage began, but it did so among the same demographic group that receives treatment in other states without insurance coverage—the white, wealthy, and educated—thus, the treatment disparities remained (Jain & Hornstein, 2005). According to this study, inequality was most significant along educational divides. Of the patients receiving IVF services, none had less than a high school diploma while 85 percent had at least a college degree.

Ideas about who should and should not mother are embedded in numerous social institutions. Social control around reproduction is especially salient within medicine. Since the medicalization of childbirth, and more recently, medical treatments for infertility, the institution of medicine reinforces notions of who is fit and unfit to reproduce. In turn, examining infertility, a medicalized phenomenon, reveals the relationship between motherhood and medicine and their basis in the intersection of race, class and gender.

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What infertility is: The medicalization of infertility and its consequences

Since the medicalization of childbirth, and more recently, the development of ARTs, the institution of medicine has contributed to the social control of reproduction. Between 1968 and 1984, medical visits for infertility tripled from 600,000 to 1.6 million (Greil, 1991). More recently, between 1995 and 2002, the use of ARTs doubled from nearly 60,000 cycles in 1995 to approximately 116,000 cycles only seven years later (Jain, 2006). Not all individuals, however, receive such treatments. In 2002, only 10 percent of women with less than a high school education received any infertility service compared to nearly 18 percent of women with at least a bachelor's degree (Chandra et al., 2005). In other words, the medicalization of infertility makes the "stratified system of reproduction" seem natural by providing the option of reproduction to some groups and not others.

Similar to the way we think about motherhood, biomedicine individualizes experiences by focusing on individual attributes (Henifin, 1993; Riessman, 1983; Scritchfield, 1989). It transforms a social process into an individual trait whereby infertility becomes a label adhered to a patient. Because of this, the infertility experience is now examined among patients rather than social actors (Greil, 1997). This framework blames women for their infertility due to their past actions or choices that do not align with social norms. There is a class dimension to such blame. For instance, lower-class women are admonished for their 'promiscuity' and subsequent sexually transmitted infections (STIs), while middle- and upper-class women are empathized for their late marriages and delayed childbearing. Blaming in such a manner legitimates the class-based provision of reproductive services and makes such inequalities invisible.

In addition to individualizing social processes, another consequence of medicalization is focusing on treatment rather than prevention. Indeed, such is the motto of American life in which we seek immediate, individual solutions to social problems (Michie & Cahn, 1997). Portraying infertility as a white, wealthy woman's issue unconsciously encourages ignorance around its public health aspects (Marsh & Ronner, 1996). Over 20 percent of infertility is preventable, as it is caused by damage to reproductive organs due to STIs, previous surgical sterilization, pelvic inflammatory disease (PID), delayed childbearing, and occupational and environmental hazards (Henifin, 1993). Many of these preventable causes are more common among lower-class women, yet they are ignored due to medicine's focus on treatment (Green, Robins, Scheiber, Awadalla, & Thomas, 2001; Mosher & Aral, 1985; World Health Organization [WHO], 1987). When such causes are recognized they are typically used as a mechanism to further exclude lower-class women from attaining medical treatments by blaming them for irresponsible lifestyles and thus their own infertility. In other words, rather than study the causes of infertility as a way to prevent its occurrence, such causes are used to justify treatment inequalities by outlining who is worthy and not worthy of medical care for infertility.

Because of its emphasis on treatment, medicine prides itself on the fact that it can 'fix' the abnormality in question. In turn, an 'abnormal' social status, such as childlessness, that does not align with a society's cultural system may be a primary target for medicalization. In the case of infertility, this limits its only acceptable treatment to one—that of producing a biological child (Becker & Nachtigall, 1992). In this sense, it is the absence of a desired condition, having a biological child, not the pathological

condition, such as hyperprolactinemia, that causes individuals to seek medical care for infertility. Infertility, therefore, does not require a cure in order to be considered 'healthy.' Indeed, treatments do not target the etiologic factors of infertility; instead, they circumvent those factors in an attempt to achieve the desired outcome, a biological child (Sandelowski, 1990). Only one treatment, tubal surgery, actually attempts to cure infertility. All other treatments aim at conceiving a biological child, but individuals remain infertile after that is accomplished (Evans, 1995). In other words, medical interventions cure biological childlessness, not infertility, *per se* (Evans, 1995; Sandelowski, 1993). However, in defining it as a physiological state, an effect of medicalization, infertility becomes naturalized, and its basis in gender, race, and class is overlooked (Greil, 1991; Greil, 1997; Scritchfield, 1989).

Medicalizing infertility, especially through the development of reproductive technologies, has thus redefined and furthered mainstream understandings of motherhood and reproduction within society. Typical expectations of fertility have shifted; involuntary childlessness was previously constructed as a disappointing, inevitable act of nature, whereas it is now expected that infertility is something to be overcome (Donchin, 1996). One researcher (Sandelowski, 1993) insightfully reflects that "infertility has only recently come to mean the potential to have a child of one's own, rather than merely the incapacity to have a child on one's own" (p. 45). In other words, treating infertility medically has reinvented the ailment as an indeterminate, liminal state of "not yet pregnant," making the "mandate" of motherhood all the more prominent (Greil, 1991). Additionally, with the development of reproductive technologies, choosing to have a child, when to have a child, and how to have a child are commonplace discussions.

Reproduction is becoming more of a 'choice,' making infertility seem all the more volitional (Sandelowski, 1990).

This new sense of 'hopefulness' brought on by medical care for infertility also makes biological childlessness seem increasingly deviant or abnormal. As a consequence, despite medicine's failure at resolving the physiological condition of infertility, women preferentially select medical treatments over non-medical solutions to resolve their childlessness. Medicine maintains the biological connection between parents and child, which many non-medical solutions, such as adoption and foster care, are unable to do. Because biological parenthood is socially significant, infertility is constructed as a clinical need. The treatment of infertility is thus based in many social forces that a focus on medicine conceals. Indeed, medicine's power as a social institution is disguised by its self portrait as an objective entity dealing with "natural" issues (Turner, 1997). Ironically, this causes individuals to pursue an unnatural, technological answer to infertility in hopes of achieving 'naturalness.'

In addition to maintaining and reinforcing social values and rules, medicalizing infertility also defines and controls to whom those norms apply. It functions within and is reflective of the "underlying moral economy of the U.S." by limiting its services to select groups (Becker, 2000, p. 20). 'Deserving' and 'undeserving' mothers, typically divided along class lines, are treated differentially by providers. As part of a "private medicalized market" (Conrad & Leiter, 2004) in which lack of insurance coverage causes patients to be consumers, infertility treatments are marketed towards specific groups, typically higher-class, white women. Part of this marketing strategy includes advocating women's reproductive choice. By excluding this choice from women who cannot afford

to make it, lower-class infertile women are instead confronted with a "double-stigma" (Spar, 2006). They are not socially recognized as mothers due to their infertility, but they are additionally shunned for their desires to be mothers in the first place. Medicalizing infertility does not unite women around the commonality of medicine (or motherhood), but instead perpetuates differences between them (Litt, 1997).

Yet, motherhood and medicine's basis in class goes unnoticed so that the ways in which they promote inequality become unconscious and unrecognizable. This is similar to their perpetuation of other social norms, such as heterosexuality. For example, cultural conceptions of families typically place family and motherhood in heterosexual relationships (Blank, 1997). Such heteronormative notions infiltrate medicine which perpetuates these norms by preventing unmarried couples or individuals from receiving infertility treatment. Because Black women in particular are less likely to be married when they attempt to access infertility treatment, medicine also becomes a racial gatekeeper (White, McQuillan, & Greil, 2006). Marginal populations are thus positioned through exclusion, thereby perpetuating and disguising inequality.

By situating women at the margins of the infertility experience, the medicalization process has placed lower-class women in a position with unique perspective, academically known as "outsiders-within" (Collins, 1990). Their marginality allows them to move between and among various social locations giving them a unique perspective and standpoint. Outsiders-within are able to access knowledge about a certain area or group, but the power relations contained within that group restrict them from participating in or authoritatively utilizing that knowledge.

Litt (2000) applies this outsider-within trope to Jewish and African-American women's relationships to medicalized motherhood during the 1930s and 1940s. The social inequality embedded within scientific motherhood at that time places these groups outside the category of "good mother" which is reserved for white, middle-class women; thus, they become outsiders-within. As such, Jewish and African-American women have unique perspectives on medicalization that differ from those of women who are embedded within mainstream reproductive ideas. The same may be true for lower-class women on the margins of our understandings of infertility. For instance, similar to circumstances that occurred prior to the development of reproductive technologies, lower-class women, unable to access infertility treatments, are forced to cope with the ailment as a natural part of life; however, the difference now is that they are aware of potential remedies to their difficulties that are unattainable. Economically disadvantaged women are thus outsiders-within to the "stratified system of reproduction," allowing for unique, comprehensive insight to that structure (Collins, 1990; Hays, 1996).

About this study

With this premise of inequality and diversity in mind, I set out to investigate how and why the 'social construction of infertility,' or who and what we typically think of as infertility, differentially or similarly shapes the infertility experiences of women of diverse social classes. To do so, I conducted 58 in-depth interviews with women who were between the ages of 18 and 44 and had ever been involuntarily childless for at least twelve months due to the inability to become pregnant (medical definition for infertility) or carry a child to term. Two-thirds of the participants were lower-class women of white and Black races and the remaining one-third were higher-class women, all of whom were

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white. These three particular groupings happened both purposefully and 'accidentally.' I purposefully 'over-sampled' lower-class women for several reasons. First, my primary concern in this study was to better understand the class aspects of infertility, since that is the dimension by which women are *explicitly* excluded from receiving medical treatment for their infertility. Second, the scant research that has been done on diversity in experiences of infertility examines its racial dimensions, and its basis in economics has been less explored. Third, I needed to listen to the experiences of lower-class women, not only to bring their silenced stories to light but also because their experiences, as outsiders-within, exposed nuances within higher-class women's infertility journeys for which affluent women, alone, could not comprehend.

In spite of my intended research design, this study is composed of three rather than four groups due to the perils of research and whom I was able to recruit. Initially I set out to have four groups: the three included in this study as well as Black, higher-class women. Despite extensive efforts to recruit such participants, in the end I was only able to interview three women fitting such a category, not enough for conclusive, rigorous comparison. I believe this occurred for various reasons. First, the participants in the study reflect the general demographics of the area in which they were recruited, Southeastern Michigan. There are few affluent, Black women in the region, let alone those who are infertile and willing to participate in research. Second, higher-class Black women may be less willing to participate in research because their infertility experiences have been increasingly silenced (Ceballo, 1999). While future work needs to be done on higher-class Black women, for this study, focusing on the comparisons between white and Black lower-class women and white, higher-class women makes theoretical and

empirical sense. Since I began the study primarily interested in how mainstream ideas about infertility affect its experience, comparing women excluded from those narratives (lower-class women) to women enmeshed within them (*white*, higher class women) is appropriate. Additionally, because my main focus is on class differences in infertility, it makes sense to 'oversample' lower-class women and compare them to higher-class women, generally, regardless of race. However, having the racial comparison within the lower-class groups allowed me to achieve a more nuanced analysis that did not over-generalize my findings to all women in a certain class.

At this point, it is necessary to say a word about my terms. "Social class" is an ambiguous concept, both within popular usage as well as in academic verbiage. The specific discipline to which I claim membership, sociology, cannot even agree on its definition (Lareau, 2008). One reason for this is because class encompasses many dimensions of an individual's life: income, occupation, education, family background, family size, etc. Given the sheer amount of factors involved, it is no wonder that class is a difficult thing to "measure" in an agreed-upon way. But, the very complexity and ambiguity of the concept of class should not prevent us from studying it. Class is an important and influential component of one's life and researchers have found that it plays a particularly significant role in shaping family structure (e.g., Lareau, 2003). So, given that I was not going to shy away from studying social class due to its complexity, I had to develop a way to categorize participants by social class that, I believe, satisfies both objective and subjective definitions of the concept. Before being interviewed, participants completed a demographic questionnaire in which I inquired about a variety of factors, many of which were to ascertain a woman's class status. These factors

included the woman's occupation and education along with her partner's, her mother's education, household income, household size, and a subjective question inquiring about income adequacy.

As a starting point, I began grouping women by class according to their household income. Not only is income one of the three primary variables encompassed within the concept of socioeconomic status (in addition to occupation and education), but it is also the variable upon which women are explicitly excluded from infertility treatments due to the cost of medical treatment and its connection to insurance. However, income alone does not fully encompass "class" and the stereotypes associated with it, including those that define women as "fit" and "unfit" to mother. Moreover, income is a highly sensitive characteristic and one which participants may not fully disclose. Therefore, I used the other indicators of class, including the educational and occupational characteristics of the participants and their households, in order to verify the income categorization and determine the final groupings of participants according to class. In the majority of cases, these variables, taken together, corresponded to income. For those that did not group succinctly, primarily due to a disjuncture between education and income, I based the class category on a variety of factors. For instance, a social worker who earns $35,000 annually and whose parents are professors is categorized as middle-class, whereas a factory work who earns $50,000 a year yet never graduated high school along with her parents is categorized as working-class. Despite these outliers, grouping women according to income typically resulted in consistency across income, education, and occupation. Doing so resulted in two, overarching class categories: lower-class includes

both poor and working-class women, while higher-class includes both middle-class and upper-middle-class women.

To participate in the study, the women could have experienced involuntary childlessness at any point in their lives. This means that, for some of the participants (n=8), infertility is a thing of the past as they currently have children or are no longer *involuntarily* childless because they have "moved on" in life. Having such open eligibility criteria allowed me to interview the number of participants needed for the study given the limited number of women willing to talk about their childbearing difficulties. But, the open criteria also have limitations. First, "recall bias," or skewing your story due to the inability to remember all of the details, might be of concern for those who experienced infertility many years ago. Second, there may be some misalignment between the women's current demographic characteristics (e.g., marital status, household income) collected at time of interview and those characteristics during their experiences of infertility. However, such limitations were only minimally present, if at all, in this study. The majority of participants (n=50) were still experiencing infertility during the research, as most did not have children and/or were still struggling with their childbearing pursuits. Additionally, the maximum age for participating was 44 years old, which means that infertility, if a thing of the past, is a relatively recent occurrence since women's childbearing years are limited. Moreover, in terms of demographic changes through time, much of that was resolved within the interview. For instance, when discussing how infertility affected or was affected by a participant's marital status, I phrased the question(s) to refer to the time of the infertile experience (e.g., how did your childbearing difficulty impact your relationship?). Further, for

variables, such as social class, I took extra care to insure that such demographics were consistent through time. For example, the compilation of variables comprising the class categories not only provided a thorough definition of class, but it also allowed me to examine the participants' past class standing as evinced by their parents' education and then compare it to their current status. Through such comparison, I found no evidence that class status changed for any of the participants.

One of the advantages of this research is the diversity of its participants, in turn exposing infertility as a diverse process. With such an advantage, however, comes some methodological limitations. As the sole researcher on this project, my numerous identities (e.g., gender, class, and race) only aligned with a handful of the participants. So it was important for me to consider how I was perceived by the interviewees as well as how those perceptions influenced their responses and thus the study's findings.

A common method for addressing demographic differences between researcher and participant is to eliminate those differences altogether by "matching" the participant with an interviewer that has similar characteristics, typically along one dimension (e.g., race). This is called researcher-subject concordance. Primarily done within survey and quantitative research, this tactic offers several advantages. First, one could argue that it makes the study's findings and interpretations more culturally competent (Sawyer et al., 2007). Studies have found that researcher-subject concordance leads to an increased understanding of the participant's body language and verbal meanings which can then be accurately translated in data analysis. Second, interviewees may divulge more information within the interview if talking with someone with similar characteristics. Perceiving shared language and cultural references may put the participant more at ease.

Moreover, speaking to someone of the same background may increase the participant's trust in the interviewer. Not only might this increase the accuracy and validity of the research findings, but it may also provide a more thorough and in-depth conversation within the interview.

Despite these advantages, there are several limitations to researcher-subject concordance that need to be considered. First, matching interviewer and subject along a certain dimension assumes that there is a single truth that can only be attained between individuals sharing particular traits. This "is based upon a logic of commonality as emotional and ethical unity, where race, ethnicity, and/or culture are imagined as imbuing research interactions with levels of communication, trust, and care that precede the research relationships themselves" (Gunaratnam, 2009, p. 88). I believe that experiences produce several accounts, none of which are superior to each other and all are meaningful and interesting in their own right. For instance, in a study on foster parents (a topic similar to infertility) a researcher found that Black participants shared more with white interviewers than with Black interviewers because they perceived the white interviewer as a representative of the white race and wanted to share their insights with that group (Rhodes, 1994). Other researchers have identified similar findings in a study on education-of-interviewer effects (Yang & Yu, 2008). When participants acknowledged the educational gap between themselves and the more educated interviewer, they were likely to provide more substantive answers than when they did not identify such a gap. Therefore, rather than serving as a barrier to communication, it can provoke conversation, particularly around marginalized perspectives. A second limitation to matching the

characteristics of interviewer and participant is that it has the *a priori* assumption that one social signifier, such as race, will dominate other dimensions of difference, such as class.

Ultimately, differences between researcher and participant do make a difference to a study's findings and conclusions. However, "the difference that our difference can make in researching a sensitive topic such as infertility is multilayered and multisided" (Gunaratnam, 2009). Because of pragmatic constraints of finances and time as well as the intellectual reasons I just mentioned, I accounted for differences using techniques other than interviewer matching. For instance, I designed some interview questions to explicitly parse out race effects within infertility experiences. I also developed techniques and skills to gain participants' trust within interviews. For example, intent listening, eye contact, engagement with the participant, and easing into the topic of infertility with broad, general questions with which I can relate all assisted in creating a comfortable environment for the respondents so that our differences did not preclude a healthy, in-depth conversation.

While it is likely that my identities shaped what the participants told me, there is reason to believe that their stories were not sufficiently different to skew the research findings. For example, my interviews were of similar length, and no participant ever inquired about my race or educational background and their influences on our interaction. Instead, several participants thanked me for the opportunity to talk, as several had never discussed their fertility issues with anyone else. Indeed, similar to Culley and colleagues' (2007) research of infertility among South Asian women, my research participants may have identified my status as "expert" rather than my ethnicity as the significant social identity. My affiliation with a university seemed to reassure participants of my

trustworthiness and knowledge surrounding infertility and their experiences. Since infertility is a medicalized phenomenon it is automatically associated with talking to 'objective' others, such as doctors, about the condition. Also, because infertility is gendered or considered a woman's issue, my identity as a woman may have trumped my race and class positions, and may have facilitated my conversations with participants.

<u>About this book</u>

Conducting in-depth interviews allowed me to gain comprehensive, nuanced insight into the *lived experiences* of infertility. Through the women's stories, I traced the entire infertility experience from before the women realized they had childbearing difficulties to how they coped with infertility and planned for the future. This book walks through their journeys chronologically. Chapter Two asks the basic question of why the women want to mother in the first place. Chapter Three follows by examining how the women negotiate such maternal desires within a context that portrays them as 'fit' or 'unfit' for the motherhood role. Chapter Four continues to explore life before infertility by comparing various ways women "try" to become pregnant. After "trying" and not succeeding, Chapter Five then thoroughly examines what it is like for the women to live with infertility, particularly within their social environments. Chapter Six begins to unravel life post-infertility by exploring how the women attempt to resolve the ailment, either medically or not. Chapter Seven then asks how the women cope with infertility and how they envision their futures. Finally, I conclude the book by revisiting the significance of the findings, particularly their policy implications.

The findings, reflective of recruitment, focus on the classed experiences of infertility. Yet, the racial diversity of the lower-class women allowed race to be explored

as well. Interestingly, I found class to be more salient than race in shaping infertile experiences.   The lower-class women, regardless of race, had more similar experiences of infertility compared to the experiences of the white women of the lower- and higher-classes.   When differences between races do arise, however, they are highlighted within the text. They are also summarized in the conclusion.

Exploring experiences of infertility among a diverse group of women not only challenges our stereotypical notion of who is infertile, but it also exposes differences and similarities within experiences of infertility depending upon one's social location. In doing so, this study reveals infertility as a social process rather than merely an embodied, objective medical experience. Angie and Sarah both experienced infertility, yet they were vastly different experiences. The following chapters take an in-depth look to explore how and why such variations exist, ultimately revealing the depth and complexity of infertility and its connection to class- and race-based ideas surrounding family, motherhood, health and reproduction.

Chapter Two

Why Women Want to Mother

*The existence of an institution of motherhood, as opposed to an
acknowledgment that there are simply mothers, is rarely questioned even
though the proper qualities of motherhood are often the subject of debate.
Motherhood is still largely treated as given and as a self-evident fact
rather than as the possible outcome of specific social processes that have
a historical and cultural location (Smart, 1996).*

Implicit in the very definition of infertility is intentionality of pregnancy: a

woman must want or 'try' to become pregnant in order to recognize her inability to

conceive. Thus, when studying infertility an intuitive, analytical starting point is

examining why women want to mother in the first place. Despite the abundance of

literature on motherhood and reproduction, research has not thoroughly answered this

question.

Until the 1980's, sociologists failed to inquire about why women want to mother.

One explanation for this silence may be the deeply embedded, taken-for-granted

"motherhood mandate." The answer was simply assumed; for a woman, being a mother

is not a choice, as womanhood equals motherhood (Russo, 1976). The motherhood

literature reified this assumption through its failure to ask why women would strive to

attain such a role. By not questioning it, research reinforces the idea that motherhood is a

natural desire for all women and that it is strictly a gendered phenomenon, unrelated to

race or class.

Despite its paucity, a few researchers have broached the topic of women's

mothering motivations. The landmark work, *The Reproduction of Mothering,* was one of

the first to inquire about why women want to mother. In the book, Chodorow (1978)

concludes that motherhood is reproduced through the gendered structure of parenting.

The primary characteristics of mothering, such as caretaking and nurturance, develop

within a woman's personality due to her identification with and attachment to her own

mother. In this psychoanalytic account, women pursue mothering in order to enact and

regain those feelings that have become a part of them. In a similar yet different vein,

Ruddick (1989) conceptualizes why women mother through her theory of maternal

thinking. Unlike Chodorow's psychoanalytic approach, which understands mothering as

developing within an individual's personality, Ruddick argues that those characteristics

are products of maternal practice, or the 'doing' of mothering. While both studies

contribute much to our understanding of motherhood, they universalize mothering desires

and fail to examine how such motivations may differ among women.

When studies do examine diversity within mothering they typically focus on

negative effects of race and class (e.g., welfare moms), relate the demographics to policy

issues, or include race and class to compare mothering practices rather than motivations

(e.g., Lareau, 2003). For instance, Edin and Kefalas (2005) conducted one of the few

studies that examines why marginalized women want to mother, yet such an analysis was

secondary to their primary inquiry of why poor women do not marry before having

children. Their research focused on policy rather than theory. Additionally, while their

study provides insight into why poor women desire motherhood, it did not compare such

desires among women of different races or social classes, and was thus unable to explore why or how different contexts and norms lead to different mothering ideals.

As the following findings in this book demonstrate, however, there are striking class differences in why women want to mother. For instance, lower-class women desire motherhood for the individual advantages they will gain from having a baby, so their motivations are centered around the effects of the child; whereas higher-class women want to mother not because of what the *child* will bring them, but because of the mothering role itself. Higher-class women have internalized dominant ideologies around motherhood, and it is the attainment of those social norms which motivates their desire to mother.

In the following section, I argue that the variation in responses by social class is due to both contextual and ideological diversity. Despite most responses centering on the effects of the child, the mothering motivations of lower-class women had much greater variation than the responses given by higher-class women. Such discrepancy supports the notion of increased 'cultural heterogeneity' in economically disadvantaged contexts compared to higher-class settings (Harding, 2007). Poor and working-class women draw on several competing ideologies to inform their decision-making, while middle- and upper-class women primarily draw on mainstream ideas. Additionally, dominant discourse is constructed by and based on dominant race and class groups so it reflects higher-class women's experiences. Therefore, higher-class women may be more driven to maintain and achieve their alignment with social norms than poor women since lower-class women are already the 'other' within the discourse.

Exposing such class differences reveals motherhood as a contextually-situated institution. The diversity of this study sample allows us to explore the role of cultural discourses in shaping individuals' decisions. It provides us with an opportunity to explore how women, particularly members of subordinate groups, position themselves vis-a-vis the greater society. Moreover, simply inquiring about why women want to mother reveals the complexity of motherhood, exposing how motherhood intersects with race and class. Finally, asking why women want to mother among infertile women is ideal as this group is intentionally trying to mother. This offers a prospective look at mothering which is rare, particularly among lower-class women. Moreover, it allows us to further understand the infertility experience since mothering motivations shape the consequences of infertility.

<u>Why women want to mother</u>

The pronatalist ideology underpinning many cultural beliefs and values around gender roles and parenting perpetuates the notion that "motherhood is the defining element of true womanhood" (Parry, 2005). Such gendered allocation of mothering has become essentialized in that all women are linked by motherhood. Indeed, womanhood and motherhood are treated as synonymous identities to the extent that mothering is not a choice for women, but rather it is socially mandated (Arendell, 1999; Russo, 1976). Yet such a 'motherhood mandate' is naturalized and therefore invisible through its construction. For instance, mothering is depicted as natural, stable and universal through its connection to women's reproductive capacity. By being intertwined with a woman's body and her reproduction, the social, political and moral aspects of mothering are disregarded (Lorber, 2002).

The potency and embeddedness of the motherhood mandate and pronatalist ideology, however, are evinced by the participants' mothering motivations. The only common response shared among the higher- and lower-class women was that they wanted to mother because of an innate desire. Carla, a Black, 31-year-old lower-class woman, reflects:

> I think like that's what I'm supposed—I'm supposed to be a mother. That's how I look at it. I'm supposed to be—…That's just it, you know. … I had—it was—it was in me to want to be.

Similarly, Courtney, a white, 33-year-old higher-class woman, could not explain why she wanted children because it was an instinctual response:

> I just—it's not like I ever thought about it. I just knew I was going to be a mom and it was like inbred in me. I knew—inbred—ingrained. I just—I—I knew it was going to happen.

Carla and Courtney internalized the notion that all women mother. The motherhood mandate is naturalized to the extent that they believe their desires are innate and that they are "supposed" to be mothers.

Given the essential nature of the motherhood mandate, it is not surprising that it is a theme running through all of the women's accounts of their mothering desires. Yet, beyond the universal notion that as a woman, one should mother, stark differences arise among the women's mothering motivations. Because the "maternal instinct" does not arise in biology but in the social and cultural factors surrounding it, a woman's contextual circumstances, such as what social messages are received, play a large role in her decision-making around motherhood (Donovan, 2008).

In this study, the lower-class women were focused on the *outcomes* of mothering—the baby and the effects of having a baby. They were *baby*-focused in that

all of their mothering desires centered on the child and what he or she would provide to them. Absent from poor and working-class women's accounts of their desires to mother were statements about the importance of following dominant cultural norms and mandates. This is similar to the findings of Martin (1990) regarding the medicalization of bodies and Blum (1999) on dominant norms of infant feeding in which women of marginalized groups were not conscious of or disregarded the hegemonic ideals. For example, lower-class, Black women did not feel guilty about bottle-feeding their children, unlike their white counterparts who were upset about not meeting the norm of breastfeeding. This reflects the notion that the ability to recognize dominant ideologies and then utilize those ideologies within one's reasoning is dependent upon social location.

Rather than focus on (unattainable) social norms of mothering, the lower-class women wanted to mother in order to fill a void in their lives. Many women understood that gap as not receiving enough love and attention; therefore, they desired a child in order to both give and receive love. As McMahon (1995) demonstrated, many women desire motherhood in order to escape impoverished, unhealthy situations. Motherhood is a fantasy that will allow them to find safety and nurturance. For instance, when asked why she wanted to mother, Angie, a Black, 25-year-old lower-class woman, states:

> Why actually do I want a baby so bad? I have no idea. But it has been on my mind ever since I was 16 years old and it's not going to go away until I have a kid. And I—I—I don't know what's wrong with me. I have no idea. Maybe—maybe it's because not enough affection in the family and not enough love. Maybe that's what it is. Maybe I think I can get, you know, break that cycle if I have a kid or something. (Laughs) I have no idea. I have no idea.

Angie wants to have a child for what the child will give to her—love—something that she believes was lacking in her own upbringing.

Many lower-class women wanted children in order to have someone care for them when they are older. Such a desire may reflect a fear that their childhood experience in which they needed but did not receive care might be replicated when they require caretaking again at an advanced age. Additionally, this reasoning demonstrates the cultural practice of extended kin networks within low-income communities (Stack, 1974). Given a lack of institutional and social supports (e.g., nursing homes) that are prevalent and accessible in high-income settings, individuals in economically disadvantaged neighborhoods rely on family to fulfill certain needs (Jarrett, Jefferson, & Kelly, 2010). Such needs cannot be met unless such a family exists. As Heather, a Black, 29-year-old lower-class woman, reflects:

> "Well, when I die, I don't want to die alone, whether it's before or after you." I said, "But if I'm sick and I'm dying, I want my children and my grandchildren and my family to be there." And so I guess that's a whole different perspective of having kids because it's having the extended family because my parents will be gone and my sister may or may not still be here but if I'm old and, you know, and dying, I want it to be with family. You know, and just not in a home somewhere.

Heather is aware that her nuclear family members, including her parents and siblings, may not be alive when she requires care at an older age. She therefore wants children in order to meet such a foreseeable need. This concern might be particularly acute for poor women because, as women, they are at increased risk for poverty at old age, and as impoverished women, they are more likely to be unmarried and thus lack familial support in that capacity (Lee, 2009).

In addition to wanting a child in order to receive love and support, lower-class women also wanted to be a mother in order to prove their social worth. Motherhood may be the only way poor and working-class women can achieve fulfillment, as they are many times surrounded by poverty, unemployment, crime, and drugs (Hardesty & Black, 1999). Rhonda, a white, 44-year-old lower-class woman, reflects:

> Just something to hang onto, I guess. You know, something to (pauses)—maybe to make my life complete, you know? Or, you know, that we were—to show that I could do something like maybe my life wasn't perfect but I could, you know, reverse the role and (laughs)—it would have been a good thing, too.

Similar to Angie, Rhonda hopes that having a baby will "reverse" or "break the cycle" of her life situation.

The aforementioned motivations for mothering were found relatively equally across both white and Black lower-class women. However, Black women provided a few reasons that white women did not, demonstrating motherhood as a social phenomenon. For instance, many of the lower-class Black participants want to mother in order to overcome the "stigma of maternal incompetence" (Connolly, 2000). Faced with the stereotype of being unfit to mother, some subordinated women believe that children will allow them to prove their social worth as good mothers. One way in which they hope it will do so is by providing them with middle-class characteristics. This "motive of redemptive motherhood" is based on the social construction of adulthood in which having children invokes maturity and thus leads to adult habits, such as less partying, drugs, etc… (McMahon, 1995). Candace, a Black, 41-year-old lower-class woman, demonstrates such reasoning:

> After I got a little wilder and when I got a little older, I thought definitely [motherhood] would slow me down. And people would tell me that. My

> friends and acquaintances, they'd say, "You just need a baby. You'll
> slow down." Because it—it was this loving girl and environment that was
> so messed up.

Candace was an alcoholic who had been imprisoned numerous times. She hoped that

having a baby would "slow her down" and thus resolve the drug and alcohol issues

within her life. This set of beliefs is particularly inherent within low-income Black

communities. Ladner's study (1972) reveals that Black low-income teenagers believe

that motherhood provides a transition to adulthood because the shift in status signifies the

attainment of womanhood. Ironically, such beliefs reify dominant norms around middle-

class characteristics of adulthood and serve to perpetuate the motherhood mandate.

Viewing motherhood as a symbol of adulthood is the opposite of the middle-class view in

which one strives to achieve adulthood prior to becoming a mother.

Another mothering motivation unique to the Black participants was the desire to

have a child of one's "own." This stems from the predominance of community

mothering in the context of Black, low-income women. Driven by cultural ideology and

need, Black lower-class women "share the care" of children among extended families and

social networks (Blum & Deussen, 1996). Doing so can evoke the desire to mother. For

example, Roxanne, a Black, 22-year-old lower-class woman, states:

> Because it's like very important to me to like have my own child.
> Because it's like I can like have my sister's baby or my brother's baby or
> whoever else's baby but it's like when it's time to give it back, it's like,
> "Dang, if this was my own child, I wouldn't have to give it back."

Roxanne wants a child for herself, one she can call her "own." This response was unique

to, but typical of Black lower-class women in contrast with their white counterparts. As

'other mothers,' these women care for friends' and family members' children as if they

were their "own", but at the end of the day they have to "give it back." Such a cultural

practice causes women to want children not only because it makes them realize the value of permanency in the relationship but also because community mothering makes them feel prepared to take on the challenge of parenting.

Unlike lower-class women, higher-class women do not focus their mothering desires on what the baby will provide to them individually; rather, higher-class women want to mother in order to adhere to social norms. For poor and working-class women, motherhood fulfills a need absent in other areas of their lives (Hennessy, 2009), but for higher-class women whose basic needs are fulfilled, motherhood serves another purpose—it allows them to maintain and achieve 'normality.' Therefore, mothering desires among higher-class women are centered on the *process* of mothering—its role, attainment, and trajectory. They were *mother*-focused since all of the responses centered on motherhood itself. For example, Maureen, a 40-year-old higher-class woman, wants a child in order to make her marriage and family more legitimate:

> But there's this idea that—that who we are would be more legitimate, you know, that the sense of my husband and I as a family unit would be more legitimate if there were a child in the picture.

Maureen has internalized traditional views that the purpose of marriage is for procreation and that families should include children. Therefore, she wants a child in order to achieve those ideals and thus achieve legitimacy. This demonstrates the power of the motherhood mandate. Maureen is a heterosexual, middle-class, white, married woman, all dominant group characteristics, yet she still does not feel 'legitimate' according to social norms. Not being a mother as a married woman makes Maureen the 'other' within dominant ideology of womanhood, and thus evokes feelings of illegitimacy.

In addition to receiving consistent messages about mothering, higher-class women are also embedded in a singular, dominant notion of life course trajectories (e.g., go to college, get married, have children…). Such trajectories are less normative and more varied within low-income settings. For example, many women have children prior to marriage (Edin & Kefalas, 2005) or attain a college degree while working later in life (McDonough, 1997). Therefore, unlike poor and working-class women, achieving each stage of the trajectory for higher-class women is necessary in order to maintain 'normality.' Becca, a 43-year-old higher-class woman, states:

> I guess I always wanted kids. I always thought you would just grow up and get married and, you know, you go to college and after you go to college, you get married. And then you have kids. That's what's supposed to happen.

Becca wants a child because, according to her, that is "what's supposed to happen" at this particular time in her life. In order to fulfill the prescriptions of her class, having children is the next thing to do in life. This trajectory differs from the lower-class Black women's desire to mother in order to achieve adulthood. For middle and upper-class women, you should "grow up" prior to becoming a mother.

This idea is naturalized within the higher-class contexts. For example, Nadia, a 33-year-old woman, reflects:

> Not because—it's because it's like I mean, "Hey, we're 33." And you look around and it's like, "What? Something's missing." You know, we've been married—we have—long enough that we have had time to do all we wanted to do, you know, together. We have traveled, we have, you know, got—gotten a further level of our—our relationship and it's like, "Okay, now what?" It just seems like the next step. And it is! It's naturally the next step. I mean it's a birth right, right?

For Nadia, becoming a mother is not only a natural "birth right," but *when* you become a mother "naturally" occurs after certain life events are achieved. Traveling, an established

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relationship, and doing "all we wanted to do" was not enough. Unlike lower-class women who did not receive the basic necessities in life and desired children in order to fulfill those needs, higher-class women such as Nadia whose basic needs were met, desired children because kids were "missing" from their adherence to ideological notions of womanhood and motherhood.

Religious motivation for mothering was expressed by two of the higher-class participants. For Nan, a white, 40-year-old, being a mother "was a calling as a married couple that…God desired for us." Dominant ideology is still apparent within such motivation. Like Maureen's drive for legitimacy, heteronormative definitions of family and views of procreation as the purpose of marriage are implicit in Nan's reasoning.

Adherence to social norms is what drives the higher-class women's motivations for mothering. Because of the uniformity of those norms in higher-class culture, there are far fewer types of responses and variation in reasoning among higher-class women when compared to the answers of lower-class women. Additionally, the responses of middle- and upper-class women compared to those of lower-class women were more nebulous. Many middle- and upper-class women had difficulty articulating why they wanted to mother. This reflects the naturalization and embeddedness of the social norms on which their desires are based. The reasons higher-class women want to mother are based on dominant ideologies, yet those ideologies seem so "natural" that they go unrecognized. For instance, Carole, a white, 36-year-old higher-class woman, did not know *why* she wanted to be a mother; but she just "always knew [she'd] be a mom." Similarly, Nadia, a white, 33-year-old, stumbles as she attempts to answer why she wants to be a mother:

> Oh, gosh, that's a hard—that's a good, hard question. I guess for me,
> it's—I mean I have always been rather maternal …—I don't know—you

learn—you use everything you have learned to help make a life of somebody else better. I don't know. I mean I—that's such a hard way to describe…It's—it's hard. It's hard. It's just something that I have wanted more than anything else. Very strongly.

Understanding why women want to mother sheds light on the various consequences that might ensue should motherhood not be attained. At stake for lower-class women is the unfulfillment of basic needs. They will need to look elsewhere to receive love, "hope that their nieces remember [them]" when they require care in old age, and redefine what constitutes their "own" children. In contrast, higher-class women will be required to cope with their "otherness." For many of these women, it is the first time a life goal has not been achieved and the first time they find themselves in a subordinate position (with the exception of their status as women). They will need to reevaluate normality and their place in society. All women, regardless of social position, will need to reconstruct their gendered identity. An instinctual, "innate" desire fails to come to fruition, revealing the unnaturalness of motherhood and the fragility of reproduction.

Conclusion

Higher- and lower-class women receive different messages about motherhood and reproduction. Asking why women want to mother reveals such differences. As reflected in previous research (e.g., Edin & Kefalas, 2005), poor and working-class women were motivated to mother in order to achieve value in their lives that is absent elsewhere. However, comparing such desires to higher-class women reveals the inherent complexity of women's desires to mother. Revealing the ideological basis of the middle and upper-class women's mothering motivations exposes the absence of such within the poor women's stories. This lends support to the theory of cultural heterogeneity: lower-class women receive *both* oppositional and mainstream ideas within their contexts, allowing

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for diverse reasoning and justifications for motherhood. In contrast, higher-class women are presented with one dominant idea from which to draw their mothering desires. Through its qualitative analysis, this study contributes to the theory of cultural heterogeneity by revealing the impact of such ideological differences between class groups and demonstrating its application within individuals' decision making.

Not only does this research demonstrate the role of mothering ideology in shaping individuals' decisions, but it also exposes what those ideologies are. Exposing such norms reveals motherhood as a social institution. For instance, because the dominant discourse is constructed by and based on dominant race and class groups, it reflects their experiences. Poor and working-class women are already the 'other' within such hegemonic narratives, so the achievement of them is unnecessary or unmotivated. However, for higher-class women, the dominant ideologies shape and maintain their social contexts and practices; therefore the higher-class women employ them within their reasons for wanting to mother. So, in addition to the *amount* of ideological notions present within a community, the women's mothering desires are shaped by the *applicability* of the ideologies to their lives.

This study overturns and reveals the naturalization of motherhood. Moreover, it problematizes the essential, gendered nature of mothering. Exposing the class and sometimes race differences in why women want to mother allows us to see motherhood as a socially constructed phenomenon, one that is shaped by the intersection of race, class and gender. It is a contextually-situated institution, identity, and experience. This research supports Rich's (1977) distinction between motherhood as an experience between a woman and her children and motherhood as an enforced identity and political

institution. The participants' experiences of motherhood, or why they want to mother, differ from their dominant portrayal particularly among lower-class women, revealing that motherhood as an experience should be contested and not essentialized.

How women grapple with the contradiction between their own desires for motherhood versus the hegemonic norms at play is demonstrated in the next chapter through analyzing the participants' justifications for motherhood and readiness for children. Doing so reveals how women negotiate with dominant ideologies, and how through such negotiation, they both reinforce and reject those ideologies.

Chapter Three

Negotiating Motherhood: How Women Construct Themselves as 'Good' Mothers

Mothers of all classes have not simply acquiesced to oppression, but have struggled to gain resources needed to nurture and preserve life. They have also asserted the validity of their own knowledge and skill in the face of messages that they were inadequate mothers. For this reason, it is important to look at the other side of the coin, focusing not just on the way women are oppressed as mothers, but on the way they act to assert their own standards of mothering… (Collins, 1994).

Although all the women in this study yearned to be mothers regardless of their race or class, the dominant discourse on mothering only deems certain groups worthy of attaining such a status. In other words, it is not just enough to *be* a mother, but a woman must be a *good* mother in order to be socially accepted. The construction of the good mother is based on a binary, dialectical relationship to the construction of the bad mother. Women who do not meet the idealized standards of motherhood are demonized and labeled the 'other,' allowing those who do adhere to cultural prescriptions of motherhood to be highly valued and thus 'good' mothers (Cooey, 1999).

This hierarchy of motherhood is a classed and racialized project in which economic, social and political circumstances dictate a woman's place within that hierarchy (Earle & Letherby, 2003). Ideologies of womanhood, motherhood, and family intersect to construct the heterosexual, white, middle-class, married woman as the most highly valued mother. All other women fall outside of this narrow good mother ideal, including single mothers, poor mothers, mothers of color, and lesbian mothers. Instead,

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the mothering of such groups is systematically devalued and is the subject of discourses of deviance (Arendell, 2000; McCormack, 2005).

The social construction of these groups as social problems furthers their bad mother label. The parental behavior of poor and working-class women is subject to public surveillance and thus made far more visible than the mothering of higher-class groups. Moreover, poor women are blamed for the "cycle of poverty" in which social problems are linked to the home. In this sense, poor women are 'breeders' of the underclass (Abramovitz, 1995).

Contained within the constructions of bad mothers as social problems is individualization. They focus on individual characteristics of improper mothers rather than the social structural forces at play within their lives. Rather than addressing the poverty, educational and employment disadvantages poor and working-class women face within their communities, bad motherhood is represented as the failure of individual women to properly undertake their maternal responsibilities. Framing it in such a light naturalizes the good/bad binary and reinforces the uniformity of the appropriate way to mother. In other words, the different social contexts in which women live are disregarded, as are the differences in mothering that may ensue. Ultimately, the good/bad binary that permeates motherhood discourses oversimplifies the experience. This chapter begins to examine the nuances within the categories of 'good' and 'bad' mothers and demonstrates the ambiguity of such labels.

Unlike the dominant discourse that individualizes motherhood, the majority of current research on the good/bad classifications of motherhood concentrates on its structural factors by focusing on the construction of the categories (e.g., Breheny &

Stephens, 2007; Woodward, 2003). While this begins to dismantle the blame placed upon marginalized women, it fails to understand the perspective of the women experiencing such labels. Research that does provide a more micro-analysis often focuses on a single group without comparisons. Doing so ignores the differences in the social contexts of women and variation in how women reason about motherhood. It also fails to identify how and why structural forces influence certain groups similarly and differentially.

This chapter expands on past research by comparing mothering desires between class groups. More specifically, it explores how women of different demographic characteristics confront and negotiate with the good/bad mother binary to justify their desires. For instance, given the fact that lower-class women want to mother, but are situated in a context that opposes or discourages such aspirations it is important to understand how they grapple with such a contradiction. The participants' adaptations of their circumstances to adhere to good mothering standards and their use of comparative mothering in which they compared their (hypothetical) mothering practices to others were a few of the ways in which the lower-class women rejected that negative stereotypes applied to them. Recognizing such mechanisms and comparing them to those of higher-class women demonstrates the active, rather than passive, response to mothering among lower-class women.

Weingarten and colleagues (1998) argue that there are three ways in which mothers are marginalized: first, in relation to other mothers; second, in relation to the ideal of the good mother; and third, through the silencing and invisibility of their own contexts and mothering preferences and practices. This chapter examines all three

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components and how the women attempt to overcome and/or negotiate each arena. The findings also reveal how women of the dominant group unconsciously grapple with mainstream ideologies. Such a question is often overlooked since it is assumed that negotiation is unnecessary. But this study exposes that adhering to social norms requires its own negotiation tactics as well. Additionally, the findings identify differences *and* similarities between the groups. In other words, the good/bad motherhood binary is not mutually exclusive. Ultimately, this chapter explores how women adapt to the larger social forces at play: how do lower-class women respond to mothering marginality and how do higher-class women respond to mothering centrality? Studying this question among infertile women is ideal as they are purposefully trying to enter a role for which they are classified as worthy or unworthy of attaining.

Negotiating motherhood

Context matters: Claiming and conceptualizing the 'good' mother

"Despite the pressure on women to bear children due to the idealization of motherhood, just being a mother is not enough; being an appropriate type of mother is crucial" (Ganong & Coleman, 1995). The women's desires to mother go beyond the motherhood mandate. Not only do all women want to mother, but they all want to mother *well*. Interestingly, despite the "myth" of good motherhood (Berry, 1993; Thurer, 1994) all of the study participants believed they are (or will be) good mothers. What I term the "good mother syndrome" permeated the women's discussions about motherhood, regardless of social location. For instance, according to Barbara, a Black, 44-year-old, lower-class woman, the belief that she is a good mother is her reason for wanting children:

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> I have always liked babies, you know, and I thought I would be good at it.
> You know, I thought I had something to actually share with a—a little
> person and, and just wanted it.

Deborah, a white, 39-year-old, lower-class woman, also indicates her belief that she is a

good mother by relaying others' opinions about her potential:

> In fact, everybody always told me, "I'm the one person who should have
> kids." I mean if they're looking around because, you know, I was always
> good with kids…

Similarly, Nadia and Iris, white higher-class women, 33 & 30 years old respectively, also

believe they will be good mothers:

> I think I would be—I think I would be a very good mother.

> I think that I'm good [at mothering]. Not great at it or anything but good
> at it. And so part of me I think is just—wants it innately and part of me
> thinks that it's—I'm good at the job.

But, how do the women define what it means to be a good mother? Examining

their definitions provides an initial glimpse into how the women begin to justify desiring

such a role. Edin and Kefalas (2005) first described poor women's definition of good

mothering as "summed up in two words—being there." They state that this definition of

good parenting is "unique" to the lower classes; however, this two word phrase was the

universal definition for good motherhood among all the women in this study, both poor

and rich, Black and white. But, upon closer examination, what it means to "be there"

varies among the classes and is dependent upon the women's contextual circumstances.

In other words, the women adapt their definitions of good mothering to what they are

able to provide. For lower-class women this includes merely being present in the child's

life, but for higher-class women, being there is much more "intense," indicative of the

intensive mothering ideology—again revealing the higher-class women's adherence to

dominant norms. The women mold their definitions of good motherhood in order to

claim the status.

Veronica, a Black, 27-year-old, and Lynn, a white, 38-year-old, exemplify the

responses given by lower-class women as to what makes a good mother:

> Well, they have to be able to look out for their child. Help with the schoolwork. Don't lay around. Play with 'em. Just be there for 'em.

> I think good moms are ones that show up. And I think good moms are the ones that are able to protect their kids from bad things happening. And I think good moms are there.

"Being there" for lower-class women is composed of necessities and capabilities present

within their own contexts, such as "showing up" and "protecting" children from "bad

things." The women also define good motherhood according to what not to do, such as

"laying around," which they viewed as a predominant trait of mothering exemplified in

their surroundings. Their concerns do not encompass idealized notions of good

mothering such as the amount of interaction in a child's life and the intensity of that

action. Such characteristics, however, are apparent in the responses of higher-class

women, as demonstrated through Courtney and Sarah's responses:

> [A good mother is] somebody who's there and shares almost everything with you. Probably almost too much. My goodness. [My mother and I] did everything together and so it was like we shopped, we cooked, we cleaned. We—she would pick out my clothes. She would help me get dressed. She would take me to church. She would take me to Sunday school. She would do my homework with me. Ooh, boy (cries).

> A good mother is somebody who loves their children unconditionally and who will I mean basically lay down their life for their children. I'm not saying you have to give up your life and give up everything you are. Obviously moms are entitled to have a life and that's why I have my seven best friends. But, you know, someone who is selfless and giving to their children makes a good mother. And there's certain moms who are not able to run and play catch and, you know, you know, people with disabilities or people who aren't physically fit and active. And it doesn't

mean they can't be a good mom. There's ways around everything. It's just having that desire to—to be active and—and—and interactive in your child's life.

The complexity, particularly the *"active"* engagement in a child's life, is inherently different within the higher-class definitions compared to the conceptions of lower-class women. Such *conceptual* differences parallel Lareau's findings on social class differences in mothering *practices* (Lareau, 2003). Higher-class women undertake concerted cultivation, a much more active role in childrearing, compared to the lower-class mothers' actions of the accomplishment of natural growth.

Just as they did when asked why they wanted to mother, the higher-class women adopt or adhere to dominant ideologies around mothering, such as the intensive mothering ideology, when defining good motherhood. Lower-class women, however, focus on what they can provide and the knowledge of what "not" to do as dictated by their surroundings. Not defining good mothering according to dominant ideals is one way the lower-class women are able to overcome their feelings of marginalization. The fact that all women believe they are good mothers, yet define it differently depending on their economic circumstances, demonstrates the potency of the status of motherhood, yet the flexibility in how it is defined.

The classed definitions of "being there" allowed the women to have different determinants of when they were ready to be a (good) mother. Because all of the participants at some point were intentionally trying to mother, they all believed they were ready to undertake the role. For lower-class women, readiness to mother meant less partying as well as the attainment of a job and a house. Higher-class women, by contrast, were ready to mother as determined by the path of normative life stages as well as by

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financial stability. In other words, lower-class women reshaped hegemonic notions of when an individual is ready to mother based on their own circumstances while higher-class women were bound to those notions. The cultural heterogeneity present within disadvantaged contexts may have allowed the lower-class women such flexibility, yet its absence from economically advantaged settings restricted higher-class women's views (Harding, 2007).

The idea that people should not have a child unless they can afford one has been present throughout history. In the early twentieth century psychologist, John Watson, argued that "no one should have a child until she could afford to give the child a room of its own" (Ehrenreich & English, 1979). Despite its entrenchment within mothering discourse, poor and working-class women do not adhere to such prescriptions. Instead, they focus on things they are able to provide and achieve within their constraints. For instance, Rachelle, a Black, 28-year-old lower-class woman, concentrated on her mental state when determining her readiness to have a child:

> Well, a lot of people—I think a lot of people like put [readiness] on finances. I mean finances is a big, huge part of it but I think more like just your mind state because you could have like all the money in the world but if you're not mentally ready, you won't be able to take care of them still. Like some people get, you know, depressed and stuff like that and they have money and you still can't take care of 'em. You might have to hire somebody to help you: nannies or take 'em to family members' and stuff. So I think like if your mind isn't ready, it's no good.

Given the diversity of messages present within her context, Rachelle recognizes the dominant view that readiness is dependent upon finances. Yet, she rejects this idea by claiming that an individual's mental state trumps finances in determining readiness to mother. Doing so allows her to believe that she is ready to "be there" for a child despite her economic circumstances.

Economics, however, was of utmost importance to higher-class women in determining when they should have a child. As Sarah, a 33-year-old, contemplates, "Are we ready for this? Can we really afford this?" higher-class women conflate affordability and readiness when making childbearing decisions. Nan's experience in determining when to have a child further demonstrates:

> And then we got to a point where—where I guess both of us but more so me became more anxious to start trying, you know, kind of ready, you know, to—to try. And really the only thing that was holding us back at that point was—was the income decision, you know, it got to a point where do I continue to work, have a baby, do the childcare thing or try to do it part—try to work part-time or—and then what ended up happening is Rick got offered a full salaried position at the university which provided us an income so that I could leave Ford to be at home full-time. So that's the point in time that we were overjoyed or happy. We were excited and in a position to be able to try to conceive. So.

For Rick and Nan, their readiness to have a child was contingent on the "income decision." Yet, such a decision encompassed far more than just income or money. Nan ideally wanted to quit her paying job so that she could stay at home with the child. Thus, embedded within their timing of childbearing was not only the norm of financial stability but the norm of being a stay-at-home mom as well. This demonstrates the distinct intersection of class and gender. Not only was the decision to have a child contingent on class status, but also the ability to adhere to a specific gendered ideology that places the woman at home.

Interestingly, the primary indicator of readiness to parent for lower-class women was the opposite: it was getting a job rather than the opportunity to quit a job. Overwhelmingly, the lower-class women mentioned having a house and/or a steady job as measures of being ready to mother. For them, concerns about materiality centered around attainable goals rather than fluctuating, inadequate income. As reflected in the

research of McMahon (1995), the lack of money was a "given to which one had to adjust," whereas having a home and a job were more permanent fixtures in one's life. Jewel, a white, 22-year-old, lower-class woman, reflects:

> I think if you have a job and you can take care of yourself then you should be able to take care of another child. If you don't have a job, you're living at home and everybody else is paying for you, it's not their burden to pay for your child, too. And I don't think you should have it in your mind, "Oh, well, the state will pay for this and the state will pay for that." I don't believe that either.

Reflecting on the experiences of other mothers in her community, Jewel believes that having a job makes women ready to mother because it gives them independence— independence from their families as well as the state. Jewel adopts the dominant ideology that eschews welfare dependency, yet she also makes motherhood attainable for herself by linking stability to occupation rather than to income. Similarly, Keisha, a Black, 33-year-old lower-class woman, determines her readiness to mother by adapting her contextual norms to dominant ideals:

> So (pauses) I wanted to at least be grown. I didn't want to be like a lot of young girls is having kids so I didn't want to be like that. And I wanted to be a little bit stable at least a place to stay and, you know, things like that: a job and things like that. So when I—really when I hit 18.

Given a social context in which teenagers are frequently having children, stability to Keisha is having a place to stay and a job. Her immediate circumstances dictate differing norms from the mainstream, including being "grown" at 18 years of age and thus ready to mother. In other words, stability and the criteria for readiness to mother are relative to one's immediate circumstances.

While both lower- and higher-class women discussed money and jobs as prerequisites to parenting, albeit differently, there were certain topics that only arose

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within class groups. Decreased partying is one such characteristic, exclusively

mentioned by lower-class women. Echoing the "motive of redemptive mothering" in

their reasons for wanting to mother, poor and working-class women believe they are

ready to mother when they are no longer interested in the party lifestyle (McMahon,

1995). For example, Tanya, a white, 38-year-old lower-class woman, states:

> I don't know if I just grew up or—or what. … When I was a teenager or
> early 20s and then finally it was like, "Well, I guess it's time to buckle
> down and do what you're going to do instead of just having fun."…I can't
> think of anything that really had happened. Maybe just hearing that from
> my friends growing—growing up and doing the same—not the same thing
> but—but finally had a—a way to go, you know, in life instead of just
> partying or shopping or hanging out or whatever. I think that was it. … I
> already had a good job. I had a good job so I knew about responsibility
> and that part was no problem.

Tanya's peers revealed to her that having children provided meaning to one's life,

something she was ready to attain. As she grew older, she felt that it was time to "buckle

down" and having children allowed her to do that. Tanya also reiterates the importance

of having a job when deciding to have children. Working gave her responsibility, a

necessary characteristic for mothering.

As Rachelle previously mentioned in her rejection of the importance of money to

being a good mother, many lower-class women believe having a stable mental state is of

utmost importance when having a child. Keisha, a Black, 33-year-old lower-class

woman, elaborates:

> A stable life period. Basically it's a stable life. Even if you not with
> somebody and you—… you've just got to have a good life: a good mind,
> you know, you've got to have a good heart. You've got to—because kids
> just not something you just have. You know, you—they there, you've got
> to teach 'em so they can grow and be, you know, so yeah. You've got to
> have a good mind, a house, a home and life (laughs).

Keisha recognizes the fragility and responsibility that come with parenting. Thus, a

"good mind" is necessary in order to teach children. Keisha is ready to mother since she

has a "stable life" which encompasses a good "mentality" and a house.

Higher-class women did not mention mentality or partying when characterizing

readiness to mother. Instead, they continuously mentioned normative life stages as

dictating their fertility timing. Courtney, a 33-year-old, describes:

> I had planned on having children more towards my mid 20s but my
> husband and I weren't in a hurry to get married. You know, we were both
> in school and we both wanted to be out of school and pretty well settled
> and have good careers under our belts before we moved forward with that.

Courtney was not ready to have children until she reached that stage in her life. School,

marriage, career and then children are normative steps within the middle and upper-class

lifecourse trajectory. Adhering to dominant norms, the women knew they were ready to

mother once certain milestones were achieved. Encompassed within this trajectory were

life goals that went beyond motherhood. Lower-class women did not foresee such

opportunities and for many of them, motherhood was their ultimate goal. However, as

Brooke, a 30-year-old higher-class woman, relays, many middle- and upper-class women

were ready to mother once other goals were accomplished.

> I mean I knew I had other goals for myself besides just [having children]
> and I knew I was going to go to college. I knew even going to get my
> Bachelors degree I was going to go back and get a graduate degree. And
> so I had that goal that I—I was going to be educated and successful but I
> knew that once I had completed that or was close to completing that that I
> knew that I wanted to have children. And I knew that was going to be an
> important part of my life and that that—that being educated and
> successful was only going to be a part of who I was but the most
> important thing was having a family like I had when I was growing up.

Brooke had personal goals for herself beyond motherhood. She wanted to attain an

education prior to having children. Additionally, Brooke adopted the intensive

mothering ideology in her belief that she was to make family the center of her life as it was to be "the most important thing in her life." Unlike lower-class women who continuously described circumstances in their lives they did not want to mirror, higher-class women wanted to emulate their own environment, such as Brooke's desire to have "a family like I had when I was growing up."

Not just good, but better: The practice of comparative mothering

In addition to utilizing the ideological and contextual resources at hand to prove their mothering capabilities, the participants also did comparative mothering in which they compared their (hypothetical) mothering practices to others. Women judge their own and others' mothering according to dominant norms of motherhood (Arendell, 1999). While all women practiced comparative mothering, how and why they did so differed by social class. For instance, both class groups compared themselves to 'bad' mothers, yet lower-class women also compared themselves to "poor*er*" women in order to distance themselves from that demographic group. Additionally, only poor and working-class women used comparative mothering to redefine good mothering standards. In turn, such a practice served to simultaneously resist and support stratified reproduction.

Snow and Anderson (1987) first studied how marginalized individuals are typically problematized by their social locations rather than being characterized by their own sense of self. The question of how individuals construct their own sense of meaning and value in a context that gives them none is one that can be applied to the lower-class women and their pursuit of motherhood in this study. Distancing identity work typically occurs when there is an incongruence between an individual's self-concept (e.g., *I* am a

good mother) and her role-based, social identity (e.g., poor women = bad mothers).

Rather than having this social identity placed upon them, the women actively construct

and negotiate personal identities that are consistent with their self-concepts. They often

do so through comparative mothering in which they distance themselves from poor

individuals, negatively connoted social roles, and certain institutions.

Poor and working-class women first compare themselves to their own mothers in

an effort to move away from the 'bad' mother stereotype. For instance, Michelle, a

Black, 25-year-old lower-class woman, discusses how she is a good mother because she

is better than her own mother was to her:

> I love being a mom. That's maybe like one of the one things I am good at
> is being a mother. I'm a way better mother than my mom. I just—I love
> children. I just want to hold 'em. I love breastfeeding. I love everything.
> Even changing diapers. I love everything about—about babies.

Michelle believes that she is a "good" mother because she is "way better" at mothering

than her own mother. This was a typical response for lower-class women, and it was

their first source of comparison and distancing from 'bad' mothers. Jewel, a white, 22-

year-old lower-class woman, further reveals that she can be a good mother because she

knows what not to do given her deprived upbringing:

> I think I'd be a good mother for what I've dealt with through my
> childhood. I know how you're not supposed to treat your kids, I know
> how you're supposed to treat your kids and I just—I would like to be a
> mother. I would—I feel very strongly that I could be a good mother and
> take care of my child. I'd like to show it the world and give it everything
> so.

According to Jewel, she knows how "you're not supposed to treat your kids" due to her

own treatment as a child. Her past context informs her present confidence in her

mothering abilities and allows her to overcome the construction of poor women as unfit mothers.

Beyond their familial situations, lower-class women also distance themselves from 'bad' mothers within their current circumstances. Doing so is one way poor and working-class women justify their desire of a role for which they are constructed as unsuitable. For instance, Angie, a Black, 25-year-old lower-class woman, disassociates herself from the stereotype of 'bad' mother by describing other women in these terms:

> … And there's some people out there who don't want kids and leave their kids on the porch at below zero weather and beat their kids and abuse their kids. Like I hate watching the news. Some of the stuff just kills me. Like God knows I'll probably be the best mother. Why is somebody that would treat their kid like that deserve to have a kid and I can't?

In searching for meaning to her infertility, Angie distanced herself from characteristics of 'bad' motherhood, such as child abuse. Instead, she constructs herself as the "best mother," deserving of a child. These self-representations counter the social constructions of poor women as 'bad' mothers. Angie draws her image of 'bad' motherhood from media depictions. Comparing themselves to these more extreme, well-publicized images allows the lower-class women to detach from their own contexts and thus justify their desire for children. Doing so was commonplace among this group as Lisa, a white, 39-year-old woman, refers to the "Octomom" as the image for inappropriate mothering.

In addition to comparing themselves to sensationalized constructions of 'bad' mothers, the poor and working-class women in this study also identified 'bad' mothers within their own contexts, typically among individuals close to them. Jewel, a white, 22-year-old, describes the deterioration of her friendship due to her friend's poor mothering:

> One of my friends I'm not really friends with anymore. She had a child when she was 17 and that child lives with her grandmother. She doesn't see that child, doesn't come over and spend the night or anything. Like

she's in this life but she doesn't take care of it. And she went out and she has—she's pregnant again and she's going to be due in July and this baby's going to be living with her but her other child's going to be living with her grandmother. And I don't look highly on people that are like that… That's why we're not friends. So. … I just—I know that I would be such a good mother and for her to be able to have a kid, I resent her for her to be able to do that when she's not going to take care of it. And that's like everybody. I even resent my sister a little bit.

Jewel does not approve of her friend's familial situation and current pregnancy. Through her disapproval she is able to distance herself from that type of mothering and construct herself as "such a good mother." Interestingly, the lower-class women utilize *both* dominant depictions of 'bad' mothering, as in the case of Angie watching the news, as well as mothering within their own communities, such as that described by Jewel, demonstrating the heterogeneity present within the poor and working-class environments and the intersection and significance of ideology and context in shaping one's experience.

Higher-class women also engage in comparative mothering, but do so with different intent. For example, rather than criticize and distance themselves from their families of origin, middle and upper-class women wanted to emulate their mothers' actions. Stephanie, a 35-year-old, describes:

We—so [my parents] were very family conscious and I—I could see us doing that as well and longed for those interactions. So I could see that in my future and replicating some of that and the memories, you know, traditions.

Stephanie wants to "replicate" her childhood memories through her own role as a mother. As part of the dominant class, Stephanie is able to maintain her past experiences and not sacrifice the 'good' mother characterization in doing so. Lower-class women, in contrast, must distance themselves from their 'bad' childhoods in order to claim 'good' motherhood for themselves.

Similar to lower-class women, however, middle and upper-class women did distance themselves from those considered to be 'bad' mothers according to dominant norms. For instance, Carole, a 36-year-old, reflects:

> "That scumball has six of 'em. Look, she's not even watching and that one's in the faucet and that one is in the fountain, you know, of the mall. I could take you, you, you, you and nobody would even notice." Not that you would obviously. I'm not saying I'm a kidnapper but you wonder how some of these, you know——some of these kids, you think, "Geez, I'd be doing you a favor (laughs)." Some of these ladies would probably say, "Yeah, go ahead. Take it (laughs). I didn't want her anyway." So (pauses)…

In describing the mothering of women she observes in the mall whose children she should "kidnap" in order to better their lives, Carole implies that her mothering skills are superior. Additionally, through her description, Carole employs many stereotypical characterizations of 'bad' mothers, such as their young age, implied in her use of "kids" and the belief that 'bad' mothers unintentionally have children since they "don't want them anyway." Nadia, a 33-year-old, also compares in such a manner:

> I think I would be—I think I would be a very good mother. ... I could be a better mom with my hands tied behind my back and my eyes closed than some of these idiots I see raising kids. You know, you just walk through the—the grocery store and the way the—the interactions you see between parents and children is just appalling … Nobody is perfect. But I think I'd do a hell of a job and I think I'd do—be a really good mom.

When doing comparative mothering, higher-class women tended to critique women they observed in public places, such as the mall or grocery store. Such venues are diverse in class and race and thus allow middle and upper-class women to interact with people outside of their typical social milieus. Higher-class women are already distanced from the sensationalized news stories that Angie alluded to, and they do not have the intimate exposure to family and friends considered to be 'bad' mothers, so they utilize

comportment in public places as a mechanism to maintain themselves as "better" mothers. Additionally, unlike lower-class women, the middle and upper-class participants used derogatory names to further characterize 'bad' mothers, such as Carole's use of "scumball" and Nadia's reference to "idiots." Perhaps they do so because of the class distance that exists between them. They are allowed to belittle the "other;" whereas lower-class women do not have such a distance with those whom they are criticizing.

While both women of higher- and lower- classes used comparative mothering to distance themselves from "worse" mothers, only poor and working-class women used comparative mothering to distance themselves from an impoverished identity. They needed this additional distancing because of a social identity that conflates class status with mothering ability. For instance, Roxanne, a Black, 22-year-old, attempts to distance herself from the label of being poor by comparing her situation to women in more dire straights:

> My God-sister calls me like, "I'm seven months pregnant." … She's like—but I'm like, "You're 18 and you have two kids now. And you're like not financially stable." I mean at least I am in a place where I can like take care of a baby if I was to have one.

By criticizing her God-sister for "not being financially stable" yet becoming pregnant, Roxanne distinguishes herself from poor women even though she, herself, has an annual income of less than $10,000. In distancing herself from poverty, Roxanne rejects her exclusion from motherhood. But in doing so, she further reinforces the dominant narrative that excludes poor women from 'good' motherhood.

In addition to using comparative mothering to distance themselves from negative stereotypes, the lower-class women also uniquely used that practice to expand the notion

of what it means to be a 'good' mother. Higher-class women, however, did not use comparison in that manner since good mothering narratives are already applicable to them. Such class differences reflect that motherhood is not a fixed characteristic. It is a fluid ideology and relationship that shifts depending on context (Baker & Carson, 1999). For example, Hondagneau-Sotelo and Avila (1997) found that transnational Latina nannies upheld the intensive mothering ideology for their employers who had significant material resources; however, the nannies developed more flexible notions of good motherhood for themselves given their limited finances as well as their physical separation from their children. Thus, through the comparative mothering mechanism, the nannies constructed their mothering as 'good' given their limited circumstances in relation to their employers' inadequate mothering in a context of abundant resources and proximity to their children. The nannies conceived of themselves as good mothers by manipulating the ideology of motherhood and tailoring it to fit their situations.

Similarly, Carrie, a white, 32-year-old lower-class woman, explains how within her context, time spent with children is what determines a good mother. She expands the definition of good mothering by realizing how those who are normatively recognized as good mothers because of their wealth may not live up to that ideal. In this sense, Carrie rejects the dominant narrative that places class at the center of intensive mothering.

> And I know I'm sure people think, "If you can't afford to have kids, then you can't afford to have kids (laughs). If you can't afford to make the kids, then you can't afford to have kids." I mean it's true. I really can't afford to have children. I can't. Does that mean that I shouldn't? My neighbors next door are doing it. I can do it better than them. … I mean really it's not a problem with me. It's a problem with the society that the gap between the rich and poor is so big and I mean I'd like to think that if I could afford a Hummer, I wouldn't drive one. You know, I'd like to think I am more s—conscious than those people. So just because they have money, it's not making them better or better parents … I would

rather live in a trailer and spend time with my children than live in a mansion and—and have to work all of those hours to live in that mansion (laughs).

Carrie acknowledges her exclusion from motherhood according to her social class. However, in comparing her projected parenting style to that of her employers, Carrie rebukes the current narrative around mothering since she recognizes that class and wealth do not equate with good motherhood. In turn, she redefines what it means to be a good mother given her own circumstances and what she can provide. Carrie can "do it better" by reconceptualizing good motherhood in which time spent with children takes precedence over material resources.

Jodi, a white, 25-year-old lower-class woman, also rejects the dominant narrative around mothering and redefines it according to her situation.

> Ann: And have you asked [the doctors] specifically about getting pregnant?
> Jodi: Mm-hm.
> Ann: And what has their response been?
> Jodi: "Are you really ready? Are you sure you want one? It's a lot of work." "I wouldn't be asking if I didn't know that" (laughs)[…] I mean I know it's their job so and they just want to, you know, be cautious because there are so many people that end up having, you know, that's what I don't get. It's like you have people that really want children, you know, even if it—my time is not right now, you know, really want them when the time is right. And then you have kids that have kids or other people that have them and just either do horrible things to them or, you know, just it's—they know they should—they should not have a child (laughs). And they're not ready.

Given her young age, marital status, and low income, physicians have questioned Jodi's readiness to have children. In reflecting upon these encounters, Jodi compares herself to others to reveal how even individuals that may adhere to the uniform understanding of good mothers and thus expected to be ready to have children, may not always be good

parents. Jodi expands the concept of good mothering to emphasize the desire for children. To her, being ready to have children is not based on demographic characteristics, as often purported by dominant narratives and reiterated in medical encounters; rather, it is based on the longing and desire for parenting, in general.

> Ebony, a Black, 34-year-old lower-class woman, sums it up well when she states:
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> Because even people—and it's kind of weird because even people with money maybe don't treat their kids the same as people who don't have money. ...Because just because you have money don't mean you're going to treat people right or just because you necessarily don't have as much money, you might treat people better because you know how it feels to not be as fortunate. So yeah.

To Ebony, being a good parent does not equate with having money. In fact, she employs the same tactic that Jewel did when comparing her mothering to her own upbringing— she turns her misfortune into an advantage and a reason she is actually a good mother, the ultimate use of the contextual resources at hand.

The participants use the practice of comparative mothering in two strategic ways. First, women of both lower and higher-class distance themselves from negative stereotypes of 'bad' mothers by categorizing other women in those terms. This identity work serves to reinforce the binary of 'fit' versus 'unfit' mothers. They accept the ideology, but reject the idea that it applies to them, thereby reifying the very forces that they are trying to overcome. On the other hand, only lower-class women additionally challenge that binary through comparative mothering. They redefine what it means to be a good mother by revealing how current ideological constructs of good motherhood do not equate with adequate parenting, while asserting that characteristics present in their own contexts allow good motherhood to be attained. Interestingly, the groups of women use the same technique, comparison, to both accept *and* reject dominant narratives of

motherhood in an effort to actively resist the stereotype of 'bad' motherhood. The

women construct their own hierarchy of motherhood (Collins, 1990) according to which

other women, who are both richer and poorer than themselves, are more inadequate

mothers than they are.

Conclusion

In a recent literature review on motherhood, Arendell (2000) identified four main

gaps in the research: identities and meanings of motherhood; relational aspects;

experiences of mothering; and contextual settings from within which women mother.

Arendell specifically recognized the lack of understanding around marginalized

motherhood and posed the unanswered question of "How do women actively resist the

dominant ideologies of mothering and family?". The findings in this chapter begin to

answer this question. Understanding how and why women purposefully pursue a status

from which they are excluded or constructed as unfit reveals their negotiations.

Motherhood is neither a trait nor an identity to be gained; it is a relationship that is

negotiated, applied, and constructed (McMahon, 1995).

Indeed, regardless of their race or class, all the women grappled with their social

circumstances and ideological notions to construct themselves as good mothers. The

"good mother syndrome" was achieved through adaptive definitions of what makes a

good mother, demonstrated through the women's readiness to mother, and finally,

through the mechanism of comparative mothering. This study reveals the complexity of

motherhood as an identity, institution and experience. Motherhood is an institution, but

one which individuals adapt to their own circumstances and needs. The multiplicity of

messages present within lower income communities allows them to use both dominant

and subordinate narratives in their negotiations, while higher-class women are bound to mainstream ideas. The women creatively and methodically used their resources and ideological discourses as tools to construct themselves as good mothers.

Beyond these negotiations, the women actively attempt to pursue their mothering desires. In analyzing the women's purposeful pursuits of "trying" to become pregnant, the following chapter reveals different childbearing norms between social classes, once again demonstrating the fragility and diversity inherent within the phenomenon of motherhood.

Chapter Four

Trying to Mother

What kinds of desires people can have, what intentions they can form, and what sorts of creative transpositions they can carry out vary dramatically from one social world to another depending on the nature of the particular structures that inform those social worlds (Sewell, 1992).

In establishing that all the participants want to mother and believe they will be good mothers, this chapter explores how the women go about attaining that role. As is inherent in this study's eligibility criteria, all of the participants "intended" to have children, as they were *involuntarily* childless (due to the inability to become pregnant or carry a child to term) for at least twelve months at some point in their lives. However, the mechanisms used to try to become pregnant differ between women according to their social class. Exploring those differences exposes gaps in current conceptualizations of childbearing intent and ultimately reveals the basis of this intent in class and race norms.

How we define, understand and interpret pregnancy intentions is significant because such measures have considerable implications for health and family policies. Health education programs and interventions as well as sex education are framed by our understanding of fertility intent (Luker, 2006). Moreover, unintended pregnancies are frequently used as a proxy for the reproductive health of a community and are linked to a variety of health and social issues, such as preterm and low birthweight infants (Trussell, Vaughan, & Stanford, 1999).

Despite its potential impact, the way intent is currently measured is inadequate. Typically assessed through quantitative surveys, pregnancies are dichotomized as either intended or unintended. This binary is often conflated with several other variables, such as wanting, trying, desiring, planning, and (in some cases) using contraception (Fischer, et al., 1999). Researchers have found, however, that intention and unintention are not mutually exclusive categories. Moreover, the complexity of childbearing intent does not allow for the term to be cleanly synonymous with other concepts typically used in its place. Augustine and colleagues (2009) found that there is a "continuum of intentionality" in which most pregnancies are somewhere between planned and unplanned. This finding supports the conclusion of the Institute of Medicine's Committee on Unintended Pregnancy that it is "difficult to quantify people's feelings and sort them into categories that hold comparable meaning over time and across social groups" (Fischer, et al., 1999).

Indeed, it is such variability in meaning which leads to the ambiguity surrounding the intention status of pregnancy. Recent research has shown that planning, trying and intending to become pregnant are meaningless to some groups of women, particularly marginalized women. The "conscious action" implicit in the concepts of planned/unplanned and intended/unintended may be absent from the lives of low-income women. Instead, unacknowledged decisions or non-decisions inform their childbearing pursuits, which in turn become categorized as unintentional (Moos, et al., 1997). In other words, conflating intent with 'trying,' 'planning,' or 'deciding' as it is currently conceptualized, removes lower-class women from the discourse of motherhood and in turn labels their pregnancies falsely and negatively as 'unintended.'

Such faulty categorization negatively affects poor and working-class women. "Planned" pregnancies and control over one's fertility are lauded in society, while unintentional pregnancies are constructed as problematic (Barrett & Wellings, 2002; Greil & McQuillan, 2010; Luker, 1996; Nathanson, 1991). Restricting childbearing intent to planning/deciding/trying for a pregnancy excludes economically marginalized women despite their active desire for children. This conceptualization further stigmatizes lower-class women as deviants, while higher-class women, whose practices adhere to the normative conceptions of intent, are seen more positively. In other words, the way we socially construct the "social problem" of unintended pregnancies maintains the stratified system of reproduction within the U.S. (Colen, 1986; Ginsburg & Rapp, 1991). Poor and working-class women are stereotyped as reproductively negligent and unfit to be mothers, while middle- and upper-class, white women are deemed maternally competent and good mothers.

The scholarly literature on pregnancy intentions reinforces such effects. Just as researchers do not inquire about why women want to mother, they often treat the terms "planning" and "intending" as self-evident and unproblematic, and therefore fail to identify its basis in classed norms (Barrett & Wellings, 2002). For example, in determining whether intent influenced experiences of infertility, Greil and McQuillan (2010) asked their participants whether or not they "tried" to become pregnant. By conflating "intent" with "trying" the authors may have miscategorized individuals who do not conceive of their efforts as "trying" despite their purposeful, active pursuit of pregnancy, usually low-income women. Additionally, while current research has highlighted the flaws around dichotomizing intent, it fails to analyze *why* its meaning

differs among women or *why* planning is not meaningful to certain groups. In other words, the nuances of intention and its sociocultural influences are understudied.

One reason for this gap in our understanding is the failure to examine how women themselves understand childbearing intentions (Barrett & Wellings, 2002). Moreover, even when researchers do investigate and identify their perspectives, the race and class dimensions of intent go unnoticed. The few studies (e.g., Augustine, Nelson, & Edin, 2009; Moos, et al., 1997) that have examined how race, class and other demographic characteristics relate to intent do not compare women of *different* races or classes. This gap hinders understanding how class and race matter in reproductive planning and decision making. Finally, pregnancy intentions are primarily studied quantitatively. Quantitative research can lead to broad generalizations about the effect of demographic characteristics on decision making, but overlooks the social, contextual and interpretive components of the concept (Barrett & Wellings, 2002).

By focusing on diverse women, all of whom desire pregnancy, this study demonstrates *why* the current definition of intent is inadequate and *why* various groups of women conceptualize it differently. The reasons behind such differences reveal how women relate to and use dominant ideologies of motherhood and reproduction. The qualitative nature of the research allows us to understand how intentions and desires for mothering are incorporated into everyday discourse and action rather than explicitly inquiring about ambiguous concepts. Examining childbearing intentions among infertile women is particularly advantageous because all of the participants were actively attempting to become pregnant. This reduces the bias found in most research on this subject which asks women who already have children about their intentions to become

pregnant. Such participants' original intentions may be skewed or misreported due to positive feelings after having the child.

Trying to mother

Despite the recent increase in coverage of infertility and reproductive technologies in the media, infertility remains a relatively "silent" issue, particularly in relation to its antithesis, pregnancy. Therefore, most women in the study, regardless of race or class, believed that pregnancy would be an "easy thing" to achieve and had high expectations for success before starting on their journeys. For example, Carrie, a white, 32-year-old lower-class woman, "just thought it would be easy and didn't think anything of it" and Jennifer, a 34-year-old higher-class woman, believed that "getting pregnant's going to be no big deal…that's you know a piece of cake."

Based on this premise of "ease" and with the desire for children in tact, the women undertook various mechanisms to achieve pregnancy. Such mechanisms differed by social class status, primarily around the planning, decision making components of intent. Lower-class women do not "try" to become pregnant in the sense that they do not deliberately plan or decide when or how they will achieve conception. Rather, their actions—not using contraception—imply their desire for pregnancy as well as their purposeful pursuit of it. On the other hand, higher-class women deliberately decide to become pregnant and employ specific technological mechanisms to achieve pregnancy within a certain timeframe. Such differences may reflect variations in the importance of and access to control by socioeconomic status (Lazarus, 1994; Zadoroznyj, 1999). Having a choice is a privilege taken for granted and normalized within discourse around pregnancy intent. The idea that motherhood should be chosen and planned for ignores

the lack of resources and control over sexuality present within the restricted contexts of poor and working-class women (Hill, 2004). The poverty, racism and powerlessness present within their settings cause lower-class women to take a more fatalistic attitude toward childbearing and other life events (Blum, 1999). Unlike higher-class women, lower-class women are able to wait for "god to be ready" for them to have children (Sandelowski, 1991). These controlling vs fatalistic attitudes inform the participants' reproductive behavior.

For instance, lower-class women did not decide when, where, or how to become pregnant; they, instead, waited for the pregnancy to "pop up." Roxanne, a Black, 22-year-old lower-class woman, exemplifies this mentality:

> Because it's like I know a lot of people that it's like, "Okay, well, I'm going to get this job and then I'm going to do this and I'm going to buy this car and then I'm going to try to work on the baby." And it doesn't happen that way. It maybe happens in between or it maybe happens whenever it just decides to pop up. But I don't really think when you plan it—it helps.

Roxanne is aware of the normalized lifecourse trajectory to which higher-class women subscribe. However, within her context, life just "doesn't happen that way;" therefore, planning is seen as meaningless and unhelpful to achieving pregnancy. Roxanne does not undertake the "conscious action" of deciding when or how to achieve pregnancy; rather, the pregnancy itself is the active player or agent that "decides to pop up."

Because of their lack of planning, lower-class women do not deliberately decide to "try" to become pregnant. As Judy, a white, 39-year-old lower-class woman, demonstrates, an explicit conversation outlining childbearing intentions and decisions is not part of her discourse:

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Ann:	So did—was this a mutual decision? Did [your partner] want children as well?
Judy:	Mm-hm.
Ann:	Tell me a little bit about that conversation when you talked about it.
Judy:	Well, I mean we didn't talk about it beforehand so much but we didn't try to prevent it.
Ann:	Okay.
Judy:	But he had—he wanted kids and so did I. He didn't have any kids so.

Judy's quote demonstrates how intent is not equated with planning or decision making. She and her partner fully intended to become pregnant. However, only her reference to a desire to become pregnant hints at such a purpose. My social positioning led me to phrase my questions using terms such as "decision" and "conversation," which were not appropriate for Judy's contextual experience. She successfully reframed my ideas to fit her own circumstances, as she and her partner "didn't try" but the fact that they "wanted kids" implied intent and mutual decision making.

Lower-class women not only did not plan their pregnancies, but they also literally rejected planning because they felt it interfered with nature. The lack of control and the palpable presence of fatalistic attitudes in the comments of lower-class women are especially apparent in their desire to have conception be a "natural" occurrence. Carla, a Black, 31-year-old lower-class woman, reflects:

Ann:	Were you doing anything in particular except just…no contraception?
Carla:	No…I like, you know, didn't try anything extraordinary. I didn't—nothing…I didn't time the day. I didn't know…Because I always felt like, "Okay, if it's going to happen, it's just going to happen naturally, you know."…I don't want to have to—I don't want to have to plan it. It's like, no, I want the—I want to have the feeling at least to—to know it just—it was natural.

To Carla and most other lower-class participants, planning a pregnancy was unnatural.

Such reasoning may be a product of their circumstances in which limited resources and

knowledge restricted how they approached childbearing. Disadvantaged groups typically

do not have the option of exercising choice and control around reproduction. For

example, as Zadoroznyj (1999) found in her study of childbirth, higher-class women's

resources *enabled* them to have reproductive choices, whereas such choices were

unavailable to working-class women, and thus their childbirth reactions were more

passive.

Despite the fatalism surrounding childbearing intent, poor and working-class

women *did* consciously participate in acts to achieve pregnancy, primarily unprotected

intercourse. In this sense, action coincides with intent, yet their conceptualization and

understanding of that action constructs it as natural, and thus, the women do not conceive

of it as "trying." Keisha, a Black, 33-year-old lower-class woman, exemplifies such

reasoning:

Ann:	What do you—do you do anything in particular with your current boyfriend to get pregnant?
Keisha:	No, we're just doing the regular way (laughs)…But we're not doing it really— not really (laughs)—I don't know—nothing crazy but (both laugh) just the regular way.
Ann:	Having unprotected sex?
Keisha:	Yeah…That's—that's about it.

Keisha's statements demonstrate how the lower-class women in the study interpreted

unprotected sex as natural or "regular," thereby constructing any other mechanism of

achieving pregnancy as unnatural or "crazy." Indeed, Tanya, a white, 38-year-old lower-

class woman, equates "charting your temperature or your days or trying to keep up with

when this was or when this was…is kind of like a clinical experiment or something."

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Anything beyond unprotected intercourse was considered scientific, and therefore not natural or according to "god's plan" for most of the lower class participants.

By equating unprotected sex with "natural" conception, the lower-class women may not acknowledge their actions as decisions, but they do recognize the consequences of such actions and undertake them with the intent of becoming pregnant. Ebony, a Black, 34-year-old lower-class woman, demonstrates when she states:

> Because if you're not using protection, you want kids. And that's my motto like, "Okay, if you're not using protection, you do want kids." It ain't—it wasn't a mistake. It's a mistake when you're young and you don't know and when you consciously know and you're an adult, you want kids flat out…

Ebony's "motto" reveals the women's conscious understanding of the choice to not use contraception and the implications of doing so. The lower-class women actively choose not to use contraception with the intent of conceiving a child. However, they do not acknowledge it as a decision or plan due to the naturalization of such action. Another reason that the women ignore their purposeful attempts at pregnancy may be due to their construction as 'bad' mothers who should not be attempting to have children and also because of the stigma attached to unprotected sex—ideas applied particularly to their demographic group. Demonstrating that the women are conscious of their actions is a first step in overcoming such stereotypes and has significant implications for reshaping health and sexual education programs.

Barbara, a Black, 44-year-old lower-class woman, further displays how the women are conscious of the effects of not using contraception and purposefully choose to avoid birth control in order to achieve pregnancy:

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> I am very up front about it that "I'm not using any kind of birth control so, you know, this is what could happen. And if this does happen, this is what is going to happen as a result of it." And so but I just assume by consent. But [my partners are] in by—by actions maybe that there is consent.

Barbara hopes to become pregnant by having unprotected intercourse with several different partners. She is "up front" about her intentions to become pregnant and "assumes" that the act of not using contraception implies the partner's consent. This is clearly a deliberate "plan" to achieve pregnancy, yet Barbara does not conceive of it as such because unprotected sex is viewed as "natural" and associated with casualness and informality.

The white lower-class women also utilized unprotected sex as their mechanism to achieve pregnancy, yet as the prior examples demonstrate, the lower-class Black women were much more forthright in the level of consciousness associated with that decision. Perhaps that is because within the culture of Black poor and working-class women the act of having sex itself is associated with a pursuit of pregnancy. For example, Tamara, a Black, 25-year-old lower-class woman, states, "Well, you know, most young girls the first time they have sex they almost about ready, you know, to get pregnant." Such thinking could be attributed to an "alternative lifecourse strategy" present in Black, low-income communities in which younger childbearing is seen as more acceptable than in white communities due to differing sociocultural constraints and family arrangements (Burton, 1990; Furstenburg, 1987). The increased acceptability of early, nonmarital parenthood within Black communities may allow for an increased ease of discourse around having unprotected sex for the purpose of procreation in comparison to the low-income white women.

In addition to wanting a 'natural' conception, many poor and working-class women rejected planning because it did not fit with their lifestyle. For instance, Ruby, a white, 25-year-old lower-class woman, describes how regimented timing of intercourse does not mesh with the schedule of working-class couples:

Ann:	What about like taking your temperature or—
Ruby:	I have never tried it… Never…We did it so many times, I didn't think there was a moment we could have missed. At all. And if there wasn't a moment we missed, I don't think there would be any temperature time. When he goes to work, I can't call and say, "Come home from work."

Ruby works the dayshift as an aide at a children's center while her husband works the nightshift at a local factory. He is not home in the mornings when it is assumed to be the best time to take one's temperature and subsequently have intercourse if indicated that ovulation is occurring. In the current economic climate of Michigan, many participants were in long-distance relationships, since their partners worked in other states where they could find employment. This was the case for Judy which meant months at a time where she would be separated from her boyfriend which was not conducive to "planning" a pregnancy. Such situations, intimately connected to economic circumstances, were not present in the lives of middle- and upper-class women.

Finally, many lower-class women simply did not know how to "try" to become pregnant beyond unprotected intercourse. They were unfamiliar with mechanisms such as ovulation kits, temperature charts, or cervical mucus observations as fertility aides. Jocelyn, a Black, 20-year-old lower-class woman, demonstrates:

Ann:	—did you take your temperature or, you know, [have intercourse] at a certain time of month or anything like that?
Jocelyn:	Oh, you're supposed to take your temperature? I didn't know you were supposed to take your temperature (both laugh). Really?

Similarly, Veronica, a Black, 27-year-old lower-class woman, states:

Ann: Have you ever like taken your temperature? No?
Veronica: No, I—see, I don't know about that one. You told me something new.

This lack of knowledge may be a result of less information sharing around reproduction and childbearing within low-income settings. Black lower-class women, in particular, do not discuss "personal issues" as openly as their wealthier counterparts (Hill, 2009). Additionally, more restricted access to education and health care within disadvantaged settings hinders fertility knowledge.

Unlike lower-class women, the higher-class study participants explicitly planned, intended, and tried to become pregnant. Whereas the poor and working-class participants, such as Judy, did not have an overt conversation about attempting to become pregnant, higher-class women planned every detail in advance. Doing so is reflective of the normalized lifecourse trajectory to which higher class women subscribe. They are ready to be mothers once they reach a certain life stage, typically after school, career, and marriage. Now that they have reached the childbearing stage, higher-class women attempt to be just as precise with their timing and planning. For instance, Sarah, a white, 33-year-old higher-class woman, wanted to time her pregnancy so that it would not coincide with a holiday: "In the beginning it was like, 'I don't want to have a baby at Christmas so let's not work on it this month. Let's wait.'" Such statements are in stark contrast to the lower-class women who were hoping to have the pregnancy just "pop up" on its own accord. Not only does Sarah want to schedule her pregnancy around certain events, she also considers achieving pregnancy "work" which counters the lower-class women's desires to become pregnant "naturally." The privilege of having choice and

control over life decisions embedded within higher-class contexts yet absent from disadvantaged settings produces the variations in planning.

Higher-class women literally "take charge" of their fertility by researching how and when to become pregnant. Becca, a 43-year-old white higher-class woman, states:

> Well, you know, you take—I was taking my temperature…I read the book *Taking Charge of Your Fertility* and so it tells you how to take your basal body temperature.

Becca researched fertility planning prior to starting to "try" to become pregnant. She prepared for this next stage in her life so that she could successfully conceive; much like one would study for an exam in order to attain the desired grade. It gave her the sense that she was in control of how and when conception would occur, unlike lower-class women, such as Jocelyn, who did not know how temperature was related to fertility.

The messages and practices prevalent within one's context become the "norm" to those living within that context. For lower-class women, the norm around childbearing intent was unprotected intercourse; whereas the norm for higher-class women included more technological mechanisms of "trying." The differences reflect variation in the social and cultural context of pregnancy. They also demonstrate that the current definition of unintended pregnancies is inadequate, since it is based on middle-class conceptions of the "normal" practices associated with fertility intentions. Colleen, a white, 44-year-old higher-class woman, reflects on such middle- and upper-class ideas:

> You know, we did sort of the normal stuff. I mean at first we were just having fun. And then, you know, then I'm like, "Okay, well, I did a little reading. I got, you know, a couple of books." And, you know, we'd go to Borders and pull out all the books on the shelves and my husband would sit there with a stack of, you know, accounting or hunting or something and I'd sit there with a stack of fertility books. And, you know, I tried a few dietary things, although I've never been great at that. And then we did, you know, started doing the temperature. And really, you know, I

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have always been a pretty re—I have always been pretty regular but just really was, you know, zoning in on exactly my—the number of days in my cycle and the temperature fluctuations and, you know, buying, you know, a zillion different thermometers until you found the one that seemed the most accurate. And so that's what we did at first. And I, you know, I honestly didn't expect to get pregnant right away as much as I'd hoped that I would. I certainly thought I would within six months.

To Colleen and many other higher-class women in the study, the "normal stuff" of attempting to conceive included reading about fertility, diet alterations, temperature taking, and ovulation charting. Moreover, Colleen's explanation demonstrates other fertility norms, such as the belief that the woman is responsible for planning a pregnancy and the expectation (or "hope") that achieving pregnancy would be a relatively easy and quick process, attainable within "six months." In other words, there is a different sense of normal for the class groups. Colleen's preparation for childbearing differs dramatically from the lower-class women's desires to become pregnant "naturally" through the norm of unprotected intercourse. Such differences demonstrate that motherhood and reproduction are socially shaped by the intersections of race, class and gender.

Recognizing childbearing difficulties

The research by Augustine and colleagues (2009) is one of the few studies that examines fertility intentions among the economically marginalized. With a focus on lower-class *men's* intentions, the authors conclude that despite the fact that most men's pregnancies are categorized as 'unintended' due to a lack of an explicit plan, the "analysis suggests that among those with ['unintended'] pregnancies, children might be at least ambivalently and even actively desired." Indeed, my study confirms their

intuition through studying *involuntarily* childless women in which that active desire is present.

   This purposeful pursuit of pregnancy is demonstrated by examining the participants' realization of their childbearing difficulties. They do not achieve their intended desire, pregnancy, and in turn, recognize that something is 'wrong.' Because women differ in the mechanisms they use to achieve pregnancy, how, when, and why they recognize their childbearing difficulties varies between the social classes. Given lower-class women's less controlled and cultivated attempts at becoming pregnant, most did not think much about *not* becoming pregnant for quite some time. Erin, a white, 37-year-old lower-class woman, is one example:

> I mean it didn't actually occur to us that something might be wrong or different. … And I don't think it was our main focus…We didn't miss a beat and we didn't try fertility, you know, we didn't try birth control of any sort so we just assumed it would happen eventually.

Because of her belief that unprotected sex is natural and her fatalistic understanding that pregnancy would happen on its own accord, Erin "just assumed [pregnancy] would happen eventually." The lack of planning among lower-class women allows more time to elapse before they recognize "that something might be wrong" since they are not adhering to fixed schedules or timelines. For instance, "two and a half years" go by before Barbara began wondering "what's going on here," while "three to four years about" passed before Ebony started asking "why am I not getting pregnant?".

   Having unprotected intercourse for such an extended period of time without conceiving was the first indication of childbearing difficulty for many of the poor and working-class participants. Donna, a Black, 33-year-old lower-class woman, states:

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And then it probably was like three years into it—three years into it it was like, "Whoa. Wait a minute. We ain't got no kid yet."

After avoiding contraception for three years without becoming pregnant, Donna realized that there might be an issue. Recognizing the issue implies that she was "intending" to become pregnant with unprotected intercourse, despite the lack of decision making or planning inherent within the dominant definition of intent.

Similarly, Carla, a Black, 31-year-old lower-class woman, recognizes her childbearing difficulty due to time passing:

> Like we was like, "Okay, if [pregnancy] happens, then okay, we're okay" kind of like … but one day—and I told him. I said, "You know, for the amount of sex we have (laughs), you know, you would think." That's what got it started: a conversation like that. It's surprising of all of these years we have never had a, you know."…And I think that was what sparked it. My mind started (snaps fingers) ticking like, "Yeah, you know, we haven't." And anybody else who would be in this situation would have been back and fourth three-four times by now." Really. It was really got me like that. But yeah, that's what started it.

Carla reflects on her fatalistic attitude towards pregnancy, yet her implicit desire to have a child. Such casualness and passivity allowed "all of these years" to pass before Carla realized that infertility might be an issue. When the lower-class women wait for a pregnancy to "pop up" on its own, they rarely monitor how much time elapses despite their active desire for children.

In addition to having years of unprotected intercourse with no effects, the lower-class women also recognize their childbearing difficulties due to friends' and family members' pregnancies during the period they, themselves, tried to become pregnant. Jodi, a white, 25-year-old lower-class woman, explains:

> Ann: When did you first realize that it was difficult for you to become pregnant?

Jodi: Well, I had a theory all along because I didn't lose my virginity until two weeks after I turned 18. And then, you know, everybody—everybody around me: younger, older, my age, you know, every time I see 'em, they have a child or they have another child and another child.…But yeah, I—I mean there's obviously if you have unprotected sex and you're pregnant and like I never have. And I have—I have had unprotected sex. Yeah. You know, in my time and it just—it never happened…

Jodi assumed that after losing her virginity and having unprotected sex she would become pregnant. This was the norm within her community, since "everyone around" her has children through those means. Jodi may not have "planned" for a pregnancy, *per se*, yet after having unprotected intercourse and "never" becoming pregnant she realizes her difficulties, implicitly acknowledging her intentions.

Unlike lower-class women who "do not think much about" becoming pregnant and have a large lapse of time before recognizing any childbearing difficulties, higher-class women realize their issues quickly and think about them actively. For instance, it took Brooke, a 30-year-old, "three to four months" before she "first started kind of questioning" if there was a problem conceiving, while Becca, a 43-year-old waited "maybe five months" before becoming concerned. Despite the quick recognition that something might be 'wrong,' most higher-class women waited about one year before seeking medical consultation for infertility. Linda, a 43-year-old higher-class woman, reflects:

And so then we just, you know, didn't try—I mean we did—we kept trying and then probably when I was about a year—I think I was married about a year when we went to the fertility doctor and he did all kinds of tests…

Linda had internalized infertility as a medical issue. In turn, she, like many of the higher-class participants, waited one year to seek medical care, since the medical definition of infertility is one year without conception.

While the poor and working-class women realized their fertility issues with the passage of time, a more passive acknowledgement, higher-class women take a more active role in understanding their difficulties through research. For instance, Sarah, a 33-year-old higher-class woman, explains:

> [I started researching on] the Internet…Driving me up the wall. Yeah. Yeah, it was—yeah, it was really the Internet because I don't think I really knew anybody that—none of my friends have had this. So yeah, I think probably about six months. I was like, "Yeah, you know," and then it's my husband saying, "Don't worry about it. It's normal. It could take a year. It could take over a year." But yeah, then the worry sets in so. And you can't turn that off.

After "about six months," Sarah began to "worry" that something was wrong. Because she did not know of any friends who had difficulties becoming pregnant and her husband's internalization of the medicalized view that infertility should not be an issue until one year of "trying," Sarah turned to the Internet for an explanation. She actively sought out information rather than waiting for time to pass.

Iris, a 30-year-old higher-class woman, similarly undertook research in order to understand her fertility issues:

> And but then after six months it felt like it was not on—I don't know—I—I'm a winner and I like to succeed and I felt like the—the—our goal wasn't happening…And I did way more research online. Like fanatical research online about when I could—we should have sex and—and other people who were having this and if I should be concerned yet and it didn't seem like I should and so.

Iris was accustomed to being a "winner" and "succeeding" at things in life. The control and choice she usually was able to exercise were not inherent within her childbearing

experience. Research helped her try to regain control in order to achieve her intended "goal" of pregnancy.

Conclusion

"Unintended pregnancies" are demonized in the U.S. and are indicative of irresponsible reproductive behavior, and thus used as a marker for the reproductive health of a community. Policymakers, health educators and researchers, alike, generalize about the phrase and its conceptualization, not taking into account potential differences between women, their contexts, and their interpretations of meaning. This study reveals the necessity of doing so, since there are dramatic differences in childbearing intentions across race and class groups. More importantly, the findings explore why and how fertility intentions vary between women of different social locations. Ultimately, exposing such variation begins to deconstruct the normative understandings of intent and reveals intent as a socially constructed phenomenon, based in race and class norms.

How women interpret fertility intent is dependent upon the context in which they live. Indeed, higher-class women subscribe to the dominant norms of intent in which deciding and planning for one's childbearing aspirations are inherent in its definition. This conception reflects values present within the contexts of those with resources and power: choice and control. Higher-class women attempted to control when and how pregnancy would occur by utilizing various technological mechanisms to become pregnant, timing their pregnancy according to normalized lifecourse trajectories, and researching why they might be experiencing fertility issues. Choice and control, however, are taken for granted privileges not characteristic of more disadvantaged groups (Dillaway & Brubaker, 2006). Therefore, lower-class women, not privy to having choice

for most of their life events are more passive about becoming pregnant. They employ a fatalistic attitude towards pregnancy, such as through the use of "naturalized" unprotected intercourse in the hopes that pregnancy will just "pop up." Yet the intent to become pregnant is still ever-present within their actions as demonstrated through their conscious acknowledgment of the effects of unprotected sex and their realization of childbearing difficulties after those effects are not ascertained.

In addition to contextual influences shaping differences in intent, there may be ideological ones as well. For example, many teens do not use birth control because it would imply that they plan or intend to engage in sexual intercourse, which dominant narratives construct as amoral (Brubaker, 2007). Similarly, for lower-class women and women of color, admitting to deliberately planning a pregnancy when they are ideologically constructed as bad mothers is socially unacceptable. Therefore, by letting pregnancy happen on its own or at "god's will" is a way for the marginalized women to compromise hegemonic motherhood. They are able to satisfy the "motherhood mandate" by having children, yet not claim their purposeful pursuit of a negative stereotype. In other words, the lower-class women are able to claim a "modicum of respectability" by not intentionally planning a baby, but passively accepting one if it should come along (Augustine et al., 2009).

One of the only studies (Moos et al., 1997) examining pregnancy intentions among low-income women concludes that "intendedness of pregnancy is not a valued health belief for women of low and marginal income." I would argue, however, that intent *is* a valued health belief for lower-class women, but not within the confines of its dominant conceptualization. Researchers need to move away from reifying the

generalized notion of intent as incorporating planning and decision-making. Instead, we must acknowledge variations in meaning and incorporate more affective dimensions into our understanding of childbearing intendedness. Currently, poor women and women of color are misrepresented as having a high prevalence of unintended pregnancies. By broadening our conceptualizations of intent to incorporate women living in different social contexts, we may begin to bring marginalized groups back into the motherhood discourse.

By exposing how intent is differentially conceptualized and understood by women of various classes and races, this study has the potential to inform public health policy, programs and interventions. Not only does it reveal the potential miscategorization of unintended pregnancy and where resources should be targeted, but it also allows us to develop health behavior interventions and sex education programs according to the needs and desires of particular populations and their reproductive practices. There is an extensive literature on the maternal and child health effects of unintended pregnancies (e.g., Crissey 2005; Gipson, Koenig, & Hindin 2008; Hellerstedt et al. 1998). By expanding our knowledge of intent, the findings revealed in this study will improve our understanding of the impact of intent on health and streamline research efforts. Additionally, family planning programs can be designed to use terms that are appropriate to women's circumstances by building upon cultural understandings of reproduction and intention. Moreover, having a more accurate understanding of women's pregnancy intentions will provide a more precise estimate of the unmet need for contraception.

Chapter Five

The Lived Experience of Infertility

The context of infertility is central to experiences of it. By taking account of contextually determined experiences we are able to go further in understanding the range of experiences (Jones & Hunter, 1996).

Infertility is an experience in itself and should be studied as such. It "is not something in which there are 'social factors;' it is itself profoundly social as a phenomenon for study" (Schneider & Conrad, 1983) Childbearing difficulties take place, not solely within doctors' offices as past literature and stereotypes have implied, but within the context of women's everyday lives (Jones & Hunter, 1996). Therefore, it is important to investigate how and why social and cultural factors shape the infertile experience. *Social* context in particular is especially influential in shaping an individual's understanding of and reaction to childbearing difficulties (Miall, 1985).

Most infertility research does not study infertility as a social construction; it objectifies it as a medical issue (Greil, Slauson-Blevins, & McQuillan, 2010). One effect of medicalization is focusing on an issue's treatment. For example, popular discourse on infertility focuses on its solutions, such as in vitro fertilization and other reproductive technologies, rather than hearing from the women who are experiencing infertility (Jones & Hunter, 1996). Many sociological studies on medicalized issues, such as infertility, conflate illness experience with patient experience. As infertility becomes medicalized, medical institutions and ideologies inform the context in which it is experienced. In turn,

the "sufferers" of infertility are transformed into "patients" (Greil, 1991). This is especially true for infertility research, as the majority of studies recruit participants from medical clinics, resulting in samples composed entirely of patients.

Recruiting participants in such a manner, while convenient, results in homogenous samples of white, higher-class women. Doing so generalizes infertility experiences, which in turn, diminishes the importance of context by treating the infertility experience as invariant or taking the dominant group's infertility experiences as a proxy for the experiences of all women (Kirkman & Rosenthal, 1999). But, experiences of infertility do vary, as there are many "infertilities" (Sandelowski, 1993). Infertility does not discriminate along race or class lines, yet the context in which it is lived is dependent upon such factors, and thus infertility varies accordingly (Dillaway & Brubaker, 2006).

This chapter reveals the influence of context on infertility, particularly examining how one's *human* surroundings can impact and shape infertility experiences. Hill Collins (1994) found that emphasizing the "social base" of infertility and reproduction requires a focus on variation rather than the universal. Thus, this study demonstrates how experiences change by class status, revealing infertility as a unique, variable process that cannot and should not be generalized among all women. As women researchers of color have noted, it is necessary to place marginalized women's experiences at the center of analysis in order to recontextualize infertility; otherwise, race and class become invisible when white, middle and upper-class women's experiences remain prominent. Through race and class comparisons, this chapter allows those dimensions of context to "stand out in stark relief" (Glenn, 1994). More specifically, differences in peer context, marital

norms, social support, and disclosure expose the social construction of infertility as it is based in intersectional ideologies of race, class and gender.

<u>The lived experience of infertility</u>

Internalization of norms

As I argued in previous chapters, despite sharing an equally high prevalence of infertility, poor women of color are constructed as hyperfertile, while infertility is stereotyped as primarily affecting white, middle- and upper-class women (Inhorn, Ceballo, & Nachtigall, 2009). Both women of higher- and lower-class in this study internalize those inaccurate stereotypes, which shapes their experiences of infertility. For example, Rachelle, a Black, 28-year-old lower-class woman, states:

Rachelle:	Mm, (pauses) 'cuz like pretty much brought up when I ever heard about someone not being able to have a child, they would always been white. I had never personally met or interacted with an African American woman that couldn't. .. I said, "Why did I have that image in my head?"
Ann:	Right.
Rachelle:	I don't know. I really—I think just because as far as like TV or books or magazines, every time there was an issue, I always would see a white woman.
Ann:	Mm-hm. Yeah. And do you know of any black women who are having issues?
Rachelle:	Personally, I don't…Mm-mm, I don't know of any personally.

The image of infertility as being a white woman's issue was normalized for Rachelle, in the sense that she "does not know" why she conjures up such a picture when thinking about infertility. Moreover, the stereotype is perpetuated by the media and infertility's (seeming) absence from her own context. Media references were commonplace among the lower-class women in the study. Shows such as *Jon and Kate Plus 8, Oprah, The*

Baby Story, and the Lifetime Channel were frequently mentioned when discussing

infertility. Bonnie, a Black, 33-year-old lower-class woman, gave one such example:

> Ann: Do you know anybody who's had difficulty?
>
> Bonnie: No. Only what I've seen on television…You know, when I do think about it, I do, yeah, about Oprah she did. But that's on fertilities and then trying to get pregnant but as far as like, you know, like a show actually why or information out—I mean I may be out there. I don't think it's easily accessible—you know, to find out, "Okay, what is it that women at these certain age, demographics or whatever can't have kids?"

Bonnie actively seeks out information about infertility from shows such as *Oprah*. Her

only reference for what the "infertile person" looks like is through the media, which

typically reifies it as occurring among the dominant group. Like Rachelle, Bonnie does

not personally know anyone who has had childbearing difficulty, which compounds her

notion of infertility as occurring among women of other demographics.

Similarly, Nadia, a 33-year-old higher-class woman, internalizes the norm of

infertility as a white, wealthy woman's issue:

> … I think that a lot of the minority classes have less problems with infertility and it's bad enough when you're going through it as Indian or white but what about when you're in a race where nobody has that problem? …Now whether that doesn't necessarily translate to fertility problems. And same with white women I think have a higher percentage of problems than Hispanic or white—or—or black or Asian. I think it would be worse in the other cultures. In fact, my friend without the fallopian tubes is black and she doesn't know anybody that is going through what she does. I have a friend who is Chinese. It's among the lowest infertility rates and she doesn't know anybody who is going through what she is, who is—who is Chinese. I think then socio-economically also it would be much more difficult. It's really depressing going to the RESOLVE thing and one of—I mean one of the things not to mention the other things but—but a lot of the talk was about how they couldn't afford and then they didn't have insurance because they didn't have jobs and I'm like—Jay and I walked out of there and I'm like, "Wow, we're lucky because at least even though my insurance only covers 50, at least that's part of it and at least I have a job." … You

know. You know, at least I am in a job where I can go in to work a little late because I had to go in to my fertility clinic…I think it would be a lot more difficult depending on—because there is nothing. Like if I didn't have the funds to do this myself, I'd be—I'd—I'd be out of luck.

Nadia believes that the experience of infertility would be different for women of different race and economic means from herself. She has internalized the stereotype of infertility as an issue among women of her demographic: white and high-income. Additionally, that stereotype is perpetuated by her friends of marginalized racial groups who also believe that infertility is a white woman's issue, since they do not know of anyone of their race who is infertile.

In addition to internalizing the norms as to who is infertile, the participants also internalized the gendered norm that all women mother. Previous chapters revealed the naturalization of the motherhood mandate. The women believed their desire to mother was innate and a natural part of womanhood. The internalization of this pronatalist ideology causes all the women in the study to feel alone and marginalized. However, for lower-class women this is compounded by the belief that infertility only occurs among white women of higher classes. In other words, higher-class women are marginalized within motherhood and thus womanhood, whereas lower-class women are marginalized within both motherhood *and* infertility itself. Poor and working-class women must challenge two dominant stereotypes: that all women are mothers and that all infertile women are higher class (Letherby, 1994).

Peer context

Studying the social surroundings of the participants examines how the internalization of these norms plays out and is compounded by contextual circumstances. For example, in Brubaker and Wright's (2006) study of teenage pregnancy, the teenagers'

interactions with others were shaped by the dominant, internalized norms around teen pregnancy that construct it as a negative life experience and identity. Infertility is also intimately connected with social functioning and relationships. Sandelowski and Jones (1986) found that infertile women struggle with socializing in a pronatalist culture. But such effects vary depending upon one's social location. The cultural heterogeneity that may be present within lower-class settings differentially shapes how low-income women experience infertility in relation to their personal surroundings compared to the more homogenous narrative within higher-class contexts (Harding, 2007). Pronatalism informs how higher-class women react to infertility, while poor and working-class women are faced with that dominant ideology *combined* with other norms within their contexts. Earlier childbearing, higher frequency of children and fewer life goals uniquely shape the poor and working-class women's responses to infertility.

Reflective of the internalization of the stereotype of infertility as a white, wealthy woman's issue, the lower-class women do not know many others with infertility. Tiffany, a Black, 22-year-old lower-class woman, reflects when asked if she knew of anyone who was infertile:

> Mm-mm…Nope. I sure do not. No. Like everybody in my family has at least one. Everybody.

For the few lower-class women who do know someone with childbearing difficulties it is typically someone at a distance with whom they cannot identify. For instance, Judy, a white, 39-year-old lower-class woman, describes her "distant cousin" who has experienced infertility:

> I have—I have a distant cousin and she had fertility issues but she's like really her and her husband are really overweight like they weigh like 500. She weighs like 5—4 or 500 pounds and she's allowed to have gastric

bypass. [The doctors] just approved her but they like spent every last dime they had for in vitro because they kept trying and trying and I don't know if it had to do with her weight.

Judy only knows of this one "distant" relative who has had childbearing difficulties. She is unable to relate to her cousin's experience, as Judy can not afford IVF and she does not consider herself to have the same weight issues. Instead, Judy distances herself from her cousin's fertility troubles by focusing on those differences.

In addition to not closely knowing anyone who has experienced infertility or childbearing issues, the lower-class women live in a context in which most of their peers have children, furthering their feelings of marginalization. As a "normative reference group," peers significantly influence the norms, attitudes and values of individuals due to their proximity and direct interaction with each other (Cocanongher & Bruce, 1971; Hyman, 1942; Kelley, 1947). For instance, Donna, a Black, 33-year-old lower-class woman, wanted to "get on the bandwagon" because "everybody was having 'em and everybody was getting together, you know, having kid parties and stuff so it kind of made them—me feel a little left out." Candace, a Black, 41-year-old lower-class woman, echoes Donna's feelings:

I just always thought something was wrong, I was different. I knew I was different because all of my friends had babies. And you'd see 'em in the grocery store with their children and different things. So I knew something was different (laughs).

These feelings of "difference" may be attributed to practices and norms inherent within low-income communities. Gabriel and McAnarney (1983) found that poor women have fewer life goals than middle- and upper-class women. Adult roles other than motherhood are viewed as inaccessible and are therefore less valued. As Ebony, a

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Black, 34-year-old lower-class woman, explains, motherhood is the primary identity, role

and action for women in her demographic group:

> But then it's more like my friends and their—them having a lot of kids, it's like, "Okay, we have kids. That's what we do." Like, you know. .. to have kids was just the norm. That's the norm like, you know, you might have a kid by this guy, this guy, which is—that's not classy or that's very nasty, they call it or people say it. But some people do it to start a family or do whatever they—whatever plan they have is why they do it. You know.

Having children is what women in Ebony's community "do." It is the "norm," and thus

the focus of their life goals and behaviors because other rewarding activities, such as

occupations or hobbies, are not attainable. Such limited aspirations and fulfillments

cause the childless lower-class participants to no longer relate to their peers. They do not

have a variety of life events and occurrences to discuss. For example, Jocelyn, a Black,

20-year-old, explains that she "don't have nothing in common with [my friends]

anymore." Ruby, a white, 25-year-old lower-class woman, further elaborates:

> It's—I don't feel socially accepted sometimes because all my friends now have children or are settling down and have children. None of them have problems I guess. And I have quite a few friends…But I don't feel socially accepted in any way… I can't bond with the adults [at work] because I just can't. I have—and I ha—what (crying)—what interests do I really have to them if they're—have families? I have—me and my husband have barely any (pauses) friends work-work related and I—other than high school friends that I have, we don't have any friends that we can go out and go, "Let's go have a drink because we have interests. You know, because we have families. We—we can't do that." We tried joining a bowling league right here and trying that and that fizzled out. You know. We either are too young for the people or we don't have kids and we're not family. We're odd ball. It just—I just—I just—a horrible thing.

Ruby feels that she and her husband are "odd balls" because they cannot fit in socially.

People their age all have children and those without children tend to be too old to share

similar interests. Ruby's social isolation is a product of her circumstances. With fewer

life goals, low-income women have a more difficult time relating to each other on interests beyond mothering. Additionally, this is coupled with earlier childbearing norms in which poor and working-class women have children at younger ages which leaves fewer childless couples in middle age (Burton, 1990; Furstenburg, 1987). In other words, in addition to feeling left out because most of their peers have children, the lower-class women can also no longer relate to their peers.

The earlier childbearing norms among those of lower-class settings cause even the participants who were eventually able to have children to feel abnormal. Their fertility difficulties delayed their childbearing, leaving them older at first birth than their peers. Barbara, a Black, 44-year-old lower-class woman, reflects:

> Sometimes you feel I guess it would be just left out. You know, when all of your other friends because my—my peers, my friends, my college friends and everything, their kids are now, you know, at least—at the—at the very least, in their tee—in their teens. But, you know, most of them have children who are adults. You know, when I say adults I mean 18 plus years old. So and here I am with a two-year-old. You know, so, you know, it—it's a—it's a lonely place to be because again, you don't have a lot of parents but not a lot of parents around you who are in the same place…. I don't have a lot of friends who have young children.

Barbara is "lonely" because most of her friends have older children while she is the mother of a two-year-old. Laura, a white, 40-year-old lower-class woman, reiterates Barbara's concerns:

> So that hurt seeing the family, you know, my nieces having kids when I should have been having 'em. Like now my sister, she's raising her grandson and he's two years older than Molly, you know, so she's raising her grandchild and I'm raising my daughter.

Laura "should have been having" children earlier according to the norms of those around her, but her infertility made it impossible to do so. As a result, she has difficulty relating to family members who are at different life stages.

In addition to early childbearing norms and fewer life goals, the low-income women's norms of "redemptive mothering" in which they believe that motherhood will cause them to mature also shape their infertility experience in relation to their social context (McMahon, 1995). For example, Tanya, a white, 38-year-old lower-class woman, relays:

> …My friends growing—growing up and doing the same—not the same thing but—but finally had a—a way to go, you know, in life instead of just partying or shopping or hanging out or whatever.

Tanya was jealous of her friends' ability to "grow up" after having children. She felt that she was unable to achieve the same stature due to her childless state. Candace, a Black, 41-year-old lower-class woman, expresses the same concerns:

> …All of my friends growing up were having babies and I mean that could have been good for me but I didn't think that at the time. They was having babies, moving out of their moms' houses, getting apartments. So I moved down out of my mom's house and got with my boyfriend. But I always still wanted a baby. And I think it affected me in some ways in my life. I'm still a big kid. I look younger for my age and I act younger.

To Candace, her friends were able to grow up as a result of having children. She seems to yearn for their more "adult" lifestyle and believes that her childlessness causes her to remain a "big kid." Her statement also reflects other social norms within disadvantaged communities: "all" of her friends have children and they had them at younger ages when they were still living with their mothers.

The infertility experiences of higher-class women diverge from those discussed among lower-class women due to differing norms within their communities, such as more delayed childbearing. Like their poorer counterparts, middle- and upper-class women do not know of many others with infertility, which attests to the silence and invisibility of infertility as a social problem. However, unlike lower-class women,

higher-class women are able to relate to those that they do know or the images they see because the stereotype of infertility matches their demographic characteristics. For instance, Sarah, a 33-year-old, states:

> I mean I heard of people that I kind of knew growing up and my mother would say, you know, "So-and-So had to go to wherever and have *in vitro*." And I was like, "Oh, wow." You know, but there was no—no, I didn't know anybody. Nobody close. And now there's only—it's only two really. The one I work with and the one I used to work with who I don't really talk to but she and I had one conversation about it recently. Because another friend who I do stay in touch with had said, "You and Jen should talk" so we just got on the phone one night and talked for an hour and she actually had gone to the exact same doctor that I am seeing now so we had very similar—but no, I didn't know anybody. This was like really foreign because I really didn't think that it would ever happen to me.

Even though Sarah did not know anyone "close" to her that struggled with infertility, she was aware of women in similar circumstances who experienced difficulties in childbearing. Acquaintances of Sarah's mother and friends provided Sarah with an image of the characteristics of women who experience infertility although she did not know these women well. Indeed, she had "very similar" experiences to a friend of a friend so could relate well enough to her to "talk for an hour." This contrasts with Judy's experience of distancing from her obese cousin.

While the lower-class women felt like they did not fit in with their peers due to early childbearing norms and limited life goals, higher-class women felt marginalized because they failed to conform to the dominant norm of pronatalism. For instance, Nadia, a 33-year-old, states:

> I, you know, I have never had mine…and it's really hard because it's always around you. You know, it's like it's not like you can avoid it. You know? It's not like you can shield yourself from it. You go to work and people are talking about kids and you turn on the TV. People, you know, there's kids commercials, you know, you drive down the freeway

and there is-- I just today saw, you know, about this hospital being great for, you know, delivering babies and I mean it's all—everywhere and especially in the last few years it's fashionable to have kids. Now it's the thing. I mean ten to 15 years ago you didn't see it, you know, on *People* magazine. Now it's the thing to do.

Pronatalism has become naturalized within Nadia's surroundings. Billboards, television and magazines all display children, families and mothers to the point where Nadia cannot "avoid it." Due to her race and socioeconomic status, Nadia is part of the dominant group that is typically reflected in the media. Unlike lower-class women on the margins of motherhood, who refer to not fitting in with their peers, Nadia expresses not fitting in with society at large.

Additionally, the norms present within higher-class contexts allow the middle- and upper-class women to still be able to relate to and fit in with their peers. For instance, rather than having children at younger ages, higher-class women live in an environment in which delayed childbearing is normal. This allows many of the high-income participants to continue to have many childless friends unlike the poor and working-class participants who found themselves isolated. Sarah, a 33-year-old higher-class woman, states:

> I still have quite a few [friends] that don't [have children]. People that just haven't worked it into their schedule to start trying or they're a little younger or I have—we hang out with quite a few people who are much older, some not married and some that were never able to have kids for other reasons. So yeah, there are lots of people that we hang out with that don't have kids, too. So yeah, I don't get that so much 'cuz they're not constantly in my face. Yeah, so I guess that's good.

Sarah, unlike Ruby, does not feel like an "odd ball" because she has friends who do not have children. This is due to different lifecourse trajectories and "schedules" in which examples of delayed childbearing, delayed marriage and perhaps more voluntary

childlessness are present in Sarah's higher-class social environment. Life goals beyond

children coupled with the ability to control and choose one's actions, such as

reproduction, are present within higher-class contexts, and thus differentially shape their

experiences of infertility.

Marital context

Not only do higher- and lower-class women have different peer norms, but they

also have different marital and partnering norms as well, ultimately shaping their

infertility experiences. Past research (e.g., Greil, Leitko & Porter, 1988) has shown the

significant impact of infertility on relationships, but the effects are reciprocal: the

relationship itself affects the infertility experience. The interviews reveal that women in

committed partnerships were better able to cope with infertility due to the support of their

partners. Because most lower-class women, particularly Black women, are not in a

relationship or are in a fluctuating one in which monogamy and long-term commitment

are typically absent from the relationship, they lack the social support that could help

mitigate some of infertility's negative effects.

Poor women and women of color marry less frequently than their white, higher-

class counterparts. This trend is reflected in the study sample: all white higher-class

women were married compared to only 19% of Black lower-class women and 60% of

white lower-class women. For Black women, marriage is not an important prerequisite

to having children. Indeed, more Black women have children when they are not married.

One reason for this is that children take precedence over marriage within the Black (poor)

context because they provide more stable and permanent relationships than marriage

(Edin & Kefalas, 2005). Lundquist and colleagues (2009) found that childlessness is

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actually associated with marriage among Blacks. Mikela, a Black, 30-year-old lower-

class woman, demonstrates such thinking when asked why she did not believe marriage

was important:

> … Because marriage don't work out.…The only thing that's stable is their
> kid that's going to be there for real is their kid. If you guys have a kid,
> that's it. That's what ya'll work through. If ya'll can love that kid and
> love each other, then that's fine. But you don't have to be married. I
> don't believe that…I don't believe you have to have to be married to have
> kids because marriage don't work…Marriage don't last. But that baby
> there…That's last—that's important. You've got to build that. That's the
> only type of relationship I need and if you can't give me that respectful
> type of relationship with my kids, then just don't come around.

Many lower-class women echoed and extended Mikela's claim that babies were

important to gain stability in life because marriages "don't last."

Fear of infidelity was the crux of marital instability within the Black women's

accounts. For instance, Tiffany, a Black, 22-year-old lower-class woman, explains:

Ann:	Is marriage important, do you think?
Tiffany:	Mm-mm. I'm not getting married.
Ann:	Why not?
Tiffany:	Mm-mm. I don't like that. 'Cuz marriage is supposed to be a bond between two people and not two people and like some outside people. Mm-mm…I would rather just say you're boyfriend/girlfriend, whatever and just keep it like that. We can have a common law marriage but we ain't got to be married like that. I—I'm not into the marriage thing. ..And then I look at a lot of marriages now and like how the women feel when their husband is off and doing their own thing and stuff like that. That's why I'd rather just stay your girlfriend and we can keep it like that. At least I know with being your girlfriend, I already know you're going to step up. When I'm your wife, that's something you shouldn't do.

Infidelity for lower-class women like Tiffany is not looked down upon in non-marital

relationships, such as boyfriend/girlfriend partnerships, but within marriage it is

"something you shouldn't do." Therefore, many women oppose marriage due to the fear that infidelity will continue.

A few of the Black participants were married, going against the cultural norms. This typically occurred among more religious women, such as Josie, a 24-year-old. She states:

> I wanted to be definitely married first. That's—my family, like I said, they're very religious but I didn't see myself getting married at 22 but it happened and it was a good thing. I have always wanted to be married, to have a family of my own that I kind of like took care of, you know, me and my husband or whatever. And I definitely wanted to be married before I had kids. Growing up in high school you would see girls pregnant and not that it was like a shame but I just didn't want that for myself. I just wanted to be married and, you know, make it through high school without having any kids, you know. So that was like my biggest thing.

Josie was surrounded by young women having children out of wedlock; however, due to her religious beliefs and upbringing, she did not want that for herself and considered it an accomplishment that she "made it through high school without having any kids."

While more white, lower-class women were married than Black women in the study, 40% of women in that group remained unmarried. A convergence of marginalized and dominant norms within low-income communities may contribute to the diversity in marriage rates among white, lower-class women (Harding, 2007). Jodi, a white, 25-year-old lower-class woman, displays the various partnerships within economically disadvantaged contexts:

> Ann: How about—how about for most of your friends? Are most of them in like stable relationships when they have kids or no?
>
> Jodi: Mm, yes and no. Like Miranda—Miranda, you know, Miranda has—Johnny…but [they are] no longer [together]. Let's see. Deanna, yes, she is. She's married. All of her babies have the same father. (Pauses) I mean there's just so many I can't even

count—that have either different baby daddies or not—or with other people or—or are just single.

Poor and working-class, white participants are surrounded by women who are in committed relationships, casual relationships, and no relationships at all. Such heterogeneity of norms results in more diverse attitudes about marriage among white lower-class women.

For some low-income white women, understandings of marriage mirrored those of Black lower-class women. For instance, Jackie, a white, 23-year-old lower-class woman, describes how non-marital childbearing is the norm within her context:

…Everybody (pauses)—everybody I know got—had—got their baby before they were married, you know, or got pregnant before they were married. Well, you know, most people.

Similarly, Judy, a white 39-year-old lower-class woman, describes how she does not want to marry for fear of infidelity:

But as for a lifetime relationship, I'm not—I don't know. Do you know what I mean? I don't even know—I don't think I want that with really anybody…I just don't trust men and—not at all…Because I've been cheated on before. So.

While Jackie and Judy relay reasons for not getting married, several poor and working-class white women in the study were married. For the majority of the lower-class married participants, however, it was not that *they* believed marriage was important for having children, but rather that others held such a belief. This may be an indication of shifting familial norms among low-income whites: the women's parents believed marriage was necessary for parenting, yet the women themselves did not share such sentiment. Nicole, a white, 28-year-old lower-class woman, reflects on this phenomenon:

I—I didn't want to disappoint my parents, you know, having a child and not married. That would have devastated them, you know, so I was always looking for boyfriends that would marry me, you know, just so that I could have a kid. You know, then I got married and then he doesn't (laughing) want to have them. So yeah, I kind of screwed up on that one (both laughing). Yeah. But, you know, 'cuz that would have just absolutely broken their hearts. So, you know, I always tried to—that's why I stayed on the birth control so that I wouldn't, you know, upset them and stuff so.

Nicole did not believe marriage was necessary for having children, but she chose to marry in order to not "disappoint" her parents.

Juxtaposed against these diverse views of marriage and childbearing among low-income white women, were the highly consistent views of marital norms among white, higher-class women. All of the high-income participants were married, and all believed marriage was a prerequisite to having children. As Linda, a 43-year-old higher-class woman, elaborates:

I'm not extremely like it wasn't about religion or anything like that. I always wanted to be married. I didn't think about it like I say in great de—great detail. I just sort of, you know, planned it out that way like get married and then have kids, you know, don't get pregnant or you know what I mean.

Linda "didn't think" about being married before having kids because such a norm was naturalized within her higher-class context. As the privileged environment allows, Linda "planned" her life course to adhere to the normalized trajectory. The importance of following the proper sequence of life stages is further demonstrated by Iris, a 30-year-old higher-class woman:

Yeah, well, we—I didn't want us to start trying until after we got married because I wanted to—because we got married 15 days after I graduated from graduate school and so I didn't want to be pregnant during graduate school and I didn't want to be pregnant and during the wedding. So we didn't really start before that. So as soon as we got married, we started and we knew that that was how it was going to be.

Dominant norms define a (good) family as a (heterosexual) married couple with child(ren) (Ikemoto, 1996). This stratified reproduction is naturalized within the typical life plans of higher-class women in that they cannot articulate why it is necessary to be married before having children, but rather "knew that that was how it was going to be."

Adhering to the normative order of life stages was the reason some of the higher-class participants were struggling with their fertility. Waiting for marriage before childbearing caused many of the women to experience age-related infertility. Colleen, a 44-year-old higher-class woman, is one such participant:

> I didn't like it. Well, it's not that I didn't like being single. I enjoyed my single years. I had a fantastic job, I traveled, I, you know, I had great friends, I took trips. But I really wanted to be married and have a family. So that was—that was very, very hard for me and I knew I wanted kids and so, you know, the older I got, it got harder and harder and, you know, I tried not to be bitter. But it was tough because all of my friends were doing, you know, doing my thing on my time line. You know, they had all gotten married, you know, I was the maid of honor in like five different weddings. And, you know, then I was godmother to how many different kids and throwing all of these baby showers and I mean that was even before I knew I was going to have trouble.

Despite wanting to be married, Colleen did not find the right partner until later in life, and was thus not able to adhere to the typical higher-class "time line." The precedence of marriage before children led to delayed childbearing and ensuing infertility.

The differences in marital norms between the three groups greatly affected the women's infertility experiences. Due to lower rates of marriage, lower-class women, particularly Black women, did not receive spousal support for their childbearing difficulties. Moreover, because of the more on again/off again relationships in low-income communities, the poor and working-class women who were in relationships

feared that their boyfriends would leave them if they found out about their fertility issues.

As Angie, a Black, 25-year-old lower-class woman, explains:

> Ann: Why do you think that your current boyfriend might not stay with you if you tell him that you can't have children?
> Angie: Because it's like—because it's part of like—I don't know—well, like to me, it's part of growing [a family]. If—if you can't, you know, like grow with me and us have a wonderful life, what are you here for?...We can be together until we're old but I mean I know—I know he wants to have kids. I want to have kids. But me telling him that I can't have kids, I just feel he'll leave…Because a guy always want to, you know, plant their seed and, you know, they always want to have a kid.

Angie, like many lower-class women, had not told her boyfriend about her childbearing difficulties. Because she was not married, her boyfriend could easily leave her to "plant his seed" elsewhere. Such fears are class- and race-based, but also represent gendered understandings that the ultimate "purpose" of women is to reproduce—"what else are you here for?" Moreover, impregnating a woman may be one of the few opportunities men are able to achieve a semblance of masculinity due to living in a context absent of other virile prospects (e.g., lack of job, money, 'providership').

Evidence of the additional support marriage provides to infertile women is apparent among lower-class women who were married. For instance, Josie, a Black, 24-year-old lower-class woman, relays:

> [My husband] is like the best. He's—he's totally like, "Okay. It's okay. If we can't have our own kids, we'll adopt kids. It's not a big deal." You know, he's just like—one day I thought that I kind of was pregnant and I thought I was having symptoms and I am just completely in tears and I didn't tell him what was wrong with me and he's like—when I finally did tell him, he was like, "I figured that was what was wrong with you." And he kind of stayed home with me from work. He's like totally supportive. Just 100%.

Roberta a white, 39-year-old lower-class woman, expresses similar experiences with her

husband:

> You know, honestly [my husband] was so supportive and even since then when I get down about it or whatever and I talk to him about it, he just, you know, "Honey, it's all right. It wasn't meant to be. It's not that, you know, it's not a problem."

Roberta's husband provides her a person to talk with about her struggles. He also

provides her with words of advice and reassurance.

One of the most consistent responses among higher-class women was the

significant support they received from their husbands. Only one of the seventeen higher-

class women's relationships was disrupted to the point of separation because of infertility

and even they made amends and are now a "success." Stephanie, a 35-year-old higher-

class woman, demonstrates this high level of support:

> Yeah, I don't—[my husband] never was negative about it. He was very positive, which I'm sure played a huge role in me feeling that way…I think if it had been any other way, he would have, you know, I would have felt worse. Even after the fact that we knew that it probably had nothing to do with his body and it had something to do with mine, he still was very supportive. We joked about it, you know, in fun but we could because it was just the two of us. It wasn't anyone else joking about it. But then it stayed there tabled and it—and we just moved forward. And so he was a positive influence.

Stephanie's husband's optimism "played a huge role" in her coping with infertility. In

fact, it was his "positive influence" that allowed them to "move forward" in their

childbearing journey. Becca's husband was similarly influential on her infertility

experience. She reflects on his positive support when she states, "And I sometimes

accuse him of having a little play book on the other side of the bed that he looks up the

answers to because they're all so perfect."

Rather than tear relationships apart, as feared by Angie, infertility often brought higher-class couples closer together. Nan, a 40-year-old higher-class woman, exemplifies:

> In truth [infertility] has drawn us closer. Much closer. Just we've had to really kind of cling to each other and, you know, pouring out our sorrows to each other or mostly me but him, too. Just it drew us much closer going through—going through something like this together…It just, you know, like I mentioned before, it always felt like it was just something that we were experiencing together and it wasn't—it wasn't like a me against him kind of thing. So it was just something that we went through together and we weathered the ups and downs of it together and it drew us closer. You know, I had to learn to communicate with each other on a deeper level and how to comfort each other and be patient with each other.

While not the case for many infertile couples, the childbearing struggles experienced by the higher-class women in this study seemed to benefit relationships rather than hurt them. Not knowing many other women who have gone through infertility, couples relied on each other to cope with their difficulties. When that support is not present or is impermanent, as is the case for many lower-class women, particularly Black women, the infertility experience is a lonelier journey.

Social support

Beyond spousal and partner support, other forms of support shape infertility experiences. The economic and racial contexts of the participants shape the presence and prevalence of various types of support. For instance, lower-class women do not have the resources nor the access to attain certain types of support, such as therapy. By contrast, higher-class women not only have the economic means for such support, but they also have the knowledge to access it.

Poor and working-class women never mentioned friends or peers when discussing their support system. The absence of such support may be an effect of the peer context in lower-class settings as discussed previously in which the lower-class women in the study could no longer relate to or fit in with their peers due to earlier childbearing norms and fewer life goals within their environments. In addition to losing support from friends, childless lower-class women in the study also discussed a lack of support from family. Ruby, a white, 25-year-old, explains:

> So and everybody just—I know that's the reason they cater to [my sister] because she has children. They—and she throws and she gets her way and I'm just like, "That is so unfair." And everybody will deny it. But it is—my husband sees it so. And outsiders see it. It's just my family's in denial. Oh, it just—it pisses me off sometimes…So. And no one—no one thinks to call me first about something. They call my sister…So. It's—that's—that's probably like the worst of it all is no one will remember you because you didn't have a family socialness going on. So yeah, that's probably the worst.

Without children, Ruby does not have "family socialness" so she is "forgotten" by her family. She believes that her sister receives more attention and money from her parents because she has children. Ruby's childlessness marginalizes her socially as well as economically and personally with her family.

Although support was mentioned infrequently among lower-class participants, some cited religion as helping them get through their difficulties. For instance, Angie, a Black, 25-year-old lower-class woman, states:

> My pastor [provides the most emotional support]…Yeah, we prayed about it. He told me, you know, "When it's time, it's time (laughing)." Okay, it's God's work…He's really I mean giving me good support. But I haven't actually gotten down in detail of, you know, me not having or being able to have kids. But he knows something is wrong and he's just not saying anything.

Angie's pastor provides her with more support than any other person, yet it is indirect

support since she has not told him about her struggles with childbearing. As will be

discussed later in this chapter, poor women, particularly Black women, do not frequently

disclose their fertility issues due to cultural norms. The mere presence of having

someone know that "something is wrong" provides Angie with some peace of mind.

A few of the lower-class women turned to the internet for support. Tamara, a

Black, 25-year-old, explains:

> So I'd rather blog about it…then speak about it and maybe someone else
> besides myself who had –25 years old who's experiencing the same thing
> I am going through and you've got to lift yourself up no matter what
> family or friends they say to you, you can always do it, you know.

Blogging allows Tamara to relate to other women like herself who are experiencing

childbearing issues. Poor and working-class women do not receive much support from

friends or family nor do they know of many other infertile women, so the internet is a

way to "lift yourself up" in spite of such conditions.

The lower-class women offer several theories as to why they lack support for

their fertility troubles. Donna, a Black, 33-year-old, explains how it is due to her lack of

disclosure about the issue:

> No, [I don't have much support] because like I said (laughs), don't
> nobody know. So. And then they think I like not having kids. So no, it's
> kind of like that. I have to like run in the corner a little bit and cry it
> without and then everybody do but. It don't affect me that much like it
> had been maybe within the last year or so. But yeah, so it hadn't been
> that—that much of a problem. But no, socially, no, I'm a loner (laughs) a
> little bit.

As mentioned previously, the majority of the lower-class participants do not tell many

people of their childbearing difficulties. Donna is a "loner" perhaps as a result of her

childlessness, but from her story it is clear that she is struggling emotionally with

infertility. Rather than recognizing Donna's childbearing troubles, people "think [she] likes not having kids," demonstrating their internalization of infertility stereotypes which place poor women of color outside of its bounds as well as the internalization of the motherhood mandate in which it is natural for all women to have children and unnatural to do otherwise.

Another reason offered by the poor and working-class women for their lack of support is due to their social class standing. Mikela, a Black, 30-year-old, believes:

> Somebody that's either getting help or wealthy enough or—economically speaking…—like have a good support system that helps you that way. You know? That it matters.

According to Mikela, money "matters" in that having a "good support system" is something that depends on economics. Rachelle, a Black, 28-year-old lower-class woman, concurs:

> Maybe like financial options 'cuz like I know a lot of those fertility clinics and things like that cost a lot of money, you know, and—I don't know— maybe—I think people probably do have more support than I did. I don't know. At least somebody you could talk to or something.

Rachelle did not have anyone to talk to about her childbearing difficulties. She could not even talk with a physician about it because of her inability to access health care, something she attributes to her economic circumstance.

In addition to monetary restrictions, the poor and working-class women's disadvantaged context also limits their knowledge of what resources and support are available. Formal support groups for infertility abound, but are mainly composed of white, higher-class women due to the groups' marketing tactics, location, and focus on medical treatment. Angie, a Black, 25-year-old lower-class woman, describes her lack of knowledge about such groups:

To not have no support is how this is crazy. I haven't ever even heard of any groups out there, you know, for people like me. And because there will probably—I don't know—I never even thought anything like this before but my friend has and it was crazy. But kidnapping—it would probably cut down a lot of kidnappings and, you know, people trying to take, you know, people's kids.

Angie has not "ever even heard of any groups out there" due to her social location. This lack of knowledge causes women in her situation to turn to drastic measures, such as "kidnapping," in order to resolve their childlessness. Angie wants more support but does not know how to access it.

Higher-class women, in contrast, not only know about support resources available, but they utilize them to their full advantage. For example, Colleen, a 44-year-old higher-class woman, describes attending RESOLVE, the largest national support organization for infertility:

And we were going to RESOLVE meetings. .. They were great meetings for us. It was good to have other people to talk to who got it. Who got how it controlled your life. Who got how you could never make plans and how tiring it was to go to—for appointments, you know, driving to the university and parking in that God awful structure to go in for a blood draw. You know, I mean they got it. And it was good for resources to talk about doctors and to talk about pharmacies. "What's the best pharmacy to get your drugs?" Because, you know, certainly a rural pharmacy's not going to have a full, you know, selection of Gonal-F and all of these other things you have to take. And so it was great from that standpoint and it was great to hear what other people went through because it really gave us things to talk about. …But so from that standpoint, you know, those meetings were great for us. And we, you know, I wouldn't say we became friends with those people. We—it was very nice to be there and we would always go out afterwards, you know, for whatever

Attending RESOLVE provided support to Colleen on many levels. It provided her with others in her situation that could "relate" to her experiences, and they socialized together. It also gave her resources, such as access to medical knowledge. Lower-class women

already have restricted access to such entities. Their exclusion from groups such as RESOLVE further exacerbates their absence.

Higher-class women also receive professional support such as therapy that is economically not an option for lower-class women. Iris, a 30-year-old higher-class woman, explains her experience:

> Yeah, yeah, did I have support. I think I had a lot of support when I was going through it and when I made the choice to—to do [IVF] and we were like on board and doing the drugs, there was definitely a lot of support then…But also my therapist—a couples therapist we had at the time was—also happened to be a therapist for the clinic, the IVF clinic. So she was very aware of the emotions that I might be going through…So she was really helpful.

Iris was the one higher-class participant whose relationship suffered because of fertility problems. However, due to her ability to access therapy she and her husband made amends and are currently thriving. This same therapist was able to support Iris emotionally around her childbearing difficulties. Lack of insurance, funds, and knowledge faced by many lower-class women prohibit the same provisions to be available to them.

Due to their ability to relate to their peers on levels beyond just mothering, the higher-class women maintained more friendships than the poor and working-class women as previously discussed. Doing so allowed peers to be a strong support system for middle- and upper-class women, unlike their absence from the support of lower-class women. Stephanie, a 35-year-old higher-class woman, elaborates on her friends' support:

> I do [think I had support]. I do. Because interesting enough, like when someone would be pregnant, the closest of close friends would know— they would say, "Are you okay?" Just checking in. Not to dwell on it, not to make it more than what it was but just making sure.

Stephanie's friends were able to counteract any negative influence by consistently "checking in" when necessary. They knew what triggered her emotions around childbearing issues and "made sure" that she was "okay" in their presence.

Similarly, Melissa, a 33-year-old higher-class woman, describes her support:

So I think we've got a lot of support, which is nice…You know, people that we can rely on not to judge and just be supportive and sometimes say the right things when you need it. So and then I also have friends that are absolutely against having children themselves and they're like, "If you want to, that's fine but I don't really—it doesn't even appeal to me (laughs)." Okay. So it's kind of—for me, I've got a lot of people that have different opinions and so it's kind of nice.

Melissa's statement reiterates the diversity of friendships among higher-class women. In contrast to "all" of the poor and working-class women's friends having children, the delayed childbearing, voluntary childlessness and more diverse life goals among higher-class women allows them to be able to relate to others. Moreover, those maintained friendships provide a support network for the higher-class women that is missing from the experiences of lower-class women.

Like poor and working-class women, however, a few of the higher-class women turned to religion for support. For example, Nan, a 40-year-old higher-class woman, "had two priests that I would talk to frequently who were friends and I could talk to them in kind of spiritual counseling."

Despite the numerous resources and individuals available to support higher-class women with their fertility struggles, some of the participants believe that it is not enough. Nadia, a 33-year-old higher-class woman, explains that:

…We don't really—there's really no formal support for women going through this. It's, you know, if you were going through a divorce, your friends rally around you. If you're going through a death, there's a

funeral and there's closure and you move on. With infertility, it's like month after month you're almost—… It's like you're mourning a loss every month that doesn't happen. It's almost like the loss of a child that never was. It's almost like mourning a death and one thing I did read is that they say that going through infertility is like more traumatic than, you know, is as traumatic or more than any other thing they have measured on a trauma scale in life. But yet, what do they have out there? RESOLVE.

Given the "traumatic" and ever-present experience of infertility, Nadia yearns for more support than she receives. The lack of a concrete event, like divorce, or a definitive ending, like death, makes infertility unique, and thus it requires more and different support than is currently available. Medicalizing infertility objectifies the experience and its emotional, personal, and social repercussions go unnoticed, leaving the women who experience it with limited options regardless of their social location.

Talking about childbearing difficulties

Infertility is a "hidden" issue, in that it must be verbalized for others to know of its existence (Remennick, 2000). Whether or not the participants revealed their infertile status to others depended on their social location. Rates of disclosure differed by race and class, as cultural practices influenced the likelihood that participants' would discuss their childbearing difficulties. In turn, these differences furthered variation in experiences of infertility.

Poor and working-class women, particularly Black lower-class women, do not tell many people, if any, of their childbearing difficulties. Not talking about their experiences furthers the stereotype that infertility is a white, wealthy woman's issue and maintains the feelings of isolation and loneliness among marginalized groups. For Black women, however, not discussing personal issues is a cultural practice and one normalized within their discourse and interactions. This silencing may stem from the "strength

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mandate" imposed on Black women which implies that they are "less than a woman" if

they show signs of weakness (Hill, 2009). Hill (2009) concludes that the strength

mandate is a barrier to intimate relationships and denies Black women the companionship

that they need. Donna, a Black, 33-year-old lower-class woman, reflects on the

employment of this stereotype in her social situation when she states that her family

"don't really want to touch [on her fertility struggles]. They think it's probably too

sensitive so." Barbara, a Black, 44-year-old lower-class woman, further elaborates:

Barbara:	I wouldn't say [I know] a lot [of people with infertility] because there—I—I bet it's not something you just readily talk about with people. I guess I have my one girlfriend, I talk about it with her because she's my friend and I know her history and she knows mine. But other than that, no… Not really…It's not something you talk about…I think it's probably not as open a subject for discussion in my community as it would be in some others.
Ann:	…And why do you think that is?
Barbara:	I think it's just cultural differences. And that's the only thing I can attribute—attribute it to is just cultural differences. And it's just sort of the things you don't discuss…That just is. And I don't know that it's necessarily any different than it would be for some other social—some other—some other groups either. I—I—I suspect that in some ways that other ethnic groups also would have the same kind of thing but just, you just don't do.

Barbara recognizes the inherent silencing of personal issues within her racial

"community." Infertility is "just sort of the thing you don't discuss" because it "just is,"

demonstrating the normalization and embeddedness of restrictive discursive practices in

Black culture.

Keisha, a Black, 33-year-old lower-class woman, describes why she does not

discuss her childbearing issues with others:

> So I'm not going to tell [my mom] or nobody else because I know this is
> something I have to do because it's like personal (laughs) to me. So I
> wouldn't share it with nobody. But, you know, the person I'm going to be
> with or somebody like you (laughs). So yeah. That's like a tense
> situation for me…And I can get on—on the computer all day and that's
> not going to help me. That's not going to do anything. Even if I told my
> mom, that's not going to do anything (laughs). So it's like—it's
> something I have to do.

Keisha's motivation for being silent about her fertility struggles reflects the strength

mandate imposed upon Black women. To Keisha, infertility is a "personal" issue and

"something she has to do" on her own to resolve. The fact that no one can help her but

herself causes her to not share her struggles.

Ebony, a Black, 34-year-old lower-class woman, demonstrates the normalized

absence of infertility discourse within her context:

> I don't think I tell—do I tell people? (Pauses) I might have told two
> people but not really. The doctor and maybe—it's not that it's a secret.
> It's just that that's not really nothing that—I don't really find people that's
> really talking about it because most of my friends like I say have kids so
> where—I don't understand where that falls in the something to talk about,
> you know, for us.

The silencing of infertility is so normalized within Ebony's surroundings that she cannot

even remember whether she discussed her issues with anyone. In addition to being an

effect of cultural norms, the Black lower-class women also did not talk about infertility

due to their peers, most of whom have children. *Troubles* with childbearing are

marginalized within social interactions, while childbearing itself is the center of

conversation.

In addition to cultural practices, there are other reasons lower-class women, both

Black and white, do not discuss their fertility difficulties. One reason is that by sharing

their struggles the women are admitting that they desire a pregnancy and are 'trying' to

conceive. This is problematic for some lower-class women because of the ideology that they should not be mothers in the first place, given their economic status and other demographic factors. Despite the earlier childbearing norms within lower-class settings, many of the participants reported being criticized for being too young to attempt to have children. For instance, Roxanne, a Black, 22-year-old lower-class woman, states:

> [I don't want to tell my mom] because she's—I don't know—she's going to say, "(I'm) too young. Why are you trying? You this. You that. You don't have a job right now. I'm too young to be a grandmother." And that's the first thing she's going to say. And I'm looking at her like, "You're almost 50." It's, "I don't have any grey hair." "So?" I'm like, "I don't care, Mom." I'm like, "When I'm ready, I'm going to be ready."

Julie, a white, 19-year-old lower-class woman, has a similar experience:

> Well, I wanted to talk to my mom about it but I never did…And she asks but, you know, I—sometimes I lie to her and like, "No, we're using protection," you know, or whatever but, you know, I really—she thinks I should be further in my career to start having children but I think I've been working there a year and a half now and like I think I'm in there good enough.

Julie and Roxanne are criticized by their mothers for going against the norm of "good" motherhood. They desire the role despite their young ages and lack of an established career. Julie and Roxanne negotiate with those stereotypes through avoidance or "information management" (Remennick, 2000); they do not tell their mothers, or choose to "lie" to them, about their childbearing difficulties in order to not be criticized for their mothering desires. Higher-class women do not face such conflict due to their embeddedness within norms of 'good' motherhood.

Another reason lower-class women did not talk about their fertility struggles was due to their fears of being embarrassed, stigmatized, or perceived as abnormal. Given the motherhood mandate which naturalizes motherhood among women, the inability to

achieve motherhood constructs infertility as unnatural. The women internalize the

negative connotations around infertility and self-label their fertility issues as a

"discreditable attribute" (Goffman, 1963; Miall, 1985; Schneider & Conrad, 1980). In

turn, the women do not want to expose what they consider to be an undesirable trait to

others and choose not to disclose their childbearing issues. For example, Mikela, a

Black, 30-year-old lower-class woman, explains:

> Ann: Have you talked to many people about it?
> Mikela: Mm-mm.
> Ann: No? Why?
> Mikela: 'Cuz, no! I'm not going to ruin that just—mm-mm.
> Ann: What would you ruin?
> Mikela: Them knowing that I was abnormal for whatever reason,
>   something wrong. Something else to talk about.
>   Something that I don't need to be—that's none of their
>   business. It's obviously up to me and God.

Mikela has not discussed her childbearing difficulties with anyone because she is afraid

that it will "ruin" her relationships due to its "abnormality." Her quote also reiterates the

lack of discussion around personal issues in her community. She does not talk about it

with others because "that's none of their business." Resolving it is "up to her and God,"

as a "strong" woman, similar to Keisha's reasoning.

In addition to being embarrassed about infertility in general, some participants

such as Ruby, a white, 25-year-old lower-class woman, do not disclose their difficulties

due to their inability to resolve them:

> And that's something of that I think I hide most from people because I
> don't talk about my situation as much because I am more so embarrassed
> that I can't do something about it.

Ruby is uninsured, and therefore cannot access medical treatment for her infertility. The

construction of infertility as a medical event is naturalized to the extent that Ruby is

"embarrassed" by the fact that she cannot (medically) resolve her issues. In other words,

she is abnormal for her lack of medical treatment for infertility. This abnormality causes

Ruby to refrain from discussing her childbearing difficulties with others. However, Ruby

turns to the internet, which provides a safe "virtual community" in which she can discuss

infertility without revealing her problems to others in her actual community:

> I play an online video game once in a while and I have tons of friends on
> that. And I can tell one of my friends on there everything and anything
> and I feel good for the day and it's off my mind. You know, they aren't
> going to judge me past that. They aren't going to see me at the mall
> tomorrow doing the opposite of what I'm going to say, you know,
> sometimes. But I probably could not talk to someone else about it.

Ruby is able to discuss her fertility issues with her online "friends" because they do not

"judge" her. Her nonmedicalized, infertile identity becomes "demarginalized" on the

internet. The anonymity the internet allows provides a safe haven for those with

"concealable stigmatized identities" (McKenna & Bargh, 1998). She will not "see" them

"tomorrow" which allows for freedom of expression and identity. The internet forces a

face-value conversation, one that is undisturbed by context, body language, and even

normative values. Ruby can be herself without fear of repercussions or judgment.

Higher-class women are hesitant to talk about their childbearing issues with

others because of its stigma. For instance, Jennifer, a white, 34-year-old higher-class

woman, explains:

> Ann: Why don't you want people to know?
> Jennifer: I think it's because I'm embarrassed mostly…Because it's
>   not the natural order of things. Do you know what I mean?
>   …I just—I don't know—I just—it's not right to me. Do
>   you know what I mean? It's not—this isn't supposed to
>   happen so. And I don't like people to feel sorry for me
>   about anything.

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Jennifer is "embarrassed" about her inability to conceive, as it is "not the natural order of things." Her naturalization of the motherhood mandate incites feelings of abnormality. Rather than "ruin" relationships as in Mikela's case, Jennifer does not want others "feeling sorry" for her. This variation mimics the effects of infertility on partnerships: lower-class women feared men would leave them if they found out they were infertile, whereas higher-class women received support from their significant others.

Despite their hesitancy due to the stigma associated with infertility, most higher-class women talked with others about their childbearing issues. Unlike Ebony and the absence of infertility and discussion of personal issues within the lower-class Black discourse, many higher-class women disclosed their fertility troubles precisely to quell conversation about them. For instance, Carole, a white, 36-year-old higher-class woman, states:

> Yeah, I [told] close friends and stuff. You do want some people to feel sorry for you and you do want people to shut up, too, like I say, you just have to tell 'em because you don't want them to ask you anymore (laughs). I'll—and I used to—I remember saying something like, "You know, if there's any good news, I'll tell you. Don't, you know, don't keep asking me because it kills me and I die a little every time somebody asks me." You do—you just die a little 'cuz, you know, they think they're just being cute and you're just like at your wit's end.

Ideologically, as a married, white, heterosexual higher-class woman in the U.S., it is abnormal not to have children. Thus, when you are a woman of that social location without children people tend to question your childless status. Carole told her close friends in an effort to "shut up" their constant inquiries about children. "Coercive social exchanges" such as these in which women are forced to give information are commonplace in (higher-class) experiences of infertility (Sandelowski & Jones, 1986). The pain of their questions was greater than the pain of revealing her difficulties.

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Because lower-class women do not typically discuss personal issues, such questioning was less common in their environments and more silent assumptions were made.

Despite telling others about their struggles, most higher-class participants said their friends and family did not understand what they were going through. Sarah, a white, 33-year-old higher-class woman, explains:

> I have several close friends and, you know, I don't know. They, you know, they say they understand but I know they don't…And I do confide in a couple of close friends and I just feel like they're—they just feel really sorry for me. But no, they don't understand. They can't. My mother, she just—she's just sad. She can't understand it either. She says, "I'll just listen but I don't know what to say."

Sarah's friends "can't understand" what she is experiencing because they have not lived it. However, talking with others such as her friends and mother is a way Sarah copes with her infertility:

> So yeah, I guess about two weeks ago [my husband] was like, "I don't know. I think you need to go talk to somebody." And I say, "But I talk to everybody. This is my—that's my therapy," you know, I talk to all of my friends and…it's like—I don't know… I don't know. Because I feel like—I guess I feel like I talk enough to people: to my friends and this friend at work and—I don't know.

Disclosing her childbearing difficulties is Sarah's "therapy." She has maintained friendships and has supportive family members who are there to listen to her stories even if they cannot fully understand her experience. Lindsey, a 31-year-old higher-class woman, also talks with others as a way to deal with her fertility struggles:

> And I think that's almost my—my outlet, you know, I really like to communicate with people and really pick their brains like, "Oh, this happened to you? Well, what happened? You-or what did you do? You had another baby. Well, what worked for you?" You know? So really talking to other people about what worked and what didn't and just kind of hearing through the grapevine.

For Lindsey, talking with others about her struggles not only provides her with emotional support, but she also discloses as a way to gain knowledge and resources about how to resolve her issues, perpetuating the knowledge and resource gap between classes.

<u>Conclusion</u>

Infertility is a "social experience" beyond the doors of medicine, as it takes place in the context of everyday lives (Lorber, 2002; Schneider & Conrad, 1983). Race and class norms inform social practices, which in turn shape how women live with infertility. More specifically, reproductive, marital and discursive norms shape women's social surroundings and how they live with infertility within such environments.

Peer groups and their reproductive norms differ by class, resulting in divergent infertility experiences. For lower-class women, "having kids is what they do;" therefore, it is difficult for the participants to relate to their peers when motherhood is the primary goal in life and "all" of their peers have children. For higher-class women, however, later childbearing norms cause more women to be childless. Additionally, more varied life goals allow the higher-class participants to relate to their peers, including those with children, on levels beyond mothering, which maintains friendships and thus support. In other words, infertile lower-class women are "odd balls" both on the societal level as they do not fit the stereotype of infertility, as well as personally, as they do not fit in with their peers.

Marital norms also construct how infertility is experienced and varies across race and class groups. Culturally, lower-class Black women marry less frequently and reject the notion that marriage is a prerequisite to having children. In turn, most lower-class participants in this study were unmarried. The instability associated with those

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relationships caused the women to fear that their partners would leave them upon learning of their childbearing difficulties. In contrast, to fulfill the normative life stages which place marriage before childbearing, all of the higher-class women were married. Infertility tended to strengthen their relationships and marriage was the strongest support system for the high-income women. In addition to marital support, the higher-class women were also able to access support groups and therapy, entities unknown and economically unavailable to lower-class women.

Finally, discursive norms in which Black lower-class women do not typically discuss "personal" issues with others cause them to not talk about their infertility as much as higher-class women. Yet, disclosing their difficulties is a way the high-income women cope with their struggles and also furthers their support.

Examining the lived experience of infertility exposes the influence and impact of social norms on the infertile experience. Such norms incite varied experiences due to race, gender and class standing. Infertility is not merely an objective experience that can be generalized to all women; rather, it is one based in ideological notions and influenced by the context in which it occurs. Indeed, as the next chapter demonstrates, how the women attempt to resolve their childbearing issues is dependent upon the context in which they live and further elaborates on the social basis of infertility.

Chapter Six

Resolving Infertility[*]

> *Medicine as a profession and reproductive medicine in particular, have played central roles in the mediation, (re)production, and regulation of sexuality and particular definitions of "legitimate" family. These, in turn have had serious implications for the shaping of a range of social inequalities and specifically for the importance of medicine in that process (Steinberg 1997).*

Infertility is an undesired event, as it leaves women *involuntarily* childless; therefore, all of the participants in this study aim to overcome their childbearing difficulties. But, how they go about doing so is dependent upon their social location. Race and social class shape women's desired type of resolution as well as the accessibility to that resolution.

Since the development of reproductive technologies in the 1970s and 1980s, infertility has increasingly been constructed as a disease and something to be treated rather than a social construction and natural part of life (Bates & Bates, 1996). Thus, one of the most common ways women attempt to resolve their infertility is through medical treatment. Accessing such treatment, however, is limited by a woman's class status. One reason for this is that the medical establishment functions within and is reflective of the "underlying moral economy of the U.S." in part by limiting its services to select groups

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[*] Portions of this chapter appear in the following manuscripts: Bell, A.V. (2009). "It's way out of my league": Low-income women's experiences of medicalized infertility. *Gender & Society, 23*(5). Bell, A.V. (2010). Beyond (financial) accessibility: Inequalities within the medicalization of infertility. *Sociology of Health & Illness, 32(*4).

(Becker, 2000). Medicine is both a social institution and ideology that is founded upon and reifies class meanings and practices (Collins, 1998). The selection of who receives treatment is driven by a "private medicalized market" in which only a few select individuals can afford treatment; thus, infertility may only be medicalized for some (Conrad & Leiter, 2004).

In the case of infertility, medicine serves as a gatekeeper determining who should and should not mother according to hegemonic norms of motherhood—norms that are divided, particularly along socioeconomic lines. The medicalization of infertility is the intersection of the ideologies of medicine and motherhood. Society has deemed certain groups worthy of motherhood (e.g., white, higher-class women) and medicine perpetuates that construction via the process of medicalization. The medicalization of infertility naturalizes the ideology of motherhood and its inherent stratification by providing the option of reproduction to some groups and not others. For example, Medicaid covers contraceptive methods but not infertility treatments, while the reverse is true for several private insurers (King & Meyer, 1997). In other words, there are "those for whom there is contraception if they'd only use it, and those for whom there are infertility treatments" (Cussins, 1998).

Research on infertility perpetuates the stereotypes of reproduction by overlooking the experiences of infertility among lower-class women. Most infertility studies utilize convenient, treatment-based samples, typically composed of higher-class women (Heitman, 1995). While this provides insight into one type of infertility experience, it reinforces the stereotype that infertility is an affliction of the rich and overlooks non-medicalized experiences of the phenomenon. Additionally, when research studies

examine disparities in infertility treatment, they typically limit their analyses to financial

reasons, such as its exorbitant cost and sparse insurance coverage, rather than looking to

structural explanations (e.g., Henifin, 1993; Staniec & Webb, 2007). This is particularly

problematic since researchers have shown that even when accessibility is standardized, or

equal across strata due to mandated insurance coverage, disparities still exist. For

instance, Jain and Hornstein (2005) found that in Massachusetts, a state with mandated

comprehensive insurance coverage, the use of services had indeed increased, but it had

done so among the same demographic group that receives treatment in other states

without insurance coverage—the white, wealthy, and educated—thus, the disparities

remained. According to the authors, inequality was most significant along educational

divides; of the patients receiving IVF services, none had less than a high school diploma

while 85 percent had at least a college degree. While subsequent researchers have

echoed these findings (Bitler & Schmidt, 2006; Schmidt, 2007), few, if any, studies[†] have

examined *why* the inequalities persist or what mechanisms drive inequalities beyond

financial accessibility issues. In other words, previous research has relied upon

medicalized explanations for inequalities in infertility treatment (e.g., decontextualizing

the experience and focusing on the technology), while overlooking other intrinsic

disparities present in the medicalization process itself.

Qualitatively comparing the experiences of infertility among women of various

social class groups overcomes the limitations inherent within past research. This chapter

examines the process of medicalization and how it contributes to the development of

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[†] See White and colleagues' (2006) review paper examining disparities in help-seeking for infertility. They
develop a theoretical model depicting factors that may influence individuals' behaviors.

disparities through its perpetuation of dominant ideologies. In other words, this study explores the *social* exclusion of lower-class women from the hegemonic ideals of motherhood and medicine (Bhalla & Lapeyre, 1997). Examining the medicalization of infertility reveals how poor and working-class women are not only marginalized along economic dimensions, but social and political dimensions as well. As Bhalla and Lapeyre (1997) describe in their conceptualization of social exclusion, the political dimension of such exclusion involves an institution that "is not a neutral agency but a vehicle of the dominant classes in a society." The process of medicalization is precisely the vehicle used by medicine in order to preserve and naturalize the stratified system of reproduction in which it is based. Examining the context in which medicalization is framed alongside the context of the infertility experience will reveal much about *how* medicalization participates in the maintenance and reification of the social norms of class and motherhood, in turn exposing implicit disparities of medicalized infertility.

<u>Medicalization of infertility</u>

Attitudes toward medical solutions

Since the medicalization of infertility, medical treatment has become its normalized solution. Therefore, all of the study participants pursue medicine or at least think about it in some form. For example, more lower-class women seek medicine, not for its treatment of infertility, but rather for an "answer" or diagnosis of why they are experiencing childbearing difficulties; whereas, higher-class women pursue medicine for both diagnosis *and* treatment. Such differences are reflected in and may be attributed to their attitudes about medical solutions to infertility as well as their structural and contextual circumstances.

How individuals make sense of health experiences is dependent upon and varies according to their social location (Silva & Machado, 2008). Research suggests that lower-class women, especially Black women, are wary of medicine and many times do not pursue it as a solution even when it is accessible. They dislike "external control of the body," as demonstrated by Black mothers' rejection of breastfeeding (Blum, 1999). Similarly, Martin (1990) found that working-class women tend to reject medicalized dominance over their bodies, particularly in relation to reproductive processes such as menstruation, while more middle-class women internalize such views. Franklin (1992) also suggests that women who are less concerned with molding to dominant norms of reproduction, such as lower-class women in a culturally heterogeneous setting, are less likely to pursue IVF than women who define their lives according to the normative conventions, such as higher-class women as evinced in previous chapters. Moreover, there is a historical mistrust of medicine among the Black population, given past instances of grave medical mismanagement among their demographic, including negligence in the treatment of sickle cell disease and the failure to treat syphilis in the infamous Tuskegee studies (Hill, 1994). Such mistrust instigates a fear of medical treatment, particularly of medicines ingested into the body, such as pills and injections. For instance, Black women are less likely to take oral contraceptives due to their beliefs that such birth control is a form of genocide (Thorburn & Bogart, 2005). Opinions of medical treatment for infertility are also reflective of how women approach reproduction in general. Higher-class women use medicine, such as oral contraception, to prevent pregnancy, while fewer lower-class women use such means. Additionally, more higher-

class women use technological mechanisms to try to become pregnant, as demonstrated in Chapter Four, than do lower-class women, who prefer more "natural" approaches.

Some researchers (e.g., Fraser, 1998) have found Black women to be more embracing of medicine and technology in other 'reproductive' realms compared to infertility, such as childbirth and infant feeding. Both processes, however, lack the very thing for which the marginalized women 'fear' and reject about medical care discussed above—medicine itself. For example, researchers found that lower-class Black women may accept hospital childbirth due to the naturalization and valorization of "technocractic" birth, but they reject the use of epidurals during childbirth more often than their middle-class counterparts (Dillaway & Brubaker, 2006). Additionally, infant feeding with formula, while a "medicalized" and scientific process, is not projected as such and may be interpreted as any other nutritional food source, and thus, the women's contextual constraints (e.g., time to breastfeed) outweigh any medical connection that may be present (Blum, 1999).

In other words, Black women do not merely reject medicalization for its own sake. They are hesitant to accept and pursue medicine, particularly medical treatment ingested into the body, due to its negative symbolic meaning developed from centuries of historical abuses. Such opinions and normalized ideas are applied to resolving infertility (Molock, 1999), as Barbara, a Black, 44-year-old lower-class woman, demonstrates when she states, "I don't want to be somebody's science experiment." Veronica, a Black, 27-year-old lower-class woman, has similar sentiments regarding medical solutions for her infertility:

> Veronica: The little injection things. I don't—I don't want to try that.
> I just want it to come, you know, naturally.

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Ann:	Mm-hm. And what do you mean? What are the injections?
Veronica:	I—I—I don't know what they're—that's what I said "the little injection" things…And so I was like, "Yeah, I don't want that though."…And so I'm going to keep doing it the natural way…Because I don't want to take no—because I—plus I don't know what that would do to me. You know, that might—I don't know what—I have been hearing horror stories about that and so I don't want any— yeah…Like on the Internet. Like a baby might come out with a extra, you know, finger or a toe or—and I'm like, "Uh-uh." I don't want that to happen.
Ann:	How about reproductive technologies?
Veronica:	No, mm-mm…I don't even want to—oh, that word is so nasty: repro—no, uh-uh…I'm just—it makes me think of a alien baby or something. I don't—no. …That makes me— no, like a little green baby going to pop out or something…I don't want to look at them images. Just the word alone just---…It spooks me out.

Veronica is fearful about treating her childlessness medically, as she "doesn't know what

that would do to [her]." Her understanding of medical resolutions stem from the internet

and "horror stories…about little injection things" which may also be rooted in Black

women's attitudes towards medicine more generally. Rachelle, a Black, 28-year-old

lower-class woman, echoes Veronica's fears:

Rachelle:	Like about a year and a half ago or two years [my doctor] had mentioned [treatments] to me and I told him I wasn't interested.
Ann:	Mm-hm. Explain to me in more detail why you're not interested in that.
Rachelle:	I don't know. I just felt like—I don't know—kind of part of me felt like if it was meant for me to have 'em, I would have just had 'em. And—I don't know—I don't want to do anything that may harm me trying to have 'em when if it was meant to happen, I should have just had 'em.

Rachelle "is not interested" in treating her infertility medically because, like Veronica,

she "feels like" having a child should come more "naturally." She is also concerned that

the treatments may "harm" her and shatter her fatalistic hopes of having a child that is "meant" to be.

The lower-class women's negative attitudes toward medically treating childbearing difficulties stem from as well as contribute to their lack of knowledge of such treatments. For instance, Sherry, a white, 32-year-old lower-class woman, "don't know anything" about reproductive technologies, and Angie, a Black, 25-year-old lower-class woman, does not "even know where to start to even think about" seeking medical treatment for her difficulties. Bonnie, a Black, 33-year-old lower-class woman, reflects:

> I'm sure there's a lot [of medical treatments] out there. I just don't know much about—I'd say probably the only thing I know about it is with the—the cleansing and in vitro cleansing stuff like that and then—I don't know—it was maybe about two months—I know it was this year where this—these two women, they went to a clinic and for some reason somehow they got pregnant and they were implanted with each other's eggs…

Bonnie "does not know much about" treating her childbearing issues medically. Like many other Black lower-class women, she conceives of treatment as "cleansing," perhaps reflective of stereotypes that construct lower-class women as dirty and inappropriate mothers. What knowledge she does have about infertility treatments derives from the media and reflects medical negligence.

Similar to their understanding of infertility and its stereotypes in general, most lower-class women receive their information about medical treatments for infertility via the media. Celebrities such as Angela Bassett, Sarah Jessica Parker, Celine Dion, and Connie Chung are mentioned throughout the lower-class women's dialogues when discussing medical solutions to infertility. For instance, Tiffany, a Black, 22-year-old lower-class woman, states:

> Like I have watched too many movies and like when people be going through that and needles and—and then like when it don't take and then when you do get pregnant, you end up pregnant with like six kids at once. I don't—I don't want that! That's too much. I just want one at a time or twins. I can do that. But as far as six-seven-eight kids in your stomach at one time, I know that's uncomfortable. … It was on like the Discovery channel, the Bio channel or whatever there. That's just crazy.

To Tiffany, the media presents medical treatments for infertility as "crazy" "needles" that result in multiple children. For those who are uneducated about medical treatment options and are based in a cultural context in which medicine is not trustworthy, the media becomes an outlet of information that perpetuates their fears.

Unlike lower-class women, remember that higher-class women "take charge of their fertility" through research and use of technology. Thus, when it comes to resolving their childbearing difficulties, medical treatment is the desired solution and the middle- and upper-class women inform themselves of what it entails. For example, Becca, a white, 43-year-old higher-class woman, notes:

> Ann: So did you have a conversation with your husband before going to the fertility specialist… about seeking care and checking this out?
> Becca: Yeah, I think even before we got married I talked about it…So I'm like, "Well, we'll give it six months…You know, we'll try this. I'm doing everything I can think of and if it doesn't work, we'll go make, you know, an appointment."

Becca had a plan and timeline regarding her fertility. Before she even knew of her difficulties she concluded that she would resolve them medically and "make an appointment" with her physician should they arise.

Despite higher-class women's overwhelming desire for medical treatment once childbearing issues began, they were still disappointed that pregnancy required such intervention. Brooke, a 30-year-old higher-class woman, reflects:

I am (pauses)—I am okay I think with the medications. And I can't decide how I feel about the technologies yet. Part of me just doesn't care. Whatever gets me to the end point. The end point is being pregnant and having a baby. That's fine. I'll do it. I don't care. I'll do it right now. You just tell me what I gotta do and I'll do it. And then part—another part of me really doesn't want to have to go there. Like I really—I don't want to have to go through some kind of, you know, very sterile, very impersonal treatment to have children.

Brooke is open to medically resolving her childbearing difficulties because it will allow her to meet her "end point" or goal of having a child. However, adhering to her life plan in such a manner is disappointing because it is not the normative way children are conceived. Yet, like many higher-class women, Brooke believes that medicine is the answer to her difficulties, and she has high expectations for its success. Colleen, a white, 44-year-old higher-class woman, shares Brooke's optimism:

"Oh, my gosh. This is the answer. An [intrauterine insemination] IUI. It's perfect. We're going to take, you know, we're going to make sure I have what I need and then we're going to make sure he has what he needs and we're going to put 'em together and of course it's going to be a baby. How could it not? How could you miss? It's perfect." And—and of course, you always know somebody who knows somebody who had that work the first time. And filled with all of that hope…

For Colleen, medicine is the "answer" to resolving her childbearing difficulties. The science behind it is "perfect" and "could not" fail. Colleen's hopes are furthered by knowing others for whom medicine has succeeded in treating their issues, unlike lower-class women whose only references are the "horror stories" on television. The optimism held by the higher-class women counters the fears and negativity towards medicine held by their lower-class counterparts.

Exclusion and inclusion: Inequalities within the medicalization of infertility

Despite the various attitudes surrounding medical treatment for infertility, women of both higher- and lower-class sought out medical care due to its normalized presence

within infertility discourse. However, poor and working-class women sought medicine for diagnostic answers, rather than treatment, *per se*, while higher-class women desired both diagnoses as well as treatment for their issues. Such differences not only stem from varying attitudes toward reproductive technologies and other medical treatments, but also from the normalized exclusion and inclusion of their groups from reproductive medicine, in general.

Davidson and colleagues (2006) found that lower-class individuals are aware that their socioeconomic position contributes to the health disparities with which they are faced. They have a "consciousness of their victimization" which allows lower-class women to reflect upon the dominant context of which they are not a part as well as develop ways to grapple with and resist the hegemonic forces placed upon them (Riessman, 2000). This recognition is rarely shared by higher-class individuals because it is an invisible privilege (e.g., McIntosh, 2001). Indeed, lower-class women in this study are "outsiders-within" to the medicalized context of infertility. They are marginalized within reproductive policies and practices, yet aware (albeit with limited knowledge) of the potential resolutions that they offer. This unique perspective allows inequalities to be illuminated (Collins, 1990). The following passage from Donna, a Black, 33-year-old, captures how the poor and working-class women in this study understand their own experiences of infertility through their awareness of the dominant group's experiences.

> No, I haven't [thought about medical options]. I haven't. My—it's probably a denial stage like I am more or less in denial but like I said, I see it on TV and you hear about it and it's like, "Wow, that sounds interesting." Let's see. Was it—I think it was Angela Bassett was the last thing I seen and she got twins but they took her egg out of her and put it in another woman and used her husband's sperm and I'm thinking, "Wow, that is quite a bit." So that was kind of amazing to me. But I know that's expensive so that's way like out of my league but that's something interesting and I

thought about like, "Wow. She couldn't have kids and that was something really nice opportunity she had to have her own child so that was really nice." Yeah, but I haven't really looked like for myself…

Through media representations of infertility experiences, Donna is well aware of potential remedies, such as surrogacy, that are available for infertility. However, she also acknowledges that those solutions are "way out of [her] league" due to the excessive expense. Donna's story reveals how the experiences of lower-class women provide depth to our understanding of infertility by reflecting upon both the dominant *and* subordinate experiences, and thus the powers that shape them.

The medicalization of infertility is based in a "private medicalized market," which results in a for-profit, business structure of healthcare provision (Bates & Bates, 1996). As Carrie, a white, 32-year-old participant, reflects, "It's a money-making business is what it is." While fertility doctors may be "living the high life" according to Carrie, the institution of medicine cannot be reduced to such simplicity. The commercial activity is situated in and informed by a specific ideological context. In addition to securing a profit, medicine maintains and secures the norms in which it is based. Consumers help drive the medicalization of infertility (Conrad & Leiter, 2004), yet the institution of medicine still explicitly and implicitly determines who those consumers are based upon its foundation in social norms.

The middle- and upper-class context of hegemonic motherhood is at odds with the context of lower-class women. For instance, intensive mothering discourages working outside of the home, but for poor and working-class women, that option is not available (Hays, 1996). Similarly, the context of medicalized infertility, in which medicine is a "middle-class constituency," is incongruent with that of women of lower-classes

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(Steinberg, 1997). The sequence and scheduling of appointments is based in a middle-class context in which autonomy and flexibility at work (or at home) are assumed. However, for poor and working-class women, such characteristics are non-existent. Nicole, a white, 28-year-old lower-class woman, reflects:

> The only way I could ever talk to [physicians] is if I have an appointment and I don't understand that. And they—it's like they don't understand that, you know, we can't just always pay $20 all the time or $25 every time just to have an appointment just to talk to you for two seconds. You know, and that's the frustrating part is that they don't get it. And then they always want you to have an appointment in the middle of the day and, you know, well, you know, I go to work to be able to afford this appointment (laughs), you know? It's—and it's very frustrating. Yeah, so I mean like last year I went to doctors' appointments so many times and it was—I had to work, you know, my bosses were giving—giving me like, "Okay, why do you have so many doctors' appointments?" And, "I'm, you know, dealing with a lot of stuff and medical issues right now" and luckily I kept my job, you know, they didn't let me go or anything, which I was really grateful for and so everybody understood and this year I just let it go for the most part because I just can't do that all the time. Just—I mean my job is my number one priority right now. I've got to keep my job.

The appointment structure of reproductive care is a prime example of how medicine is constructed by middle-class interests, neglecting the circumstances of lower-class women. Nicole had to "let [fertility treatment] go" because of the inflexibility of her job. In a sense, she had to choose between having a family and earning a living, a choice many women of higher economic standing do not confront. Physicians, however, "don't get" the dilemma in which they have placed Nicole due to medicine's middle- and upper-class lens and ignorance of the social and cultural context of its patients' lives.

The decontextualization present in medicalized infertility may explain why even when women are insured, as in states with comprehensive coverage, disparities still exist. For instance, according to some participants, physicians conduct more procedures when

they are aware a patient is insured in order to get maximally reimbursed. This excessive

use of procedures is especially troublesome for women with limited disposable income,

for whom the extra fees and more frequent co-pays are significant expenses. Jackie, a

white, 23-year-old lower-class woman, relays such difficulty:

> …I mean because I have insurance, [physicians] try to put me on this
> stuff, which I understand because our health coverage is great. All we've
> had to pay through this thing is like $40 to the doctor's office…But our
> actual prescription insurance is really awful and they put me on Premicare
> 1, which is the prenatal vitamins so they told me. And it was like a $92
> co-pay every month I have to pay…And I mean we have a very tight
> budget because I don't work and that $92, I mean it doesn't really fit in
> (laughs).

Taking prenatal vitamins "doesn't really fit in" to Jackie's budget. She is forced to

prioritize and navigate all of the services offered. Physicians' lack of awareness of the

participants' financial contexts causes them to conduct more procedures and overlook

excessive expenses. In effect, insurance places more constraints on the less financially

well-off and hinders the proper care of poor and working-class women. Even when

treatments are accessible, a hierarchy of care remains.

In addition to disparities due to the presence of insurance, the *type* of insurance

also matters in shaping physicians' responses to infertility treatment. Keisha, a Black,

33-year-old lower-class woman, describes her denial of medical care based on her status

as a Medicaid recipient:

Ann:	So have you ever talked to [the doctor] about becoming pregnant besides, you know, when you go in for [other reasons]…?
Keisha:	No, because I feel they're going to be like, you know, you're on Medicaid and you—they don't cover for this and that and this and that. And I don't want to be let down like that, you know, I really don't. And I feel because I'm on Medicaid, I do try to get some help in some other way and that—and they're like, "Well, you're on Medicaid, you

know, you shouldn't be, you know, trying to do all of this on Medicaid."

Medicaid does not cover infertility treatments. In addition to this explicit exclusion, however, Keisha is also implicitly excluded from receiving fertility care because of her fear of being "let down." She has been told too often that she should not be "trying to do all of [these things] on Medicaid" so she avoids that conversation altogether by not inquiring about her infertility. Medicaid is a status marker for class. Not only does this preclude the inclusion of infertility treatment coverage within its policy, but it also shapes the treatment women on Medicaid receive from physicians. The context in which insurance policies for infertility are constructed is one that is historically constituted in class and race-specific ways. Thus, such policies regulate who can and should reproduce and mother according to sociodemographic dimensions (Steinberg, 1997).

This normalized exclusion of lower-class women from receiving medical care for their infertility is further perpetuated by the circumstances surrounding the doctor-patient relationship. Physicians are considered "experts" and are revered as authorities over all things health-related (Freidson, 1972). Moreover, lower-class women are further distanced from doctors due to differences in their class and many times race positions. Fisher (1986) has argued that women, particularly marginalized women, have been socialized to accept the authority of others. Tamara, a Black, 25-year-old lower-class woman, demonstrates such submission when she states that she "just let [the doctor] do her job and felt like it was going to be right." Such trust in the physician causes many of the poor and working-class women to not mention their childbearing difficulties because they assume the doctor will identify them if they exist. Donna, a Black, 33-year-old lower-class woman, is one such example:

Yeah, but still if they tell me everything normal, then that kind of ease for me instead of me telling them like, "Oh, I can't have a baby. Could you tell me"—I'm thinking if they check me up and then they'll let me know if they find something wrong. So that's my way of thinking of it. And probably me not wanting to hear it (laughs). They do—yeah, me putting them onto, "Well, oh, take this test. And this is what's wrong with you." So yeah. Every time I go like give blood work and everything but that's normal and so that kind of soothes me like, "Mm, maybe nothing is wrong." So yeah.

Donna is reassured that "everything [is] normal" when the doctor does not indicate otherwise. She waits for the physician to identify or probe about an issue rather than acting on it herself. The doctor is the expert of Donna's body, not Donna herself.

In addition to halting communication with physicians, the social distance between lower-class women and doctors also incited *mis*communication. The communication (and contextual) divide between the highly educated doctors and the less educated women pursuing care caused many of the poor and working-class women to discontinue medical treatment for their infertility. Jocelyn, a Black, 20-year-old lower-class woman, reflects upon such interaction:

Ann:	Did they explain to you why you needed [infertility treatment]?
Jocelyn:	Not really. They just, you know, they didn't—they didn't even give me a booklet. I had to find me a book and research on my own. [How can you] be a physician and [get] a degree and … not [be] open with the patients and you're not showing them that you're caring?…I had to do everything by myself. I had to buy a $25 book; [money] that I could have…kept in my pocket…
Ann:	Because the doctors wouldn't explain it to you?
Jocelyn:	Not like they did—I mean just they come back, "Take these pills, you know, for three months. Come back." (laughs) I mean that's crazy.

In this brief dialogue, Jocelyn highlights numerous ways in which her interaction with her physician was negative and unproductive. The doctor was not only uncaring, but also not

informative about Jocelyn's specific reproductive problem as well as the purpose of the treatment to resolve that issue. This medical treatment was the only one Jocelyn received for her infertility. The lack of communication and its negative tone caused her to seek out her own sources of information and not bother returning for follow-up care.

Similarly, Bonnie, a Black, 33-year-old lower-class woman, did not pursue the physician's prescribed treatment due to its incongruency within her contextual circumstances:

> Oh, he gave me some pills. He gave me some pills to take. I'm like, "Oh, I'm tired of taking pills."… I didn't take 'em…Like it was—it was weird because I was supposed to take this like the first three days and then take something the next five days. I'm thinking, "Look, this is too much. Sometimes I don't even know what 2 + 2 is." You know? So what makes you think I'm going to remember to do that? I mean he had got a calendar out and drew it out and this and that and then. And my fiancé's supposed to go to some kind of clinic and give his sperm and I'm like, "Uh-uh, no."…that's too complicated.

The doctor's prescription was "too complicated" to fit into Bonnie's life. Because of medicine's ignorance around social context, the physician fails to recognize the incongruence, and therefore does not seek to simplify the treatment or assist Bonnie in better understanding how she may adapt her circumstances to adhere to the medical resolution, leaving Bonnie without any solution.

Miscommunication and health literacy and its effects are further demonstrated in the experience of Kayla, a Black, 20-year-old lower-class woman:

> Ann: Did you ever go to the doctor to ask about it?
> Kayla: No. I always tried to ask them do they have something to help me get pregnant but they say no.
> Ann: Do you—do you know of anything that they could have done for you?
> Kayla: No, but my brother's baby mama told me that they had some type of pills that can help you get pregnant because she heard it from

> her auntie but she don't remember what the pills was called. And
> she told me to ask them but they said no.

Kayla lacks knowledge about the specific treatments available for infertility. Instead of telling the doctors about her difficulties conceiving, perhaps due to the Black cultural practice of not disclosing personal issues, Kayla inquires about "something to help [her] get pregnant." Given this phrasing, the physicians may not have realized Kayla's troubles. This misunderstanding coupled with the normalized stereotype that young, poor, Black women are 'bad' mothers, may have led the doctors to say "no" to Kayla's request.

Many times doctors utilize their construction as experts as a way to discourage 'unfit' mothers from reproducing. "Doctor knows best" is the epitome of physicians' institutional authority, and it is exemplified within their interactions with patients. For instance, doctors advise patients and many times attempt to persuade them by "implying dire consequences" if the patient does not comply (Fisher, 1986). This tactic is evident within Keisha's experience. This Black, 33-year-old lower-class woman, describes an interaction with physicians after she had a miscarriage at age sixteen:

> … They—they just—they just seem like they just didn't want me to have
> any kids (laughs) at all. At all. And that was sad. They, you know, they
> scared me into even trying to have any more. They tried—they tried to
> get me not to even have anymore […] They was really scaring me.
> That's why I—I said, "Oh (laughs). Never again, Holy Grace Hospital.
> Never again." Because they scared me and it was just—just crazy.

Although physicians "scared" Keisha into not trying to have any more children, she subsequently had two children and is now suffering from secondary infertility. Yet, this incident, occurring nearly two decades ago, has precluded Keisha from seeking medical care for her current reproduction difficulties. "Never again" will Keisha seek the care of

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medical professionals regarding her trouble conceiving, which in turn serves to further drive the class-based divide of medicalized infertility.

Josie's experience also exposes the doctor-patient relationship as one based in power. This Black, 24-year-old lower-class woman, contemplates:

> So I was actually thinking about going to see someone else… And I'm just like, "Do I really want to start over with someone else?" And then at the same time I don't want to like hurt his feelings—not like hurt his feelings but like, you know, I don't want to—I don't want him to feel like I am stepping over him to get a second opinion but I kind of am because you're not really, you know, telling me anything. So I'm not for sure if I'm going to see this other doctor or not. I've been thinking about it. I guess I'm still thinking about it as to what I'm going to do with that.

Josie is dissatisfied with her current practitioner because he "isn't telling [her] anything." Yet, despite this dissatisfaction, she is hesitant to switch providers for fear that she will be "stepping over him" and "hurt his feelings." To Josie, there is a clear hierarchy of care and she is hesitant to disrupt or move herself up that ladder, thereby sacrificing the quality of the care she receives for her childbearing issues.

The influence of doctor-patient communication on the experience and construction of infertility is also apparent among women who did not receive medical care specifically for their infertility issues. Given their marginalized status and construction as 'bad' mothers, many lower-class participants perceived discrimination from medical providers when they requested reproductive health care during general medical visits. These experiences can deter the women from seeking such care. Breheny and Stephens (2007) found in their research on teen mothers that the young women avoided medical care because of the negative reactions they received from health professionals. The authors conclude that the "wider discursive context of 'judgmental' health care provision" must be taken into account when examining the utilization of

medical care among marginalized populations (Breheny & Stephens, 2007; Brubaker, 2007). Such a context is evident in Michelle's experience with reproductive health care. She is a Black, 25-year-old lower-class woman:

> Ann: Have you been to the doctor about [your infertility]?
> Michelle: No…because I thought that, I was thinking you could just get pregnant. I don't know what--well they probably could tell me some stuff that I could do. But most doctors try to talk you out of getting pregnant.

Michelle could not conceptualize the medicalization of infertility given her previous interactions with physicians in which they tried to "talk [her] out of getting pregnant." Doctors had normalized Michelle's exclusion from reproduction in two ways: first, by discouraging her from even trying to become pregnant, and second, by Michelle's internalization of that exclusion which subsequently prevented her from seeking their assistance when she was having difficulty conceiving. They discouraged both her fertility as well as the resolution of her infertility.

Tiffany, a Black, 22-year-old lower-class woman, attributes such discrimination to her African American race:

> Like if like most—like if [my friends and I] wanted to go in there to get tested and stuff like that, [the doctor] always like trying to push you to get like the little UID or whatever…And like we like, "We don't want to be on birth control. Why are you trying to make us get on this?" And then like she'll just give us condoms and stuff. Okay, that's fine and dandy but you don't have to just like always push it at us, you know, as black people or—…I don't know. She was just really rude. I think that's another reason why I really didn't get no help because she was my doctor there…It was—it was plenty of us that she did that to. Like she used to try to force us to take birth control. And like she was like, "You should try this. You should do this. You should do that." I am not going to do it because I don't want to…I don't want to be on the pill. I don't want to— be on the patch. I don't want the shot and I don't want that UID thing. Y'all are not sticking that in me…I'm like, "I'm trying to get pregnant. Not trying not to get pregnant."

Tiffany was limited to seeking care at a low-income health clinic which only had one doctor. This structural barrier intersected with ideological barriers in that this particular physician, according to Tiffany, employed racial stereotypes by discouraging rather than encouraging her reproduction, so Tiffany "really didn't get no help" for her infertility.

In addition to race, practitioners also discriminated along other demographic characteristics, including marital status. Within the middle- and upper-class culture which is also the culture of physicians, marriage is necessary prior to having children. Thus, as in the case of Lisa, a white, 39-year-old lower-class woman, physicians discourage reproduction among unmarried women:

> I did have one doctor that she just wanted to do a hysterectomy and get it over with…And I was—it was when I was 32. She was like, "Well, you're 32 and not married. Do you really want to have kids?" I'm like, "What does it have to do with being married to anyone?" You know. And, you know, when I—I was dating the guy in Cleveland and she's like—"How do you expect to get pregnant when you don't live together?" And I'm like, "I know lots of people who get pregnant and don't co-habitate. This isn't—they're not directly related to each other.

Despite Lisa's childbearing age, her unmarried status led her physician to suggest a hysterectomy rather than considering other options to resolve Lisa's reproductive problems. There was a conflict of norms between the patient situated in one context versus the doctor situated in another.

Ultimately, the women's experiences of exclusion within medicalized infertility become naturalized, reinforcing the stereotype that infertility occurs among economically and racially dominant groups. Because of this, many lower-class women in the study, consciously or unconsciously accept hegemonic notions of classed fertility, failing to recognize the forces behind such inequality. The stereotype of infertility as a higher-class

issue combined with the perpetuation of that myth within medicine, meant that Candace, a Black, 41-year-old lower-class woman, did not even try to seek treatment.

> I believe I could have did a lot of things to change it. I didn't think—I didn't think—I thought maybe only a rich person could do it maybe. Or maybe—I don't know—maybe—I didn't think I could really do it like get a—get fertility pills or get my uterus scraped or—I had heard of things but maybe I didn't really think I could do it.

Candace interpreted the medical treatment of infertility as something for the "rich;" the exclusion of lower-class women from medicine was naturalized. Candace cannot articulate why only a "rich person could do" infertility treatments. In turn, she perpetuates such constructions and thus her exclusion by not pursuing medical care for her infertility.

Lower-class women face barriers to infertility treatment both inside and outside the medical realm. By examining the lived experiences of infertility among women marginalized in reproductive narratives, inequalities within medicalized infertility are apparent. The structure of medicine, doctor-patient interactions and insurance policies are informed by dominant norms, in turn regulating reproduction and motherhood by placing poor and working-class women outside the bounds of infertility, and thus, its resolutions.

The experiences of medically resolving their childlessness among higher-class women greatly diverge from those described by lower-class women. Not only are higher-class women able to financially access infertility treatments, but they are also included within mainstream medicine, both structurally and ideologically. Moreover, they are in control of and in partnership with physicians for their reproductive care.

The middle-class bias apparent in medical institutions conforms to the needs, schedules, and resources of women within that same class location. Unlike lower-class women, higher-class women are able to attend the frequent appointments required for infertility treatment because they have flexibility within their jobs or do not work due to sufficient support from their partners. For instance, Sarah, a white, 33-year-old higher-class woman, describes her ability to adapt to medicine's rigid requirements:

> [My supervisor] came into my office and she's been so supportive all along and she said something like, "You've been asking for too much time off to go to doctor's appointments. You know, you need to be able to change these. You need to be—to pay attention to your schedule" and whatever…But she retracted her statement to once I started crying and— and telling her, "You can't go on any other day or any other time."

Like Nicole, Sarah had difficulty juggling all of the appointments required by infertility treatments. However, unlike Nicole, Sarah had the status and agency to be able to negotiate with her supervisor to continue medical care. Being able to talk back to one's superior is a privilege and one not held by all women.

This privilege also extends to interactions with physicians. For middle- and upper-class women, the doctor-patient relationship was more of a partnership than one based in power differences. Similar demographic characteristics placed the higher-class women on a more equal level with physicians. Additionally, the increased agency and control typical among women of higher-class settings also diminished the hierarchy of care that was so prominent within lower-class women's experiences. It is within their nature to "take charge" of their reproduction.

The casual equality apparent within higher-class women's relationships with their physicians is exemplified by Colleen, a white, 44-year-old higher-class woman, who called her physician, "Brian," by his first name. They were friends, peers, equals,

working together to resolve her childbearing difficulties. This scenario significantly

contrasts with the revere, authority, and distance lower-class women ascribe to their

physicians, ultimately affecting their care. In other words, unlike lower-class women,

higher-class women are inundated by the medicalized experience, so much so that their

inclusion becomes normalized and fused with their everyday experiences. For example,

Nadia, a white, 33-year-old higher-class woman, describes her interaction with

physicians:

> I could tell that I knew more than [the doctor] did. I mean because I—I tend to do research and read anyway and I'm probably one of those patients who drive doctors crazy but it's not like I'm going on like chat rooms or, you know, random web forums. I'm really doing research and I still had access to the online medical library from when I was doing my MBA so I would access medical trials and read and I just didn't feel like she knew much. It wasn't until I got to my R.E. that I felt like she could answer my questions…I lied actually. I had only been trying for six months but I told her I had been trying a year because I had a feeling that it was going to be problematic and I didn't want to waste any more time.

Rather than being discouraged from getting pregnant like Michelle, Nadia actually went

to physicians with her own diagnoses, questions, and treatment ideas. Her access to

resources and knowledge allowed Nadia to believe that she "knew more" than the initial

physician she visited. Additionally, Nadia had the agency and ability to know how to

work the system rather than be removed from the system—she could access infertility

treatments earlier by being aware of medicalized definitions of infertility and gaining the

respect of her reproductive endocrinologist. Unlike Tamara who "let the doctor do her

job," Nadia was in control of the medical interaction.

Such active presence within the higher-class women's medical care is further

demonstrated by Becca, a white, 43-year-old higher-class woman:

> I was like on the accelerated plan. I found out every single test I had to
> have, figured out where in my cycle it had to be done and got everything
> done in like two months… But I mean like that CDC website I went
> through every single clinic and then made a spreadsheet for my age range.
> And then when I would go into the doctor's office, I had all of the tests
> and they were all color coded with little tabs and like a little notebook. I
> do, you know, looking back like most people throw like a manila
> envelope at 'em, you know, with their tests in 'em and they're like, "Did
> you want this back?" And I'm like, "No, that's your copy."

Rather than wait the one year to seek infertility treatment, as indicated by the medical definition of infertility, Becca was "on the accelerated plan." She not only had the ability to dictate her own timeline of care, but she had the knowledge to do so. Unlike Donna who depended on the physician to tell her if something was wrong, Becca took information to the doctors rather than wait to receive it from them. She researched which fertility specialists were the most successful for her age group, and in her words, "interviewed them" for the best fit. In contrast to the experiences of lower-class women who were limited by their insurance or low-income status to certain doctors and clinics, such as Tiffany, Becca "did [her] homework" and had the privilege of choice when selecting a care provider. Such a scenario reflects Freidson's (1960) conceptualization of referral structures. Due to the lack of insurance coverage for infertility, its medical treatment is a highly client-dependent practice, thus it truly is "like a business" in which physicians try to attract middle-class patients. According to Freidson, this structure is a "lay referral system" in which the clients or patients have more control as opposed to a "professional referral system" in which physicians have more authority. As such, it allows Becca, a higher-class woman for whom control and choice come naturally, to gain power within the medical interaction rather than minimize her power.

Whereas lower-class women, such as Josie, were fearful of "stepping over" their physicians to switch doctors, higher-class women frequently made such transitions. Stephanie, a white, 35-year-old higher-class woman, elaborates:

> [The doctor was] like, "Oh, you just haven't given it enough time" basically. And I thought, "Well, I think I have" after, you know, at this point I'm thinking, "I have. I've given it a lot of time in my book." And—and so I waited for a few more months and then I went, "You know, I'm still not happy with that answer and I feel not valued. I feel like my—my voice still needs to be heard. Like there's got to be something more." So I got a recommendation from somebody else and saw another doctor…And for the first time I felt like validated.

It was important to Stephanie that "her voice be heard," as she is used to such acknowledgment within her daily life. She disagreed with the physician on timing of infertility treatment, thereby diminishing his expertise (or technical knowledge) and went elsewhere. Stephanie had the support and resources to get a recommendation for a different physician, allowing her desires and ideas to be "validated."

Such teamwork and equality inherent within the higher-class women's discussions of their medical interactions is exemplified in the experience of Iris, a white, 30-year-old higher-class woman:

> [After receiving the infertile diagnosis] we just tried—we suddenly went into like, "What can we do—what anything we can do. What can we do?" And it seemed—it—it was like, "Well, you just wash [the sperm]." We'll just, you know, we just went in there like to the clinics saying like, "Just wash 'em. That should work."

Iris and her husband had an active, agentic response that placed them on the same level as the physician. "What can *we* do" as if a team, was their initial reaction to her husband's diagnosis of infertility. The ease of overcoming their reproductive issues implied in their suggestion to simply "wash" the sperm is indicative of their ability to overcome most

difficulties they have faced in life. In their minds and within their context, Iris and her husband should be able to control their infertility, including its resolution.

Not only are higher-class women structurally included within medicalized infertility, but their inclusion is normalized as it reflects their own circumstances in which they typically have control and access to their desires and equality (if not superiority) in their relationships. Higher-class women have the ability to choose their physician, how and when their care will take place, and what that care will entail. They are socialized to have the tools to intervene in the medical institution and get what they want (Lareau, 2003). For middle- and upper-class women, doctors are not the experts or gatekeepers determining what information is given and received, but are a means to an end in which the higher-class women themselves dictate their care plans. In other words, unlike lower-class women who are excluded from receiving medical care for their infertility, higher-class women have the option of excluding certain doctors from treating them for their childbearing difficulties.

Beyond medicalization: Other options to resolve childlessness

Despite its normalized presence, medicine is not the only option to resolve infertility. Indeed, many of the participants were begrudgingly confronted with the "why not just adopt" inquiry from friends and family. But, adopting a child is not such a simple solution. Like medicine, adoption is situated in a social context in which dominant norms shape its practices and policies, including who can access it. According to Thompson (2005), adoption is a form of "social engineering" in which its home study or parental screening system is informed by race, class, sexuality, and marital stereotypes resulting in exclusionary practices in order to create an "ideal family." Rothman (1989)

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describes how all levels of the adoption process are situated in social class. The women

giving up their children for adoption are typically of a lower-class than those seeking to

obtain children through adoption. Moreover, adoption is a type of commodified

motherhood through which children are bought and sold, providing an advantage to those

with higher incomes. In other words, "adoption is as much a class issue as it is anything

else" (Rothman, 1989).

Reflecting their recognition of exclusion from medical options for infertility, the

lower-class women in the study also acknowledge their marginalization within adoptive

policies. For instance, Judy, a white, 39-year-old lower-class woman, states:

> I have thought about [adoption] but then I don't think that—I don't think
> they would give me a baby because I'm not married and, you know, they
> don't just give any old person a baby. Especially when you don't have
> like a lot of money and, you know?

Judy was open to adopting a child, yet she recognizes that her class and marital statuses

will probably prohibit such a desire. Because "they don't just give any old person a

baby," Judy has not pursued adoption.

In addition to implicitly excluding poor and working-class women from adoption

by judging parental adequacy at least partly on monetary criteria, adoption is also

explicitly prohibitive for lower-class women because of its financial cost. Jessica, a

white, 36-year-old lower-class woman, explains:

> [The cost is prohibitive], mm-hm, yeah. We just weren't and still aren't,
> you know, even when we looked at adoption. You know, 'cuz we
> seriously talked about adoption after a while…You know, which is still
> again, you know, $20,000. $15-$20,000. I'm like—and it's all cash up
> front. I'm like, "We don't have, you know." I'm like, "I'm working full-
> time and going to school just to pay the house payment and everything
> else 'cuz, you know, my husband's laid off every other month or six
> months from the automotive industry." You know, and now he's going
> back to school and so forth. But I'm like, "I don't ever see us just having,

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you know, $15-$20,000 cash to do." So it's like, you know, we never give up on the idea. It's like and I guess somewhere in the back of my head I never give up on, you know, it's like, "Well, maybe that miracle will still happen." I don't hold my breath anymore but I think there's a part of you that just can't ever let go of that hope that, you know

As a working-class woman, Jessica is unable to make the "up front" costs required for adoption. Her husband's insecure job along with their educational costs does not leave room for extra expenses. Being able to adopt would be a "miracle" for Jessica, but she is "not holding her breath."

For the majority of higher-class women, including those who adopted, adoption was their second choice after medical treatments. This is reflective of the medicalization of infertility which has naturalized medicine as its resolution, further perpetuating biological motherhood as the norm. The secondary status of adoption is also due to the motherhood mandate in which women are naturally supposed to bear children (Letherby, 2002). Nadia, a white, 33-year-old higher-class woman, clearly articulates this view:

Sometimes I don't even like to think about [adoption] because then that means there's no hope for my own biological kids. And in some ways, it's like it's very egoic. I recognize that because if you want kids, what difference does it make if they're your own? Well, okay, fine, let's say you even get past that. So the thing is people are like, "Well—" and I—I really want to strangle people who say, "Well, you can always adopt." As if that's easy. Well, on average it's about $30,000 to adopt a newborn. It takes several years. It takes a lot of—you will go through so much scrutiny that—to get—go through the approval process to be adoptive parents…It's like any idiot off the street can have kids but to adopt, you have your life torn apart. You have to have interviews for everything. Everything tested. All kinds of stuff. They come through your house. They look at everything. You know, you have to perf—you know, basically you're on, you know, you have to perform perfectly. You have to prove that you're worthy to be a parent as if you haven't gone through enough proving in your own mind and feeling of unworth…In fact, we're starting on the process just because I don't want to reach the end of the biological road and find, "I have to do another two years worth of stuff leading up to that." So just in our back pocket. So yeah, I'm not thrilled

about it. But I figure, "If it gets to that point, I will be happy." But I don't think the—the adoption process is very great here either.

The social construction of parenthood, family, and mothering has developed a hierarchical distinction between biological motherhood and social motherhood (Letherby, 1999). This "blood bias" is central to conceptualizations of family as it represents the ultimate bond of human relations (Parry, 2005). Such thinking is reflected in Nadia's opposition to adoption because it means "there is no hope for [her] own biological kids." Adoption is her "back pocket" option that she will force herself to be "happy" about should it come down to that. Like the lower-class women, Nadia recognizes the complexity and scrutiny involved in the adoption process; yet, unlike lower-class women, Nadia is able to afford it and has the race, class and marital characteristics of a 'good' parent. She is not fearful of her exclusion from adoption; she is fearful of having it become her only option.

In addition to privileging biological motherhood over social motherhood, many higher-class women are hesitant to adopt because it diminishes the amount of control they have over the childbearing process. Sarah, a white, 33-year-old higher-class woman, elaborates:

> I guess the biggest thing is we're very conscious over food and what we put into our bodies, my husband and I. And so it's like if I don't know exactly where this child has come from and like—I don't know—that's the piece. It's like this whole—it's the—it's the nature part that—I don't know—I don't know if I could deal with someone else's and not knowing what was going to surface as the years go on. I think that's the piece that I'm like, "Really?" But I think—I don't know if I could ever let that go. I don't know. Like, "Will this kid end up with something?" It's like at least I can—I feel like I guess when I am pregnant, I can control what I do and what the unborn fetus is getting or not getting.

Sarah and her husband are afraid to adopt because they are not in "control" of the environment in which the fetus will be during pregnancy. Sarah and her husband know their bodies, their history, and how they care for themselves. However, they do not have that knowledge about others' lives. If they adopt an infant, the nine months of pregnancy is the only part of that child's life for which they are not in charge. However, control is such an important component within Sarah's life that even that short timeframe overshadows a lifetime with a child.

Despite the hesitancy and negativity surrounding adoption, five out of the fifty-eight participants resolved their childlessness by adopting a child. Four of those five participants were middle-class, and one was working-class whose wealthy parents paid for the process. The higher prevalence of adoption among middle-class women may be reflective of the ability of wealthy, upper-class women to pursue medical treatments longer and the lower-class women's exclusion from adoption due to its cost and ideological basis. Like medicine, adoption is expensive, so for middle-class women on fixed incomes, the "odds" of success become a factor in decision-making. With adoption there is a much higher likelihood of having a child at the end of the process compared to one round of IVF, yet they are approximately equivalent in cost. Stephanie, a white, 35-year-old middle-class woman (annual household income approximately $55K), explains such reasoning:

> [The doctor] said, "Well, here's a couple options for you. But if you're interested in not going any further with the process of, you know, to blowing out your tubes" and like all of these different things that she talked to us about, "then I really think that if you are—if you are longing so desperately to still be parents, that maybe adoption is the way for you all to go."…And she said, "I can pretty much guarantee that if you go adoption route, there may be bumps in ro—and bruises but you're not going to have the—the chance of disappointment in the extreme sense that

you would if—if we go down this [medical] path because you still may not conceive, depending on what we find."

After several infertility tests and a few drug treatments, Stephanie and her husband were faced with surgeries as the remaining medical options to resolve their infertility. Due to their financial concerns over such procedures, their physician suggested they consider adoption because it is more of a "guarantee" of a child compared to the "extreme disappointment" that may ensue with continuing medical care. They heeded the physician's advice and adopted twin boys "who were born in [their] hearts."

While not permanent, foster care is another solution to overcoming involuntary childlessness. No higher-class women were open to becoming foster parents, yet several of the lower-class participants not only liked the idea, but they preferred it to biological motherhood. The openness to foster care among the poor and working-class women is reflective of their familiarity with it within their lived environments. Most lower-class women know of others, if not themselves, who were fostered as children. Jodi, a white, 25-year-old lower-class woman, is one such example:

> Yeah, there—there is adoption and, you know, if—if I did find out later in life that I really can't have children then, you know, I would think about fostering or adopting because I, you know, that's what happened with me. I—I was given that chance. So, you know, why not give it to somebody else who needs it? And you already know what, you know, you have been through so you know what to do and what not to do and what signs to look for if you get a hellion (both laugh).

Jodi was "given a chance" through foster care as a child, so is open to the idea of becoming a foster parent. Her past experiences give her knowledge and confidence in her own ability to foster, components missing among higher-class women which prevents them from pursuing this social mothering option.

Like Jodi, Regina, a Black, 37-year-old lower-class woman, also wants to be a

foster mother given her personal connection to the system:

> [I have wanted to be a foster parent] I think as long as I can
> remember…Yeah. Because I know that a lot of these foster parents that
> kids get placed with should not be foster parents. …Yeah, from my own
> experience so I feel like at least I know that there will be one out there
> that I know for sure that, you know, is getting the kids because she loves
> kids and not just because she wants the check or, you know…And I know,
> you know, there is a couple other foster homes that we was in that was
> just really terrible. …And that I know should not have been foster
> parents. So I feel like, you know, like I said, I know that when I become a
> foster mother, this is what I want to do because I love kids and because I
> want to help them and because I don't want them being mistreated…I
> remember telling myself that, you know, "When I grow up, I'm going to
> be a foster parent and, you know, make sure that these kids—kids will not
> be treated the way we were being treated." It was horrible. They took us
> away from our mother to put us in an even worse situation, you know.

Despite some of the women's desires to be foster mothers, there was an absence of such

action. No participants pursued such a role, perhaps due to the complex bureaucracy of

the foster care system or because the lower-class women were still waiting for a

definitive "answer" regarding their childbearing difficulties before moving forward with

a resolution (Hasenfeld, 1993).

In addition to having more intimate knowledge of foster care than adoption, there

are several other differences between the social mothering systems that may have swayed

the participants towards one option over the other. Adoption is costly (approximately

$30K) yet foster parents are paid for their services. The permanency of the relationship is

also significantly different since foster children many times return to their biological

parents. Additionally, the evaluation of prospective parents, while done on both foster

and adoptive parents, is more rigid in the case of adoption. It adheres more to

mainstream ideas of what makes a good mother. Paperwork and bureaucracy are also

more stringent within adoption than foster care, although fostering still requires coursework and form completion.

Biological mothering is preferable to most women in the study due to normalized definitions of motherhood and family in the U.S. However, when that option is not available, participants turn to forms of social mothering, such as adoption and foster care. But, higher-class women are hesitant to choose those options given their circumstances in which control is valued and foster care is not prevalent. In contrast, lower-class women are open to such choices, but face the same structural and financial barriers to adoption that are present in medical treatment for infertility.

Conclusion

Due to cultural beliefs and sociohistorical relations with medicine, lower-class women, particularly Black women, are hesitant to seek medical treatment for their infertility. Despite such negativity, the lower-class women still pursued medicine for an "answer" or diagnosis for their difficulties. However, as the findings reveal, such a pursuit falls short due to medicine's inaccessibility to marginalized women. Medicalization is a contextual process situated in dominant ideals and serves as a gatekeeper determining who should and should not mother, or who should and should not remain infertile. It is common knowledge that lower-class women are excluded from medical treatment for infertility due to its economic inaccessibility. However, "to define reproductive choice/rights in terms of democratization of access to treatment would seem to assume that women's reproductive agency is both without and transcendent of context" (Steinberg, 1997). The restrictive circumstances of lower-class women alongside the institutionalized classism of medicalization construct and constrain the women's choices

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around reproductive health. The main solution to achieve biological motherhood, medical treatment, is financially out of reach and inherently exclusionary. Yet the primary source to gain social motherhood, adoption, is also a classed system.

In contrast to the normalized exclusion of lower-class women, higher-class women are inundated in the medical experience. They plan the timeline of their treatments, select which doctor they will see, and then work with the physician to develop a treatment plan that suits their lifestyle and desires. Their demographic characteristics characterize them as 'good' mothers, allowing adoption to be a "back pocket" option if need be. Contrasting the classed experiences of resolving infertility ultimately exposes the intersection of the two institutions that control reproduction—motherhood and medicine—and the maintenance of social norms between them.

Being positioned through inclusion or exclusion within both motherhood and medicine greatly shapes the infertility experience, as the following chapter reveals. The seemingly unlimited options to resolve childlessness among higher-class women compared to the limited choices of lower-class women determine how infertility impacts and affects their daily lives.

Chapter Seven

Coping with Infertility[‡]

Women do not mechanistically respond to economic forces. Rather, they assess their options and make choices that allow them to forge meaningful lives despite the…economic conditions in which they and their children find themselves (Jarrett, 1994).

The infertility journey does not end with the choice (or lack thereof) of a resolution. The resolution itself greatly shapes how a woman experiences infertility. In particular, the participants' class circumstances as well as whether or not they used medicine to resolve their infertility influenced how they coped with infertility and envisioned the future.

This final chapter of the infertility experience, however, is not captured within our current understanding of the affliction. Most prior literature focuses on a cross-section of the experience, typically when women are in the midst of it, such as when they are receiving medical care. Thus, "post"-infertility experiences, such as the effects of that care on the experience, go unexamined. However, as Schneider & Conrad (1983) allude, to understand the complete 'illness' experience we "must consider people's everyday lives lived *with* and *in spite of* illness."

[‡] Portions of this chapter appear in the following manuscripts: Bell, A.V. (2009). "It's way out of my league": Low-income women's experiences of medicalized infertility. *Gender & Society, 23*(5). Bell, A.V. (2010). Beyond (financial) accessibility: Inequalities within the medicalization of infertility. *Sociology of Health & Illness, 32(*4).

Most medicalization literature, however, is unable to thoroughly capture these components due to its lack of focus on race and class. As Dillaway and Brubaker (2006) note, "No research…has been done on whether women from different class locations make different choices about [reproductive] medical interventions, or perceive the procedures themselves or the information about procedures differently." But, as previous chapters have alluded and other researchers have found, medicalization is based in race and class ideas (Litt, 1997; Steinberg, 1997), making it all the more pertinent to examine how such demographic characteristics may or may not alter the process and effects of medicalization.

This chapter examines the final stages of an individual's journey through infertility. In doing so, it reveals how medicalization is refracted differently through the class structure; and thus, how class-based encounters with medicalization shape experiences of infertility. First, it explores the implications of medically resolving infertility compared to non-medical resolutions for infertility. Second, the chapter examines how women cope with infertility, much of which is shaped by those effects and resolutions. The findings not only extend our understanding of the experience of infertility but they further demonstrate how infertility is a social experience, dependent upon the context in which it occurs.

The effects of medical exclusion and inclusion

For most study participants, infertility is a devastating experience, regardless of class. But how that devastation manifests is dependent upon context, including the presence of (other) stressors in one's life, and 'choice' of resolution. The findings thus far demonstrate that social location does indeed differentially shape infertility

experiences (Dillaway & Brubaker, 2006). The following results further that notion by

exploring how the process of medicalization, as part of that social location, influences

experience. Foucault (1975) demonstrated how the "clinical gaze" transforms an

experience. Once an event is medicalized, much of its context is situated within medical

institutions and worldviews, impacting the way an individual interprets and reacts to

social norms (Greil, 1991). For the women in the study who received medical treatment

for their infertility, namely those of higher-class, medicine consumed their lives and

shaped their coping mechanisms. In contrast, the participants who did not receive

medical care for their infertility, primarily lower-class women, were faced with limited

options and thus forced to put infertility on the "back burner."

As the previous chapter described, most lower-class women have limited, if any,

access to medical resolutions for infertility. Their options are finite. For instance,

Roberta, a white, 39-year-old, laments, "I'll just keep doing what I'm doing. And I think

there's nothing else I can do." Jewel, a white, 22-year-old lower-class woman, echoes

Roberta's stalemate when she states:

> I just—I know there's something wrong and I just—there's nothing I can
> do to figure out what is wrong with me…And that's very hard to know
> that there's people out there that could tell me what's wrong with me but
> it's all about money. And that drives me crazy how this world is about
> money when you could help me and figure out so I could have a baby and
> you can't. That's just not happening… Honestly I don't know where to
> go from here. I'm going to try to see about getting this doctor and
> everything, but other than that, there's no—no other place I can go to
> unless if I fall into a bunch of money and I can go have this done.

Such limitations force lower-class women to cope with their infertility rather than

dwell on its presence or solutions. In effect, lower-class women try to disassociate

themselves and their lives from their infertility. Barbara, a Black, 44-year-old lower-

class woman, explains:

> But I don't allow myself really to think, think, think about it because I can't do anything about it, you know. I wish that things were different and, you know, it just doesn't happen.

Barbara does not allow herself to think about her fertility difficulties since there is

nothing she can do about them. Having to move on with life may be particularly

necessary for lower-class women, since they have several other obligations and

responsibilities which require their full attention. Judy, a white, 39-year-old describes:

> I mean it's an isolated kind of thing because at that point you also have other responsibilities and most people we have jobs, you know, we have other responsibilities and responses and things like that.

For lower-class women, infertility becomes an "isolated" event in their lives in which

other responsibilities take precedence. Lower-class women can literally not afford to

focus on something they are unable to resolve. Additionally, lower-class women may be

more apt to move on with their lives because they are used to loss and lacking control

over life events. Heitman (1995) found that while middle-class women experience

infertility as a foreclosure of choice, lower-class women, who have endured other

hardships in life, experience infertility more in terms of general adversity and less in

terms of control.

While lower-class women are faced with finite options to resolve their infertility,

medicalization produces the opposite effect for higher-class women. The seemingly

infinite treatment options available to higher-class women have their own repercussions.

Infertility is a unique "illness" in that treatment ends only when the patient chooses for it

to cease. While there are a certain number of procedures available to treat infertility,

those procedures can be repeated until funds expire or a woman can no longer handle the emotional and physical intensity they require. Moreover, it is difficult for higher-class women, in particular, to stop pursuing treatment because of their circumstances in which they are used to setting and meeting goals. Thus, quitting, rather than persisting with treatment is more difficult for them to accomplish (Sandelowski, 1991). In other words, in addition to the burden infertility places upon an individual, women receiving medical treatment have the additional "burden of not trying hard enough" if they do not exhaust all treatment options (Shattuck & Schwarz, 1991). For higher-class women, the 'choice' of medical treatment for infertility may not be a choice at all. As Donchin (1996) aptly describes, "The very fact that options are available may 'force' women to pursue it." Indeed, Colleen, a white, 44-year-old higher-class woman, reflects such sentiments:

> "This is like a drug." It is very much like a drug. You get a little bit and you don't get what you need out of it and you need more. And it's addicting. I mean you—you get so close and you find out there's this one more thing that might get you what you want. And you—you're like, "Well, I've got to try this one more thing. I have tried so much, why not try one more thing?" So I knew when we were doing IUIs that there was no way I could give up there

Colleen perceives that she was "addicted" to treating her infertility medically. The 'infertility treadmill' or 'rollercoaster,' as it is often referred to, is specific to higher-class women who are constantly on the ups and downs of hormone treatments and receiving encouragement and let-down with each new procedure and each new failure that may ensue. Such an experience is in stark contrast to that of Jewel's who was frustrated with her infertility given the fact that she could not do anything about it.

Nadia, a 33-year-old higher-class woman, further describes the seemingly never-ending options available for medically treating infertility:

It's usually in the beginning, you know, you're kind of—you're very upset but you're also hopeful. You're frustrated and bitter but you still have that hope and you're like, "Hey, it's just matter of time. You know, I've just got to control." And then you wait and wait and it doesn't happen. "Well, next cycle. You know, they say that this is just the first, you know, because there's—we're on plan B. You know, there's like A-Z. And this didn't work, no problem. We'll go to C and we'll go to D." So you keep going through that and, you know, you try to not get discouraged but each mo—each month it becomes harder. You know, it doesn't become really easier for a while. …And you go through all of these things and it's exhausting. Totally exhausting. And you get to the point where you can't humanly do any more. And it's still not happening. So that's when it gets really kind of—that's when you kind of hit bottom. And, you know, I—I kind of—and I have even taken a break and stopped with the Western medicine and gone to Eastern medicine for three months. I just saw an acupuncturist and took herbs and that didn't work. I didn't even get a period with all of the strong herbs and acupuncture and everything. So I went back to Western medicine and, you know, it's hard because, you know, it's like during those now it's three years.

Nadia provides a detailed picture of the infinite options available to higher-class women. Not only did she access "A-Z" medical treatment options, but when she was unsatisfied with their results she pursued Eastern medicine in Canada that, according to her, was "very costly." These pursuits have consumed three years of Nadia's life and she is still not done:

So I'm not looking forward to [IVF] and I'm just really terrified. Because that's it. And then after that, I don't know. I mean I guess there's still options. After that, if IVF doesn't work, we'll probably try it again but I wouldn't try it in the same clinic unless I had left over eggs because I don't know if the clinic that I'm going to is the best. There is a like wonder clinic in Colorado that a lot of people go to. Actually I know somebody who had two failed IVFs here and went to Colorado and got pregnant. So I'd probably go there. If that didn't work, then I'd go to India … and they actually have different things that they have tried and actually some of the medicine's even ironically more advanced there.

As Nadia's story demonstrates, the possibilities for medically treating infertility are endless (for higher-class women).

While lower-class women attempted to push their infertility experiences from the center of their lives, higher-class women had infertility consume their lives due to effects of medical care. Barbara could not afford to "think, think, think" about her infertility, but higher-class women, inundated within medical treatment, are forced to constantly think about their infertility. Carole, a white, 36-year-old higher-class woman, demonstrates:

> [I think about infertility] a lot. A lot. And then even when you know it's not time, you're thinking about the next time and what you're going to do to make it better and right. Surely this will be the time. And you're just going through the days. That's very true, too. You're just going through the days to get to the next time and when you have another chance. And, you know, that seems kind of sad, too. You know, I felt like I was just going through the motions of life for a while.

Carole and other higher-class women thought about their infertility so much that they "just went through the motions of life for a while." This is a precise reason why lower-class women could not constantly think about their infertility. They had other responsibilities and circumstances, such as survival and work, which required their full attention. Lower-class women did not have the capability nor the resources to lose sight of other aspects of their lives.

In addition to mental exhaustion, medically treating infertility also physically consumed the higher-class women's days resulting in drastic life changes. For example, Colleen, a 44-year-old higher-class woman, quit her job in order to accommodate the rigorous schedule required of her medical treatments:

> But the—the other interesting thing or the other thing that, you know, just really happened at this point was just the absolute control it has over your life. Because, you know, on day one, you call and then on day three you have to go in and, you know, even though I pretty much knew my cycle, day one give or take a day, well, that makes a difference. Especially if you're looking at a weekend and so people would ask us to go places and we would say, "You know, I don't know if I can because I might have to go to the hospital that day for blood work" or—I mean and that was—that

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was constant. At that point on from the time we went to Fertility University on, that was a constant thing. You know, because you just don't really ever know. And people don't understand that at all.

Similarly, Stacy, a 38-year-old higher-class woman, altered her work schedule in order to continue her infertility treatments:

I said, "I have to be able to focus on this and we're going to a doctor and we, you know, this is really important to me." And when I need to have a, you know, just a slower schedule right now so I can get into these appointments and not worry about like how I'm going to find that four or five hours… And so I went down to three days a week during that time so I could kind of do my—my—the doctor I needed to do and it wasn't always the same days of the week because when they needed to see you depended on, you know, the whole cycle of the month—

Stacy went from working full-time to working part-time in order to accommodate the frequent, rigid medical appointments required of infertility treatment. Higher-class women were in positions in which they could make such life-altering changes, unlike lower-class women.

Infertile women are often stereotyped as "desperate." Unlike the media's portrayal, however, in which desperateness is portrayed as the reason for pursuing medical treatment for infertility, the findings indicate that it is the treatment itself that causes the despair to ensue. As Franklin (1992) reflects, "It is the hope IVF gives which can cause the desperation it is said to alleviate." In other words, the "desperate" infertile label primarily applies to treatment-seekers, most of whom are higher-class women (Greil, Slauson-Blevins, & McQuillan, 2010).

The exclusion and inclusion of medical treatment for infertility result in divergent infertility experiences. By examining such experiences on the micro-level, the impact and effects of medicalization become apparent. Attaining this micro-level understanding allows us to see how the medicalization of infertility varies between social locations,

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exposing its disparities. Lower-class women have limited options to resolve their

infertility, while higher-class women have innumerable options. The availability of

resolutions combined with their class circumstances influence how a woman experiences

infertility. Lower-class women are forced to move on with their lives, whereas higher-

class women's lives are consumed by thoughts and procedures surrounding infertility.

Coping with infertility

But *how* do the lower-class women move on with their lives and *how* do the

higher-class women cope with the inundation of medicine? These groups have different

coping mechanisms and strategies, yet all women are active, agentic players in the

process. This finding is counter to much of the current understanding about coping

responses between social classes. Literature has constructed a binary of fatalistic versus

agentic attitudes socially patterned along class lines. Lower-class women are portrayed

as passive and fatalistic, whereas higher-class women are more active and controlling in

their responses to life events (Zadoroznyj, 1999). However, there are two main flaws

with such a dichotomous classification. First, agency and fatalism are not mutually

exclusive beliefs and actions. Keeley, Wright, and Condit (2009) suggest that being

fatalistic does not prevent agency. In fact, some women use fatalistic statements in

agentic ways in order to cope with and make sense of health outcomes. Second, fatalism

is not merely an attitude among low-income women and women of color. Rather, it is a

product of circumstances that shifts depending upon the context in which an individual

lives (Keeley, Wright, & Condit, 2009). In other words, there is more "fatalistic talk"

within lower-class settings given their circumstances and lack of control, but it does not

mean that they are not agentic (Bolam et al., 2003). For example, Ruby, a white, 25-

year-old lower-class woman, reflects on the lack of options she faces to resolve her infertility, resulting in fatalistic statements, yet she also demonstrates how she is able to "get through it," which requires a more active role:

> [I] keep on trucking one day at a time. I don't—I'm not—it's not going to bother me unless something major goes on and it comes up or we have a conver—my husband and I have another conversation and then I lose my cool every time. … So we'll get through it I think…It's either [grow] or, you know, keep going in a bad path and nothing's ever going to change. And I'd rather change for better instead of worse. So what can you do? You can't do nothing.

Even though Ruby believes that she "can't do nothing" about her infertility, she and the other lower-class women in the study, have numerous coping strategies and mechanisms that they utilize in order to "grow" and make "change." Some of the lower-class women are not yet ready to stop pursuing pregnancy and seek ways to resolve their childlessness. They primarily do this in two ways. First, some women were aware of their exclusion from infertility treatments and avoided medicine altogether. They derived alternative, non-medical techniques to resolve their childlessness. Second, other participants, unaware of sociostructural constraints, primarily concentrated on overcoming the economic barriers to medical treatment. Both tactics portray the resolve and fortitude of poor and working-class women, yet they also reveal the embeddedness and power of the norms in which they are based. The solutions serve to both accept *and* reject dominant norms of motherhood and medicine.

Some participants attempt to surmount the financial constraints of infertility treatment by deriving innovative ways to pay for the services. Doing so may overcome their (economic) exclusion from medicine; however, the structural barriers remain. Unlike unique ways of accumulating money that have been reported among middle- and

upper-class individuals (e.g., Greil 1991), such as re-mortgaging their homes, these opportunities may not be available to individuals of lower economic standing that do not own such assets. Instead, lower-class women must develop creative ways to utilize the limited resources at hand. Sherry, a white, 32-year-old, reflects:

> [My husband's] got like if you see out there a bunch of old Camaros and, you know, and he had like somebody came out and like assessed his cars and stuff and he's got like $1.2 million in cars. He—yeah, old cars. He's got old cars everywhere. But, you know, it came to a point to where, you know, this is—this is what we decided to do. For the next year we're going to try and if it doesn't happen, he's going to take one of his old cars and he's going to sell it and we're going to go do in vitro (laughs).

Sherry suggests selling one or more of her husband's cars as a way to pay for IVF. They are willing to part with a hobby as well as their property to seek medical treatment for infertility. Carrie, a white, 32-year-old lower-class woman, and her partner similarly make sacrifices to try to finance fertility treatment. Carrie left home at age sixteen and did not communicate with her mother for the next decade. However, after making amends, Carrie decided to let her mother who had recently lost her home live with her and her partner in their trailer home.

> [My partner is] a bus driver (laughing). We are poor. […] My mom just went through a divorce after 21 years and it wasn't mutual and it was devastating and so he got the house and she wasn't ready to buy a house. And so she moved in with us. And she was going to give us $1,000 a month. So then I was hoping she would stay for a year and so then that's IVF.

While giving her mother a place to stay seems commendable, Carrie describes this choice as solely made on the basis of earning money for IVF. In fact, Carrie goes on to describe how she is charging her mother much more than she would any other tenant as a ploy to make money faster. Carrie's plan was unsuccessful. She became unemployed and had to

use the money from her mother for living expenses rather than savings for infertility treatment. The following reflects Carrie's revised solution:

> Ann: So how long do you think it will be until you can afford IVF?
> Carrie: I think that I want to save half of it and then just go in debt for the other half. Because that seems more manageable than (pauses)—I don't—we're just so—we—we just—we live debt free, you know. So us going into debt is like a big deal. And we don't have the option of taking out a second mortgage on our house or, you know, other people do. I don't even know if I could get a loan. I am just assuming that I can. I have no idea.

Without options that "other people" have, Carrie is forced to go into debt; a position she has not been in before. She has run out of other solutions to her infertility and "there's no where to go but IVF."

Interestingly, despite all of the creativity and time spent thinking about ways to afford medical treatment, particularly IVF, only one lower-class participant, Laura, a white, 40-year-old, actually received IVF services. The procedure, a "gift" from her boyfriend who eventually became her husband, was unsuccessful, and she went on to adopt two children. The lack of medical care among the participants reflects the difficulty of attaining monetary resources to afford infertility treatments coupled with potential structural and political barriers the lower-class women confront within their medical pursuits.

The participants, however, did not only pursue medical resolutions to their childlessness. Perhaps conscious of their exclusion from infertility treatment, the lower-class women develop alternative, non-medical solutions to resolving their childlessness. For instance, Donna, a Black, 33-year-old, attempts to rub pregnant women's stomachs in hopes of achieving conception.

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> Yeah, but it's supposed to be good luck if you rub (both laugh). […] I do that a lot (both laughing). I do that a whole lot, yeah. I can see a pregnant woman on the street and I'll be like, "Please, can I rub your stomach? It's supposed to be good luck."

Employing folk methods was commonplace among the participants. Carrie, a white, 32-year-old, tried "everthing she [heard]" from "doing a few things like raspberry leaf tea…to eating an Egg McMuffin."

In addition to trying to achieve biological motherhood through medical and non-medical means, the women also crafted ways to achieve social motherhood to resolve their childlessness. This echoes Parry's (2005) finding that infertile women extend their understandings of family beyond the traditional ideology focused on biological children. However, for economically disadvantaged women, options for such extension are limited, due to the classist basis of adoption. Given this exclusion, women turn to other forms of social mothering. Several of the lower-class women in this study undertook the primary role of stepmother to fulfill their mothering desires. For example, Heather, a Black, 29-year-old, reconciles her infertility in this manner:

> Ann: So if you were to outline the next five or ten years of your life, which of those options, [adoption, IVF, or stepmothering], do you think will pan out?
>
> Heather: I think it's the step-mom because my husband and I have talked about him taking full custody, you know, of his younger son just due to the situation he's in. And I think that comes from wanting to be a mom plus not liking the situation he's in and if we could give him better, why are we not? I think we're obligated, you know, to give him better so he can do better.

In deciding how to resolve her infertility, Heather chooses step-mothering over adoption or IVF. Perhaps her acceptance of being excluded from the latter options causes her to prioritize the one that is most attainable. Heather justifies this decision based on the

notion that she "can do it better" than the children's biological mother. The women gain

a sense of being a 'good' mother yet are forced to apply it to situations that fit their

contexts and normalized understandings.

Taking care of others is a dominant theme around motherhood; hence, many

participants negotiate the infertility experience through this action (Hays, 1996). Jackie,

a white, 23-year-old, explains it as follows:

> I'm just trying to fill something and like with my brother coming to live
> with us, I think maybe we asked him because I wanted somebody else to
> take care of. You know, my mom said that once he starts college, he can't
> stay with us but at the same time, I feel like if he leaves, then it's just back
> to me taking care of my husband, you know. And I—it's not that I don't
> love that. I want to take care of my husband but I just—he's not there all
> the time and so, you know, he works a lot of hours. And so I just—I'm
> trying to fill it with other things and I shouldn't be.

Jackie is able 'to mother' in the sense that she is taking care of someone other than her

husband. Not only does this allow her to attain a salient characteristic of motherhood, but

it also relieves her loneliness due to her husband's absence.

Candace, a Black, 41-year-old, also extends the ideology of motherhood to

include experiences beyond biological children. After struggling with infertility for

years, Candace had a hysterectomy due to cervical cancer. This surgery dampened any

prior hopes she had for having her own children. The following reflects how she coped

with and negotiated this realization:

> Ann: So how did you feel after all of that: knowing that now you
> probably wouldn't have kids without a miracle?
> Candace: Just like—it's just like God to me because a lot of people
> are coming to me with, "You can do everything. You—
> you can still be a mother." You can take care of other
> children [by teaching] young girls to not go down the path I
> went down in the negative sense to drugs and alcohol. So I
> could be like a mother […] So that's what (crying) I'm
> going to do.

Candace can "be like a mother" in ways that extend beyond biological children, yet encompass normalized characteristics of motherhood, such as caretaking.

While stepmothering and caretaking are not limited to women of the lower classes, they are more prevalent among such groups. According to the National Survey of Family Growth (NSFG), nearly 21 percent of women with less than a high school education have cared for a non-biological child, including stepchildren and children of other kin, compared with 8 percent of women with at least a college degree (Chandra et al., 2005). Thus, the infertile lower-class women in this study, with limited resolutions to childlessness, participate in the perpetuation of the stratified system of reproduction by adopting roles typically associated with their class status.

With limited options, many lower-class women turn to religion to cope with their childlessness. Contrary to popular thinking, however, religion is not merely used as a defensive, passive response to life events (Geertz, 1973). Pargament and Park (1995) argue that such a view is overly simplistic and stereotypic. Instead, religion can be active as well as passive, assertive as well as defensive. It allows women to actively reconstruct and reinterpret negative events more positively (Ellison et al., 2001). Angie, a Black, 25-year-old, demonstrates such agentic use of religion:

> Ah, God has gave me a lot of strength. Going to church and just praying about it (pauses) has gave me strength. Just—just keeping hope in general and just keeping hope and just hoping, you know, I can have kids and this has got me through.

Angie purposefully sought out religion to cope with her infertility by attending church and praying. Doing so brought her hope, and thus allowed her to "get through" the perils of infertility.

The participants are situated in a contradictory dilemma; deriving ways to pay for medical treatment does not overcome the structural inaccessibility and institutionalized classism the women face within medicine, yet developing alternative solutions furthers their exclusion from the institution. Due to this conundrum, lower-class women, such as Heather, a Black, 29-year-old, are forced to "come to grips" and cope with their inability to conceive and move on with their life goals. Many lower-class women cope with their childbearing difficulties by changing their mentality and attitudes towards it. They shift from thinking "it is not the right time" to thinking "it is not meant to be," which allows them to move on with their lives. While both thoughts have fatalistic undertones, the women use such mentality as a coping mechanism. Keeley, Wright, and Condit (2009) found that fatalistic talk many times results from women realizing that certain life events are beyond their control. When faced with such constraints, talking positively gives them a sense of agency. In the case of infertility, lower-class women have far less control due to both contextual and structural circumstances than higher-class women, which results in more fatalistic statements among them. It is one of their only ways to cope. Tanya, a white, 38-year-old lower-class woman, reflects:

> I didn't—I would just say, "It's just not the right time." And I didn't want to say, "It was not meant to be" yet because I wasn't really quite done yet. So that says—when I was 34 or 35, I just said, "You know, it's just—it's not meant to be." So I kind of resolved myself that, "All right, forget about it and just move on."

Carla and Jessica similarly "move on" with their lives by changing the way they think about their infertility:

> Carla: Like now I go through without even like, "If it happens, it happens. If it don't, it don't." No. I'm at the point now where it's like, "Okay, I'm okay with if it doesn't happen, I will be okay" because I don't really expect it to happen. Which in me, I have

always—I have learned like a long time ago. I don't really expect a lot of things. So—because if you expect them and it doesn't happen, you feel worse. So if you just don't expect them to happen and just like (gasps), "Oh, okay!"

Jessica: "Okay, everything that I have gone through is hard and bad but, you know, I mean somewhere somehow, there's somebody that has worse." You know, it's like I still have a great—I mean I have so much. I am blessed with what I have got. It's like, "Be happy for what you have and not so much what you can't have." You know, things don't always work exactly the way we dream and plan. So but they work. So and—and like I said, I believe everything happens for a reason so somehow, some way it's going to be better.

The coping strategies of both Carla and Jessica demonstrate how it might be easier for lower-class women to deal with their infertility compared to higher-class women. Like Carla says, they have learned "not to expect a lot of things" in their lives, and as Jessica adds, many lower-class women know others in much more dire straits than what they are experiencing with their childlessness. Due to their surroundings, the lower-class women's perspectives about infertility shift, allowing them to cope with their childlessness.

While lower-class women concentrate their efforts on coping with infertility itself, higher-class women focus on "coping" with the medicalization of their infertility due to its all-consuming nature. As Colleen relayed, medical treatment for infertility "controls" your life, so higher-class women, who live in a context in which control is paramount, focus on regaining that control. One way in which the higher-class women attempt to do so is through in-depth research of infertility. For example, Nadia, a 33-year-old, explains:

… I feel so out of control and I wish someone would just swoop in and say, "Nadia, everything's going to be all right." And [my husband] says it but not like—I just almost wish someone would take control and take the

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burden off of me in some way. So yeah. [I regain control] by reading too much about fertility. But that only took me so far and then it just kind of after a while it's like a diminishing returns and then it just makes it worse. So then I have read all I can and I know all I need to know and any more is just going to depress me. And so I think I try to, you know, be a control freak in other ways of life and that helps me. But then I found that that just stresses me out so … it's a whole emotional cycle. Like a development. It kind of happens when you're going through this and it kind of leads you ironically to like let go of a lot of control because you're so helpless.

After three years of trying to "control" her infertility in various ways, infertility taught Nadia that she cannot control everything in life. Indeed, Nadia "let go of a lot of control" which helped her cope with feelings of helplessness.

In another ironic twist, many higher-class women turn to medicine to try to control their infertility. In doing so, they lose more control over their reproduction and their lives. For example, Allan (2007) found that physicians manage liminality, or that uncertain stage between health and illness, through the use of technology and medicine, but doing so incites further ambiguity. Unconscious of such effects, however, higher-class women, such as Stacy, a 38-year-old, seek medicine to stabilize their lives:

I am pretty type A so [medicine] was something I could do. I could control that, I could go, I could do this, I could, you know, it was something I felt like that I was doing to get closer to my goal of getting pregnant…So in that sense I do think it helped. …You know, and but it was also reassuring like, "I am here with this doctor and they can do all of these great things and look at all of these people they're getting pregnant and look at how they're going to increase our chance of success. And if we were just, you know, on our own trying, our chances would be this. But now with this drug and with this treatment and with this procedure, like we're just increasing our chances." So in that sense I think it helped because I felt like I was taking steps and that it was—and so I was taking more control over like making it happen and (pauses)…

The hope that medicine provides causes women to seek out its assistance. Taking the action to do so allowed Stacy to feel like she was more in control over her infertility since

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it was her choice. She also felt reassured by her decision to seek medicine because of its

"high success rate." Ironically, it is precisely this hope in medicine which causes more

desperation and angst among the women's experiences since it pressures them to

continue seeking its assistance. In reality, the "high success rate" to which Stacy refers,

may be falsely perceived. According to the most recent report from the Centers for

Disease Control and Prevention (CDC), 30 percent of ART cycles resulted in a live birth

in 2009 (CDC et al., 2011). In other words, there is a high likelihood that infertility

treatment will *not* work, thereby causing the cycle of more treatment and loss of control

to continue. The contrast between the participants' perception of medicine's success

alongside its actual results demonstrates the embeddedness of the power of science and

technology within societal beliefs.

Some higher-class women turned to their occupations to cope with their feelings

of helplessness. For instance, Nan, a 40-year-old, describes her coping strategy:

> And so I started my own business…That gave me a sense of purpose and
> a feeling of being in—in control of something in my life and—and, you
> know, built up a clientele and, you know, taught cooking classes and got a
> lot of fulfillment from that. It felt—it felt like I was doing something that
> I enjoyed, that was helping other people and I was getting good feedback
> from others, you know, that—who appreciated what I was doing…So that
> helped me to feel a little more control of my life…

For Nan, starting her own business was not only a way to regain control of her life, but it

also provided her with a "sense of purpose." Pronatalism and the motherhood mandate

construct motherhood as women's purpose in life. Thus, when motherhood is not

achieved, women must seek out other sources of meaning. Work gave the women a

sense of self-worth outside of motherhood which allowed them to cope with their

infertility.

Unfortunately, some women turned to solutions to stabilize their lives which had detrimental effects on their health. In addition to starting a new job, Nan also looked to food to help her feelings of powerlessness.

> I had a hard—hard time just dealing with life on life's terms and so, you know, the infertility was part of one of those things that I just had a hard time dealing with. And for me I guess I tried to, you know, I couldn't control this and so I, "Well, at least I can eat," you know, even though it was self-sabotaging.

Nan developed a compulsive eating disorder as a mechanism to cope with her infertility. It allowed her to feel in control of something in her life, despite its negative health effects. After eight years since starting her infertility journey, Nan is still recuperating from her eating disorder.

Due to different ways of resolving their infertility coupled with differences in norms and beliefs within their surroundings, women of higher- and lower-classes cope with their infertility differently. Lower-class women concentrate on overcoming their childlessness and coming to terms with its "reality." Higher-class women, however, do not focus so much on infertility itself *per se*, but rather, on coping with their lack of control over the experience.

Future goals

Such class differences in coping cause the women to have different visions of their futures. Despite the limited options to resolve their infertility, some lower-class women still envision having children at some point in their lives. For instance, Jewel, a white, 22-year-old, describes what will happen in the next five years of her life:

> I'm going to get married. I am going to have everything set. I want all of my bills paid and I want to be able to take care of everything. I don't want to have a lot of stress in my life. I am going to live it to the fullest and I'm going to try to have one more baby. Whether I can have one,

two, three, as long as they'll stay alive. I don't care how many I'll have. But after that if it doesn't work, then I'm not going to ever try again…I'm just going to put it on the back burner...

After having several miscarriages, Jewel is going to try to have one more baby.

However, she wants to stabilize her life through marriage, debt reduction, and less stress

before she attempts to do so. As discussed in Chapter Three, lower-class women believe

that having a stable life (regardless of income) is important in determining an individual's

readiness to be a 'good' mother. Jewel believes that by achieving such readiness she will

have a higher likelihood of having a successful pregnancy.

Similarly, Ebony, a Black, 34-year-old lower-class woman, hopes for increased

stability in the near future so that she can continue trying to have children:

Well, [in the next five years] I see myself becoming a professional certified pharmacist. And I feel like when I get back into a new professional career, I can pursue the kids. But right now I just feel like everything is just going to just get better and better and better. If kids come in play with that, then I'll have kids. But right now, everything is pretty good.

Like Jewel, Ebony wants to have a stable job before trying to have children again.

Focusing on one's self in such a manner was a much more prominent theme within

lower-class women's visions of the future than those among higher-class women.

Lacking options and being forced to deal with their infertility may allow the lower-class

women to more easily focus on individual, personal goals that go beyond mothering.

Heather, a Black, 29-year-old lower-class woman, exemplifies this idea:

But it's more of, "Look at all of the options you've got. Look at all of the things that you're doing or that you can do that you enjoy." So I think as my life has changed and I have looked at all of these other things I am able to do now and we have talked about moving out of state and stuff like that. And so it's like, "Why not? Why just limit yourself to wanting to be a mom and having kids when life has so many more things to offer than just that?"

Roberta, a white, 39-year-old lower-class woman, echoes Heather's sentiments when she describes what will happen in the next five years:

> Finishing my Masters. Getting a job teaching. Settling in somewhere and maybe even buying a house because we haven't done that yet. But that would be about it. Just, you know, going on with life.

Roberta will "go on with life" by focusing on herself rather than concentrating on her childlessness.

When asked to outline the next five years of their lives, some lower-class women had a difficult time doing so. Their class circumstances, which cause life to be unpredictable and in which control is not a valued characteristic, make discussing the future impossible for some participants. Ruby, a white, 25-year-old, explains:

> Ann: Well, if you were to outline the next five years of your life, how do you see it playing out?
> Ruby: I don't know. I can't give you an answer to that one anymore. Because five years ago, we put up our Christmas tree this year and every year we have—we buy new Christmas ornaments and one year we were so broke that I made stockings out of scrapbooking paper and on the back I asked my husband to put down five things that he wanted in the next five years. And I did one and he did one and we looked at 'em this year and our five years are up and we wanted a house, you know, or—I'm thinking of his. He wants a house, he wants some kind of car, he wants children, he wants a garage and something else. And out of all of these things on our lists, none of them came true. So I really can't even tell you that anymore because after seeing that and acknowledging that, "Wow, we didn't accomplish anything in five years," felt really horrible. "So we're just about five years off I think, Clyve. I don't know what else to tell you, Buddy. Sorry." So.

Used to not getting things in life, lower-class women are hesitant to predict a future which might not "come true."

Higher-class women outline similar futures in that they also hope to have children and they, too, have a difficult time envisioning what the future entails. However, their

class circumstances shape and alter the reasoning behind such predictions. For instance, as Nan, a 40-year-old, states, "we never considered just being—accepting childlessness. That was just not something either one of us wanted." Although both class groups wanted more children in their futures, higher-class women were much more determined to make such a goal happen compared to lower-class women who, like Ebony, were "good" if it did not happen, and would just "put it on the backburner" as Jewel described. Higher-class women's determination was typically pursued through continual use of medical treatment, so many of the higher-class women's visions of the future were mainly filled with doctors' offices. Brooke, a 30-year-old, demonstrates:

> Well, at some point in the next five years, I will have had at least one child. I really—I really think we'll have more than one by then 'cuz I still I have this feeling somewhere deep inside that part of me tries to suppress because I don't want to let posit—I am afraid to let positive thoughts surface too much because if I think too positively, then I just get crushed more. It's more of a let down. I am not as negative as I was when I was in that dark period but I'm—I'm afraid to be a super, bubbly, upbeat, positive person. But I do have this just deep seated thought that somewhere, somehow we will figure out how to get pregnant. I am not sure if we'll have to go through invasive treatments or not. But whatever that way is, we'll figure it out and we'll be able to use that same avenue to have future children.

Brooke was certain that in the next five years she "will have had at least one child." Such confidence greatly contrasts with the hesitancy inherent within the lower-class women's future predictions, in which having a child "might" or "possibly could" happen. The differences in tone and semantics reflect class variations in control over life events. It also demonstrates why moving on with life may be an easier task for lower-class women compared to their higher-class counterparts. Knowing that it might not happen allows acceptance of that possibility and focus on other aspects of life.

Part of the certitude voiced by higher-class women stems from the confidence placed in medicine. Science and technology are portrayed as infallible, and medicine is believed to provide a "cure" for all things health-related. Thus, medical treatments for infertility give women hope and assurance that their childlessness will be resolved. Colleen, a 44-year-old higher-class woman, reflects on the hope it provides:

> I—I mean I—I hope—I—I do think we'll have another [child]. I do think that we'll try for this, you know, use these frozen embryos and try for one more. Which is a very difficult decision given my age. That's what worries me the most. Just thinking about it 18 years from now. But—but I do think we will do that. And interestingly enough, in my mind, I'm thinking, "We will most certainly get pregnant." I mean like when I think about, "Are we going to do it or not?" it's, "Are we going to have another baby?" It's not, "Are we going to try this again?" I definitely in my mind I'm thinking, "Of course this is going to work. This is a great batch of embryos."

Colleen and other higher-class women are thus able to be confident that there will be children in their futures due to both social norms centering on control as well as structural accessibility to medical treatments for infertility, both of which are absent from the lives of lower-class women.

Similar to Ruby, higher-class women also have a difficult time predicting their futures. However, unlike Ruby who was unable to outline her future due to her working-class lifestyle in which predictability and control over life events is infrequent, higher-class women can no longer envision their futures because of the lack of control that infertility has introduced into their lives. For example, infertility is the first time in Nadia's life that things have not gone according to plan:

> I don't know. That's the big void that I don't know. That's why—see, I've only seen myself [as a mother] my whole life. So not seeing myself that way, it's like that's why—that kind of is it hits now in the head in where I am right now with for the first time in my life I don't have a place where I'm going. I'm not going to where I see my life heading. I don't

know where it's going. I'm just kind of there. Whatever comes, then I guess I'm just leaving it up to God or fate or whatever because I don't know. The only thing I can even picture is almost so extreme that it's almost fanciful rather than realistic. It's like just chucking everything and just going and being a nomad and maybe doing some spiritual things in India or joining the Peace Corps or something, you know?

Nadia is unable to control her fertility, leaving her helpless and lost in "fanciful" notions. Rather than focusing on life's next steps, like Heather's plans for vacations and school, higher-class women, as Sarah states, "no longer think that way anymore." Higher-class women are literally unable to plan for their futures because they have lost their previous ability to control life events. Planning and controlling were more than mere characteristics; they were embedded within the identities of higher-class women. Thus, infertility caused higher-class women to not only lose the motherhood aspect of their identities, but the controlling, predictability aspect of their lives as well.

Conclusion

The experience of infertility is truly a never-ending journey. Yet, how women learn to cope and live with infertility is largely determined by their class circumstances and the way in which they resolve it, either medically or not. The options available to resolve infertility coupled with the prevalence and ability to control life events greatly shape how women of different classes confront infertility and how they envision their futures.

The limited options available to lower-class women to resolve their infertility forces them to "not think" about it and move on with life. As Roberta aptly states, "what else [are they] supposed to do?". However, for women receiving medical treatments for their infertility, primarily higher-class women, infertility consumes their lives, largely due to the nature of the treatments. The hope medicine provides combined with its

rigorous treatment schedule and the cultural practice of "not quitting" within higher-class settings cause women to perpetually pursue treatment and its "A-Z" options.

Such differences in options and solutions to infertility cause variations in how women of different classes cope with infertility. For instance, poor and working-class women focus more on getting over the experience of infertility itself while higher-class women concentrate on regaining control of their lives and coping with the inundation of medicine. Both groups' coping mechanisms are agentic, active, and purposeful. However, for lower-class women, many times their circumstances limit their coping abilities to more fatalistic responses, such as prayer and attitude. But, the participants demonstrated how such reactions are also agentic in nature, thereby overturning prior literature on the classed dichotomy of fatalism and activism.

Ultimately, the experience of infertility has shaped how women envision their futures. Lower-class women, used to not having things go their way, are able to envision a life beyond infertility and strive to attain personal goals, such as further education or more travel. Higher-class women, however, are unable to make such a transition. They can either no longer predict their futures or they can only envision more medical treatments to achieve their goal of biological motherhood. In other words, lower-class women are able to live *with* infertility while higher-class women are determined to *overcome* it, and until they do, they cannot envision a life at all.

Chapter Eight

Conclusion: Reconceiving Infertility[§]

<u>Why and how class matters</u>

The book began with Angie's and Sarah's stories of infertility, revealing their significant differences. The past several chapters explored why and how those differences exist. In doing so, we learn how a woman's social location, such as social class, matters in shaping her infertility experience. Indeed, it matters a great deal, as the entire spectrum of the infertility experience varies among women of different social classes—from before they realized they were infertile and just beginning to think about motherhood to their resolutions and coping strategies for dealing with infertility. What are some of the reasons for this chasm? In other words, *why* does social class matter when thinking about infertility?

Chapter Two explained that one reason class matters is that it influences what social messages we are exposed to. There are existing ideologies that shape how we think about infertility—who is infertile, what infertility is, how it should be resolved, etc…But, these messages differ depending on one's class location. For instance, lower-class women hear several messages about why women mother due to living in a 'culturally heterogeneous' environment in which they receive both subordinate and dominant messages (Harding, 2007). Higher-class women, in contrast, do not receive the

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[§] Portions of this chapter appear in the following manuscript: Bell, A.V. (2010). Beyond (financial) accessibility: Inequalities within the medicalization of infertility. *Sociology of Health & Illness, 32(*4).

lower-class ideas, since such ideas are subordinated, and are thus primarily exposed to more 'homogeneous,' mainstream ideas (Hays, 1996). This "cultural heterogeneity" vs "homogeneity" results in different ways of thinking about infertility and reproduction. Lower-class women have more reasons for wanting to mother compared to higher-class women, and those reasons are less about adhering to social norms (e.g., legitimate family definitions) and more about their individual needs (e.g., receiving love). Chapter Three went on to show how both lower- and higher-class women must negotiate with ideologies around reproduction in order to be considered "good" mothers. The diversity of messages in lower income settings allows them to use both dominant and subordinate narratives in their negotiations, while higher-class women are bound to mainstream ideas.

In addition to receiving different cultural *messages*, lower- and higher-class women also have different cultural *practices* that influence their infertility experiences. Such differences were especially apparent in Chapter Four which described how the women attempted to become pregnant and how they interpreted and perceived such attempts. Lower-class women approached pregnancy more fatalistically and "naturally" compared to the higher-class women's highly planned, organized, and "mechanical" ways of "trying" to become pregnant. Such efforts shaped how and when the women came to realize they had childbearing difficulties, and particularly how much time had elapsed before they came to this realization. Poor and working-class women took longer to recognize their childbearing difficulties due to their less "planful" approaches to pregnancy. Chapter Five further highlighted the importance of class practices in shaping how women live with infertility. Having children at younger ages, marrying less frequently and not telling others about personal issues are more common among poor and

working-class women than higher-class women, resulting in divergent infertility experiences. For instance, the lack of a committed partner coupled with fewer peers they can relate to causes the lower-class women to have less support for their childbearing difficulties.

One of the more obvious reasons class matters is money. Unable to afford medical treatment for infertility, lower-class women are forced to seek alternative, non-medical ways to resolve their childlessness. Chapter Six, however, revealed that lower-class women face barriers to medical treatment that go beyond just finances. Discrimination, time constraints, and insurance limitations, are just a few of the barriers lower-class women face in the healthcare system—barriers most higher-class women do not encounter. How a woman resolves her infertility, whether medically or non-medically, influences how she copes with her childlessness and projects her future. Chapter Seven described how poor and working-class women, not inundated in the seemingly infinite options of medicine, are able to focus on getting over the experience of infertility, while higher-class women are more concerned about coping with the lack of control they have over the medical treatment itself.

Despite the strong influence of social class on infertility, it does not work alone. It "intersects" with an individual's race and gender to create unique experiences. For example, the lower marital rate among lower-class women, particularly Black women, makes them more fearful of telling their partners about their infertility and disrupting a more fragile and tenuous relationship. This class- and race-specific practice overlaps with the woman's gender, since her fear stems from gendered notions that women are meant to reproduce and men can "plant their seeds" elsewhere.

While I found class to be a more salient factor influencing infertility experiences, race also played a role in shaping experiences. Beginning with why women mother, Black women were more prone to mention the "motive of redemptive motherhood" in which mothering would bring about adulthood and middle-class characteristics, compared to the white participants. The Black cultural practice of "community mothering" also caused the Black participants to uniquely cite wanting a child of one's "own" as their reason for wanting a child, which was not present for the white women. The lower marital rates in the Black community combined with the practice of not discussing personal issues caused the Black women in the study to have far less social support than their white counterparts. Finally, Black participants were confronted with racial discrimination in their quest for motherhood and medicine, which was absent from the experiences of the white participants. For instance, Black participants cited their race as a reason providers denied requests for infertility help, while white participants frequently mentioned age or income-level. In other words, class matters in shaping infertility experiences, but race matters, too, particularly in terms of cultural practices specific to the Black community.

These dramatic differences in the infertility experience are rooted in the very different social locations of the women in this study. However, there are also important similarities in the infertility experience that should be mentioned. For example, infertility was disparaging to all women it affected. It disrupted all aspects of their lives, from their identity as mothers to their future aspirations. Yet, all of the participants, regardless of class, actively attempted to confront their childlessness. For instance, lower-class women devised alternative, non-medical ways to try to become pregnant, while higher-class

women actively researched the best physicians, practices, and treatments. Along with such activism, however, both groups also had fatalistic, or more passive, reactions to their reproductive struggles. This was especially apparent for poor and working-class respondents since they were constrained by cultural and material resources available. However, as time elapsed, higher-class participants also resigned themselves to face protracted struggles with infertility. For example, as Nadia told me, "[Infertility] kind of leads you ironically to like let go of a lot of control because you're so helpless…I have totally changed the way I look at my life. I really don't care about anything anymore. I am just kind of trying to live in the moment."

Why these findings matter

But, why are these findings important? Why do they matter? At the most basic level, understanding the class dynamics of infertility challenges the conventional wisdom about *who* becomes infertile and *what* the experience of infertility is. The findings tell us that infertility occurs among all types of women and goes beyond the doctor's office. It is a social process, influenced by the context in which one lives, including the class, race, and gendered practices and messages about infertility women receive. Thus, overcoming such stereotypes allows us to not only better understand infertility itself, but it also speaks to larger social factors at play, including reproduction, motherhood, and medicine.

The women's stories reveal the deeply embedded classist ideas about who should reproduce. In fact, the women themselves, both lower- and higher-class, employ class-based ideologies when talking about infertility and reproduction. For example, both higher- and lower-class participants reify the notion that money is necessary to be a "good" mother by comparing themselves to "bad" mothers who have children "they

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cannot afford." Institutions, such as medicine, also unconsciously utilize such thinking through their appointment scheduling, insurance coverage, and general treatment of patients. Such practices echo eugenic notions of what groups should reproduce by providing infertility treatment to middle- and upper-class women while excluding poor and working-class women from receiving services. In other words, comparing class experiences of infertility demonstrates the continued presence of "stratified reproduction" in America.

Once we recognize the deep and pervasive inequality that characterizes the way our society defines and treats reproduction, it becomes possible to envision alternative possibilities. Currently, most efforts to reduce disparities in infertility focus on increasing access to health insurance and medical treatment. But, understanding infertility as a social, rather than merely a medical issue, suggests that it is necessary, but insufficient to focus exclusively on access to medical treatment; we need to begin resolving ideological issues as well. As one researcher notes, resolving disparities within infertility will require "more than simply a call for access to choices not of our own making" (Steinberg, 1997). Without reviewing the ideological notions of class-based motherhood and the classist structure of medicine, inequalities will remain in the provision of fertility treatments. Insurance coverage would not prevent the discouragement Michelle received nor would it undo the middle-class basis of appointment scheduling with which Nicole faced. In addition to lobbying for comprehensive insurance coverage of infertility treatments, we also need to critically examine how infertility treatment is provided in order to develop context-appropriate

solutions, such as enhanced communication between fertility specialists and patients of diverse backgrounds and scheduling appointments during atypical working hours.

Focusing exclusively on medical solutions, however, limits our understanding of the experiences of infertility. Doing so fails to recognize variation in infertility experiences and also serves to reinforce the social control, social norms, and biomedical understanding surrounding the medicalization of infertility (Donchin, 1996). While treatment disparities need to be resolved, we must also recognize experiences such as Donna's and Carrie's in which non-medical, folk methods were employed. Future research must avoid "westernizing" experiences that privilege biomedical solutions (Becker et al., 2006), and instead, step outside medicalized infertility to acknowledge experiences that are not medically resolved, yet still "successfully" overcome.

This study, then, suggests that we need to broaden our thinking about infertility to address the needs of the diverse women who encounter the problem. In addition, the findings suggest that we also need to reconsider and re-examine reproductive policy, more broadly. Family planning programs, adoption procedures and welfare regulations are all based on mainstream understandings of who should reproduce and who should have children. For instance, many family planning programs target low-income neighborhoods in an effort to prevent "unintended" pregnancies. But, as the findings reveal, our understanding of pregnancy intent is based on middle-class notions of the concept, and thus, our interventions may be misguided. Researchers have estimated that "unintended" pregnancies publicly cost approximately $11 billion (Sonfield et al., 2011). Such costs may be minimized if we have a more precise estimate of the unmet need for

contraception and more efficiently use resources in programs that prevent 'truly' unintentional pregnancies.

As Angie, a lower-class, Black participant said to me, adoption agencies "pick and prod" into your life to "judge" whether or not you will be an adequate and appropriate parent. That scrutiny coupled with the exorbitant cost of adopting a child causes many lower-class women to avoid adoption as a solution to their childlessness. In addition to such explicit exclusionary measures, adoption procedures also implicitly exclude lower-class women and other marginalized mothers from adopting through restrictions, such as making adoption only available to married couples. Such a heteronormative measure not only excludes single women and lesbian women from adopting, but it also implicitly and unconsciously removes Black women from the possibility since fewer (lower-class) Black women marry than their white counterparts. The findings bring such practices to light, but they also reveal the need and desire to adopt among the groups that are excluded. Thus, efforts should be made to develop more inclusive adoption policies that are less bureaucratic and judgmental than a "Social Security" application as Angie equates them to, and more in line with the needs and desires of all potential adoptive parents.

Most of this book reveals the trials and tribulations of infertility. However, concentrating only on its negative aspects can result in negative consequences itself. For instance, portraying infertility as 'bad' reinforces the normality of motherhood and children. In other words, it reifies the notion that women should not be childless, in turn, "mandating motherhood." We need to remember experiences such as Roberta's who focused on the positive aspects of her childlessness, such as time to devote to school and

travel, and was thus able to "overcome" its negative aspects. In revealing such triumphant stories, the findings begin to increase the norm of childlessness while diminishing that of motherhood. Doing so also helps to remove infertility from the realm of medicine by showing how there are solutions to childlessness other than just trying to become pregnant. Medicine many times overshadows life beyond infertility and childlessness since it is so concentrated on attaining a biological child.

Limitations and future research

While this study is one of the first to examine the diversity of experiences of infertility, it is still limited in its scope. I focused on class diversity for several reasons, as outlined in the introduction. But, in doing so, gender, age, sexuality, and race diversity are less emphasized. I chose to only examine women's experiences of infertility as opposed to couple's or men's experiences for several reasons. First, infertility is thought of as a woman's issue due to the gendered nature of reproduction and parenting. Because of this, researchers have found that infertility is more salient in the lives of women than men (Greil, 1991). Second, most infertility research is conducted on women, but women of a certain type—white, wealthy women. Thus, limiting the study to women, but a diverse group of women, not only allowed me to converse with the current literature but it also allowed me to fill a gap in its analyses. Finally, the consistency of gender allows for a more nuanced examination of class differences in infertility. Despite these reasons, future research should examine the gender dynamics of infertility. Infertility provides an ideal setting for exploring the relationship of gender to an individual's reproductive capacity. Men's infertility, in particular, needs further examination. By not doing so, researchers only serve to reinforce the construction of infertility as a woman's issue.

Focusing on class also reduced my emphasis on racial diversity. While race is not predominant in infertility research, when diversity is examined, it is done so along racial dimensions. I limited the sample to only two races, white and Black, in order to have enough women of each race to make significant comparisons and conclusions. However, as researchers (e.g., Huddleston et al., 2010) have noted, there are differences in infertility experiences among other races and ethnicities as well. For example, Hispanic women use ARTs less frequently than white women (Feinberg et al., 2007). Such differences need more in-depth analyses, particularly investigating the social and cultural bases for such differences. Experiences differ among sexualities as well. By chance, the sample was non-diverse in sexual orientation with only one participant self-identifying as lesbian. Exploring infertility among women with different sexual identities would not only expose differences in involuntary childlessness, but also in family formation more generally. Unlike their heterosexual counterparts, lesbian couples' procreation is "forced" to be planned and medicalized. How this alters experiences needs further examination.

This book allows us to conceive of infertility in a new light. It is not merely a disease to be treated, nor is it an ailment that only affects the higher-classes. As Ulrich and Weatherall (2000) have explained, "infertility provides a lens for viewing motherhood and the disciplinary power of discourses about motherhood." Indeed, examining the class aspects of infertility exposes how reproduction is both a private and public phenomenon. It allows us to go beyond the familial and medical contexts in which it is typically studied to examine its cultural and social dimensions as well (Clarke, 1998).

In centering stories like those of Angie alongside stories like those of Sarah we can "re-conceive" infertility and the social powers that shape it.

References

Abramovitz, M. (1995). From tenement class to dangerous class to underclass: Blaming women for social problems. In N. van den Bergh (Ed.) *Feminist practice in the 21st century* (211-231). Washington DC: National Association of Social Workers.

Allan, H. (2007). Experiences of infertility: Liminality and the role of the fertility clinic. *Nursing Inquiry*, 14(2), 132-39.

Arendell, T. (1999). Hegemonic Motherhood: Deviances discourses and employed mothers' accounts of out-of-school time issues. Working Paper No. 9

Arendell, T. (2000). Conceiving and investigating motherhood: The decade's scholarship. *Journal of Marriage and Family, 62*(4), 1192.

Augustine, J.M., Nelson, T., and Edin, K. (2009). Why do poor men have children? Fertility intentions among low-income unmarried U.S. fathers. *The Annals of the American Academy of Political and Social Science*, 624.

Baker, P. L., & Carson, A. (1999). "I take care of my kids": Mothering practices of substance-abusing women. *Gender & Society, 13*(3), 347-363.

Barrett, G., and Wellings, K. (2002). What is a 'planned' pregnancy? Empirical data from a British study. *Social Science & Medicine*, 55, p 545-57.

Bates, G.W., & Bates, S.R. (1996). Infertility services in a managed care environment. *Current Opinion in Obstetrics and Gynecology*, 8, 300-304.

Becker, G. (2000). *The Elusive Embryo: How Women and Men Approach New Reproductive Technologies*. Berkeley: University of California Press.

Becker, G., Castrillo, M., Jackson, R., & Nachtigall, R.D. (2006) Infertility among low-income Latinos, *Fertility and Sterility*, 85(4), 882-887.

Becker, G., & Nachtigall, R.D. (1992). Eager for medicalisation: The social production of infertility as a disease. *Sociology of Health & Illness*, *14*(4), 456-471.

Bell, A.V. (2010). Beyond (financial) accessibility: Inequalities within the medicalisation of infertility. *Sociology of Health & Illness, 32*(4), 631-646.

Bell, A.V. (2009). "It's way out of my league": Low-income women's experiences of medicalized infertility. *Gender & Society*, *23*(5), 688-709

Berry, M.F. (1993). *The Politics of Parenthood: Child care, women's rights, and the myth of the good mother.* New York: Penguin Books.

Bhalla, A., & Lapeyre, F. (1997). Social exclusion: Towards an analytical and operational framework. *Development and Change*, 28, 413-433.

Bitler, M., & Schmidt, L. (2006). Health disparities and infertility: impacts of state-level insurance mandates. *Fertility and Sterility*, 85(4), 858-865.

Blank, R.H. (1997). Assisted reproduction and reproductive rights: The case of in vitro fertilization. *Politics and the Life Sciences*, *16*(2), 279-288.

Blum, L.M. (1999). *At the breast: Ideologies of breastfeeding and motherhood in the contemporary United States*. Boston: Beacon Press.

Blum, L. & Deussen, T. (1996). Negotiating Independent Motherhood: Working-class African American women talk about marriage and motherhood. *Gender & Society*, 10(2), 199-211.

Bolam, B., Hodgetts, D., Chamberlain, K., Murphy, S., & K. Gleeson. (2003). "Just do it": An analysis of accounts of control over health amongst lower socioeconomic status groups. *Critical Public Health, 13*(1), 15-31.

Breheny, M. & C. Stephens. (2007). Irreconcilable differences: Health professionals' constructions of adolescence and motherhood. *Social Science & Medicine,* 64, 112-124.

Brubaker, S.J. (2007). Denied, embracing, and resisting medicalization: African-American teen mothers' perceptions of formal pregnancy and childbirth care. *Gender & Society*, 21(4), 528-552.

Brubaker, SJ, & Wright, C. (2006). Identity transformation and family caregiving: Narratives of African American teen mothers. *Journal of Marriage & Family*, 68(5), 1214-28.

Burton, L.M. (1990). Teenage childbearing as an alternative lifecourse strategy in multigenerational black families. *Human Nature, 1*(2).

Ceballo, R. (1999). "The only Black woman walking the face of the Earth who cannot have a baby": Two women's stories. In M. Romero and A.J. Stewart (Eds.) *Women's untold stories: Breaking silence, talking back, voicing complexity* (pp. 3-19). New York: Routledge.

Centers for Disease Control and Prevention, American Society for Reproductive Medicine, Society for Assisted Reproductive Technology. (2011). *2009 Assisted Reproductive Technology Success Rates: National Summary and Fertility Clinic Reports*. Atlanta: U.S. Department of Health and Human Services.

Chandra A., Martinez, G.M., Mosher, W.D., Abma, J.C., & Jones, J. (2005). Fertility, family planning, and reproductive health of U.S. women: Data from the 2002 National Survey of Family Growth. National Center for Health Statistics. *Vital Health Statistics*, *23*(25).

Chodorow, N. (1978). *The reproduction of mothering*. Berkeley: University of California Press.

Clarke, A. (1998). *Disciplining reproduction: Modernity, American life sciences, and 'the problems of sex'*. Berkeley: University of California Press.

Cocanongher, A.B. & Bruce, G.D. (1971). Socially distant reference groups and consumer aspirations. *Journal of Marketing Research*, *16*(3).

Colen, S. (1986). "With respect and feelings": Voices of West Indian child care and domestic workers in New York City. In J.B. Cole (Ed.) *All American Women: Lives that Divide, Ties that Bind* (46-70). New York: Free Press.

Collins, P.H. (1990). *Black feminist thought: Knowledge, consciousness, & the politics of empowerment.* New York: Routledge.

Collins, P.H. (1994). Shifting the Center: Race, Class, and Feminist Theorizing about Motherhood. In E.N. Glenn, G. Chang, and L.R. Forcey (Eds.) *Mothering: Ideology, Experience, and Agency* (1-32). New York: Routledge.

Collins, P.H. (1998). Intersections of race, class, gender, and nation: Some implications for black family studies. *Journal of Comparative Family Studies*, 29(1), 27-36.

Connolly, D. (2000). Mythical Mothers and Dichotomies of Good and Evil: Homeless Mothers in the United States. In H. Ragone and F.W. Twine (Eds.), *Ideologies and Technologies of Motherhood* (263-294). New York: Routledge.

Conrad, P., & Leiter, V. (2004). Medicalization, markets and consumers. *Journal of Health and Social Behavior*, 45(Extra Issue), 158-176.

Cooey, P.M. (1999). "Ordinary mother" as oxymoron: the collusion of theology, theory, and politics in the undermining of mothers. In J.E. Hanigsberg and S. Ruddick (Eds.) *Mother troubles: Rethinking contemporary maternal dilemmas* (229-249). Boston: Beacon Press.

Crissey, S.R. (2005). Effect of pregnancy intention on child well-being and development: Combining retrospective reports of attitude and contraceptive use. *Population Research and Policy Review, 24*, 593-615.

Culley, L., Hudson, N., & Rapport, F. (2007). Using focus groups with minority ethnic communities: Researching infertility in British South Asian communities. *Qualitative Health Research*, *17*(1), 102-112.

Cussins, C. (1998). Producing reproduction: Techniques of normalization and naturalization in infertility clinics. In S. Franklin and H. Ragone (Eds.) *Reproducing reproduction: Kinship, power, and technological innovation*. Philadelphia: University of Pennsylvania Press.

Davidson, R., Kitzinger, J., & Hunt, K. (2006). The wealthy get healthy, the poor get poorly? Lay perceptions of health inequalities. *Social Science & Medicine*, 62, 2171-2182.

Dillaway, H., & Brubaker, S.J. (2006). Intersectionality and Childbirth: How women from different social locations discuss epidural use. *Race, Gender & Class*, 13(3/4), 16-42.

Donchin, A. (1996). Feminist critiques of new fertility technologies: Implications for social policy. *The Journal of Medicine & Philosophy*, 21, 475-498.

Donovan, C. (2008). "It's not really seen as an issue, you know, lesbian infertility it's
   kind of 'what's that?'": Lesbians' unsuccessful experiences of medicalised donor
   insemination. *Medical Sociology Online*, 3(1), 15-24.

Douglas, S.J., & Michaels, M.W. (2004). *The mommy myth: The idealization of
   motherhood and how it has undermined women*. New York: Free Press.

Dunlap, E., Sturzenhofecker, G., & Johnson, B. (2006). The elusive romance of
   motherhood: Drugs, gender, and reproduction in inner-city distressed households,
   Journal of Ethnicity in Substance Abuse, 5(3), 1-27.

Earle, S, and Letherby, G. (2003). Introducing Gender, Identity, and Reproduction. In S.
   Earle and G. Letherby (Eds.) *Gender, Identity & Reproduction: Social
   Perspectives* (1-12). New York: Palgrave Macmillan.

Edin, K., & Kefalas, M. (2005). *Promises I can keep: Why poor women put motherhood
   before marriage*. Berkeley: University of California Press.

Ehrenreich, B., & English, D. (1979). *For Her Own Good: 150 Years of the Experts'
   Advice to Women*. New York: Anchor Books.

Ellison, C.G., Boardman, J.D., Williams, D.R., & Jackson, J.S. (2001). Religious
   involvement, stress, and mental health: Findings from the 1995 Detroit Area
   Study. *Social Forces, 80*(1), 215-249.

Evans, D. (1995). Infertility and the NHS: Purchasers should avoid the moral high
   ground. *British Medical Journal, 311*, 1586-1587.

Feinberg, E., Larsen, F.W., Wah, R.M., Alvergo, R.J., and Armstrong, A.Y. (2007).
   Economics may not explain Hispanic underutilization of assisted reproductive
   technology services. *Fertility and Sterility, 88*(5).

Fineman, M.A. (1995). Images of mothers in poverty discourse. In M.A. Fineman and I. Karpin (Eds.) *Mothers in law: Feminist theory and the legal regulation of motherhood* (205-223). New York: Columbia University Press.

Fischer, R.C., Stanford, J.B., Jameson, P. and DeWitt, M.J. (1999). Exploring the concepts of intended, planned, and wanted pregnancy. *Journal of Family Practice, 48*(2).

Fisher, S. (1986). *In the Patient's Best Interest: Women and the Politics of Medical Decisions*. New Brunswick: Rutgers University Press.

Foucault, M. (1975). *Birth of the Clinic: An Archaeology of Medical Perception*. New York: Vintage.

Franklin, S. (1992) *Contested conceptions: A cultural account of assisted reproduction.* Unpublished doctoral dissertation, University of Birmingham, England.

Fraser, G.J. (1998). *African-American midwifery in the South: Dialogues of birth, race, and memor*y. Cambridge, MA: Harvard University Press.

Freidson, E. (1960). Client control and medical practice. *American Journal of Sociology, 65*(4).

Freidson E. (1972). *Profession of medicine*. New York: Dodd-Mead.

Frost, J.J., Singh, S., and Finer, L.B. (2007). Factors Associated with Contraceptive Use and Nonuse, United States, 2004. *Perspectives on Sexual and Reproductive Health, 39*(2).

Furstenberg, F.F. (1987). Race differences in teenage sexuality, pregnancy, and adolescent childbearing. *The Milbank Quarterly, 65*(2).

Gabriel, A, & McAnarney, ER. (1983). Parenthood in two subcultures: White, middle-
class couples and black, low-income adolescents in Rochester, New York.
Adolescence, 18(71), 595-608.

Ganong, L.H., and Coleman, M. (1995). The content of mother stereotypes. Sex Roles,
32(7/8), 495-512.

Geertz, C. (1973). *The Interpretation of Cultures*. New York: Basic Books.

Ginsburg, F., & Rapp, R. (1991). The politics of reproduction. *Annual Review of
Anthropology, 20*, 311-343.

Gipson, J.D., Koenig, M.A., and Hindin, M.J. (2008). The effects of unintended
pregnancy on infant, child, and parental health: A review of the literature. *Studies
in Family Planning, 39*(1).

Glenn, E.N. (1994). Social Constructions of Mothering: A Thematic Overview. In E.N.
Glenn, G. Chang, and L.R. Forcey (Eds.) *Mothering: Ideology, Experience, and
Agency* (1-32). New York: Routledge.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. New York:
Prentice-Hall.

Gordon, L. (2002). *The moral property of women: A history of birth control politics in
America*. Urbana: University of Illinois Press.

Green, J.A., Robins, J.C., Scheiber, M., Awadalla, S., & Thomas, M.A. (2001). Racial
and economic demographics of couples seeking infertility treatment. *American
Journal of Obstetrics and Gynecology*, *184*, 1080-1082.

Greil A.L. (1991). *Not yet pregnant: Infertile couples in contemporary America.* New
Brunswick: Rutgers University Press.

Greil, A.L. (1997). Infertility and psychological distress: A critical review of the literature. *Social Science & Medicine*, 45(11), 1679-1704.

Greil, A.L., Leitko, T.A., & Porter, K.L. (1988). Infertility: his and hers. *Gender & Society*, 2(2), 172-199.

Greil, A.L., and McQuillan, J. (2010). "Trying" times: Medicalization, intent, and ambiguity in the definition of infertility. *Medical Anthropology Quarterly, 24*(2).

Greil, A.L., Slauson-Blevins, K., and McQuillan J. (2010). The experience of infertility: A review of recent literature. *Sociology of Health & Illness*, 32(1), 1-23.

Gunaratnam, Y. (2009). What difference does our difference make in researching infertility?. In L. Culley, N. Hudson, and F. van Rooij (Eds.) *Marginalized reproduction: Ethnicity, infertility and reproductive technologies* (pp. 80-94). London: Earthscan Publishers.

Hardesty, M. and Black, T. (1999). Mothering through addiction: A survival strategy among Puerto Rican addicts. *Qualitative Health Research*, 9(5), 602-619.

Harding, D.J. (2007). Cultural context, sexual behavior, and romantic relationship s in disadvantaged neighborhoods. *American Sociological Review, 72*, 341-364.

Hasenfeld, Y. (1993). The nature of human service organizations. In Y. Hasenfeld (Ed.) *Human Services as Complex Organizations*. Newbury Park, CA: Sage Publications.

Hays, S. (1996). *The Cultural Contradictions of Motherhood*. New Haven: Yale University Press.

Heitman, E. (1995). Infertility as a public health problem: Why assisted reproductive technologies are not the answer. *Stanford Law & Policy Review*, 6, 89-102.

Hellerstedt, W.L., Pirie, P.L., Lando, H.A., Curry, S.J., McBride, C.M., Grothaus, L.C., and Nelson, J.C. (1998). Differences in preconceptional and prenatal behaviors in women with intended and unintended pregnancies. *American Journal of Public Health, 88*(4).

Henifin, M.S. (1993). New reproductive technologies: Equity and access to reproductive health care. *Journal of Social Issues*, 49(2), 61-74.

Hennessy, J. (2009). Morality and work-family conflict in the lives of poor and low-income women. *The Sociological Quarterly, 50*, 557-80.

Hill, S.A. (1994). Motherhood and the obfuscation of medical knowledge: The case of sickle cell disease. *Gender & Society*, 8(29), 29-47.

Hill, S.A. (2004). *Black intimacies: A gender perspective on families and relationships*. New York: Rowman & Littlefield Publishers.

Hill, S.A. (2009). Cultural images and the health of African American women. *Gender & Society*, 23(6), 733-46.

Hondagneau-Sotelo, P., & Avila, E. (1997). "I'm here, but I'm there": The meanings of Latina transnational motherhood. *Gender & Society, 11*(5), 548-571.

Huddleston, H.G., Cedars, M.I., Sohn, S.H., Giudice, L.C., Fujimoto, V.Y. (2010). Racial and ethnic disparities in reproductive endocrinology and infertility. *American Journal of Obstetrics & Gynecology, 202*(5).

Hyman, H.H. (1942). The psychology of status. *Archives of Psychology, 38(*269).

Ikemoto, LC (1996). The In/Fertile, the too fertile, and the dysfertile. *Hastings Law Journal*, 47(1007).

Inhorn, M., Ceballo, R., and Nachtigall, R. (2009). Marginalized, invisible, and
   unwanted: American minority struggles with infertility and assisted conception. In
   L. Culley, N. Hudson, and F. van Rooij (Eds.) *Marginalised Reproduction:
   Ethinicity, infertility and assisted conception*. Earthscan Publishers.

Jain, T. (2006). Socioeconomic and racial disparities among infertility patients seeking
   care. *Fertility & Sterility*, *85*(4), 876-881.

Jain, T., Harlow, B.L., & Hornstein, M.D. (2002). Insurance coverage and outcomes of in
   vitro fertilization. *New England Journal of Medicine*, *347*(9), 661-666.

Jain, T. & Hornstein, M.D. (2005). Disparities in access to infertility services in a state
   with mandated insurance coverage. *Fertility and Sterility*, 84(1), 221-223.

Jarrett, R.L. (1994). Living poor: Family life among single parent, African American
   women. *Social Problems, 41*(1).

Jarrett, R.L., Jefferson, S.R., and Kelly, J.N. (2010). Finding community in f*amily*:
   Neighborhood effects and African American kin networks. *Journal of
   Comparative Family Studies, 41*(3), 299-328.

Jones, SC, & Hunter, M. (1996). The influence of context and discourse on infertility
   experience. *Journal of Reproductive and Infant Psychology*, 14, 93-111.

Katz, P., Nachtigall, R., & Showstack, J. (2002). The economic impact of the assisted
   reproductive technologies. *Nature Cell Biology & Nature Medicine*, s29-s32.

Keeley, B., Wright, L., and Condit, C.M. (2009). Functions of health fatalism:
   Fatalistic talk as face saving, uncertainty management, stress relief and sense
   making. *Sociology of Health & Illness, 31*(5).

Kelley, H.H. (1947). Two functions of reference groups. In G.E. Swanson et al. (Eds.) *Readings in Social Psychology*, (pp. 410-414). New York: Holt, Rinehart & Winston.

King, L., & Meyer, M.H. (1997). The politics of reproductive benefits: U.S. insurance coverage of contraceptive and infertility treatments. *Gender & Society, 11*(1), 8-30.

Kirkman, M., & Rosenthal, D. (1999). Representations of reproductive technology in women's narratives of infertility. *Women & Health*, 29(2), 17-35.

Ladner, J.A. (1972). *Tomorrow's tomorrow: The Black woman*. Lincoln: University of Nebraska Press.

Lareau, A. (2003). *Unequal childhoods: Class, race, and family life*. Berkeley: University of California Press.

Lareau, A. (2008). Introduction: Taking stock of class. In A. Lareau and D. Conley (Eds.) *Social class: How does it work?*, (pp. 3-24). New York: Russell Sage Foundation.

Lazarus, E.S. (1994). What do women want?: Issues of choice, control, and class in pregnancy and childbirth, *Medical Anthropology Quarterly, 8*(1).

Lee, S. (2009). Racial and ethnic differences in women's retirement security. *Journal of Women, Politics & Policy, 30*(2-3), 141-172.

Letherby, G. (1994). Mother or not, mother or what? Problems of definition and identity. *Women's Studies International Forum*, 17(5), 525-532.

Letherby, G. (1999). Other than mother and mothers as others: The experience of motherhood and non-motherhood in relation to 'infertility' and 'involuntary childlessness'. *Women's Studies International Forum*, 22(3), 359-372.

Letherby, G. (2002). Challenging dominant discourses: identity and change and the experience of 'infertility' and 'involuntary childlessness.' *Journal of Gender Studies*, 11(3), 277-288.

Litt, J. (1997). American medicine and divided motherhood: Three case studies from the 1930s and 1940s. *The Sociological Quarterly*, *38*(2), 285-302.

Litt, J.S. (2000). *Medicalized motherhood: Perspectives from the lives of African-American and Jewish women*. New Brunswick, NJ: Rutgers University Press.

Lorber, J. (2002). *Gender and the Social Construction of Illness*. New York: Altamira Press.

Luker, K. (1996). *Dubious conceptions: The politics of teenage pregnancy*. Boston: Harvard University Press.

Luker, K. (2006). *When sex goes to school: Warring views on sex—and sex education—since the Sixties.* New York: W.W. Norton Press.

Lundquist, J.H., Budig, M.J, and Curtis, A. (2009). Race and childlessness in America, 1988-2002. *Journal of Marriage and Family*, 71.

Marsh, M., & Ronner, W. (1996). *The empty cradle: Infertility in America from colonial times to the present*. Baltimore: Johns Hopkins University Press.

Martin, E. (1987). *The Woman in the Body: A cultural analysis of reproduction*. Boston: Beacon Press.

Martin, E. (1990). The Ideology of Reproduction: The Reproduction of Ideology. In F. Ginsburg and A.L. Tsing (Eds.) *Uncertain Terms: Negotiating Gender in American Culture* (300-315). Boston: Beacon Press.

McCormack, K. (2005). Stratified reproduction and poor women's resistance. *Gender & Society, 19*(5), 660-679.

McDonough, P. M. (1997). *Choosing Colleges. How Social Class and Schools Structure Opportunity.* Albany, New York: State University of New York Press.

McIntosh, P. (2001) White privilege: unpacking the invisible knapsack. In Rothenberg, P.S. (ed.) *Race, Gender, Class in the United States: An Integrated Study*. New York: Worth Publisher.

McKenna, K.Y., and Bargh, J.A. (1998). Coming out in the age of the Internet: Identity "demarginalization" through virtual group participation. *Journal of Personality and Social Psychology, 75*(3).

McMahon, M. (1995). *Engendering motherhood: Identity and self-transformation in women's lives*. New York: Guilford Press.

Miall, C.E. (1985). Perceptions of informal sanctioning and the stigma of involuntary childlessness. *Deviant Behavior*, 6.

Michie, H., & Cahn, N.R. (1997). *Confinements: Fertility and infertility in contemporary culture*. New Brunswick, NJ: Rutgers University Press.

Molock. S.D. (1999). Racial, cultural and religious issues in infertility counseling. In L. Burns and A. Covington (Eds.) *Infertility counseling: A comprehensive handbook for clinicians* (151-159). New York: Parthenon.

Moos, M., Petersen, R., Meadows, K., Melvin, C.L., and Spitz, A.M. (1997). Pregnant women's perspectives on intendedness of pregnancy. *Women's Health Issues, 7*(6).

Mosher, W.D., & Aral, S.O. (1985). Factors related to infertility in the United States, 1965-1976. *Sexually Transmitted Diseases*, 117-123.

Nathanson, C. (1991). *Dangerous passage: The social control of sexuality in women's adolescence.* Philadelphia: Temple University Press.

Pargament, K.I., and Park, C.L. (1995). Merely a defense? The variety of religious means and ends. *Journal of Social Issues, 51*(2).

Parry, D.C. (2005). Women's experiences with infertility: The fluidity and conceptualizations of 'family.' *Qualitative Sociology*, *28*(3), 275-291.

Remennick, L (2000). Childless in the land of imperative motherhood: stigma and coping among infertile Israeli women. *Sex Roles*, 43(11/12), 821-840.

Rhodes, P.J. (1994). Race-of-interviewer effects: A brief comment. *Sociology*, *28*(2), 547-558.

Rich, A. (1977) *Of Woman born: Motherhood as experience and institution*. New York: Bantam Books.

Riessman, C.K. (1983). Women and medicalization: A new perspective. *Social Policy*, 3-18.

Riessman, C.K. (2000). Stigma and everyday resistance practices: Childless women in South India. *Gender & Society*, 14(1), 111-135.

Roberts, D. (1997). *Killing the black body: Race, reproduction, and the meaning of liberty*. New York: Pantheon Books.

Rothman, B.K. (1989). *Recreating Motherhood: Ideology and Technology in a Patriarchal Society*. New York: W.W. Norton & Company.

Ruddick, S. (1989). *Maternal thinking: Toward a politics of peace*. Boston: Beacon
Press.

Russo, N.F. (1976). The Motherhood Mandate. *The Journal of Social Issues, 32*(3), 143-
153.

Sandelowski, M.J. (1990). Failures of volition: Female agency and infertility in historical
perspective. *Signs: Journal of Women in Culture and Society*, *15*(3), 475-499.

Sandelowski, M (1991). Compelled to try: The never-enough quality of conceptive
technology. *Medical Anthropology Quarterly*, 5(1), 29-47.

Sandelowski, M. (1993). *With Child in Mind: Studies of the Personal Encounter with
Infertility*. Philadelphia: University of Pennsylvania Press.

Sandelowski, M., & de Lacey, S. (2002). The uses of a "disease": Infertility as rhetorical
vehicle. In M. Inhorn and F. van Balen (Eds.) *Infertility around the globe: New
thinking on childlessness, gender, and reproductive technologies* (pp. 33-51).
Berkeley: University of California Press.

Sandelowski, M., & Jones, L.C. (1986). Social exchanges of infertile women. *Issues in
Mental Health Nursing*, 8, 173-189.

Sawyer, L., Regev, H., Proctor, S., Nelson, M., Messias, D., Barnes, D., et al. (2007).
Matching versus cultural competence in research: Methodological considerations.
Research in Nursing & Health, *18*(6), 557-567.

Schmidt, L. (2007). Effects of infertility insurance mandates on fertility. *Journal of
Health Economics*, 26(3), 431-446.

Schneider, J.W. and Conrad, P. (1980). In the closet with illness: epilepsy, stigma
potential and information control. *Social Problems*, 28(1).

Schneider, J.W. and Conrad, P. (1983). *Having epilepsy: The experience and control of illness.* Philadelphia: Temple University Press.

Scritchfield, S.A. (1989). The infertility enterprise: IVF and the technological construction of reproductive impairments. *Research in the Sociology of Health Care*, *8*, 61-97.

Sewell, W.H. (1992). A theory of structure: Duality, agency, and transformation. *American Journal of Sociology, 98*, 1-29.

Shattuck, JC, and Schwarz, KK. (1991). Walking the line between feminism and infertility: Implications for nursing, medicine, and patient care. *Health Care Women International*, 12(3), 331-9.

Silva, S. and Machado, H. (2008). The diagnosis of infertility: patients' classification processes and feelings. *Medical Sociology Online*, 3(1), 4-14.

Smart, C. (1996). Deconstructing motherhood. In E.B. Silva (Ed.) *Good enough mothering?: Feminist perspectives on lone mothering* (37-57). New York: Routledge.

Snow, D.A., and Anderson, L.. (1987). Identity Work among the Homeless: The Verbal Construction and Avowal of Personal Identities. *American Journal of Sociology*, *92*, 1336-1371.

Sonfield, A., Kost, K., Gold, R.B., and Finer, L.B. (2011). The public costs of births resulting from unintended pregnancies: National and state-level estimates. *Perspectives on Sexual and Reproductive Health, 43*(2).

Spar, D. (2006). *The baby business: How money, science, and politics drive the commerce of conception*. Boston: Harvard Business School Press.

Stack, C. (1974). *All our kin: Strategies for survival in a black community*. New York:

Harper and Row.

Staniec, JFO, and Webb, NJ. (2007). Utilization of infertility services: How much does

money matter? *Health Services Research*, 42(3).

Steinberg, D. (1997). A most selective practice: The eugenic logics of IVF. *Women's*

Studies International Forum, 20(1), 33.

Thompson, C. (2005). *Making parents: The ontological choreography of*

reproductive technologies. Cambridge: MIT Press.

Thorburn, S. and Bogart, L.R. (2005). Conspiracy beliefs about birth control:

Barriers to pregnancy prevention among African Americans of reproductive

age. *Health Education & Behavior, 32*(4).

Thurer, S. (1994). *The myths of motherhood: How culture reinvents the good mother*.

Boston: Houghton Mifflin.

Trussell, J., Vaughan, B., and Stanford, J. (1999). Are all contraceptive failures

unintended pregnancies? Evidence from the 1995 National Survey of Family

Growth. *Family Planning Perspectives, 31*(5).

Turner, B.S. (1997). From governmentality to risk: Some reflections on Foucault's

contribution to medical sociology. In A. Petersen, & R. Bunton (Eds.), *Foucault,*

health and medicine (pp. x-xxi). New York: Routledge.

Ulrich, M. and Weatherall, A. (2000). Motherhood and infertility: Viewing motherhood

through the lens of infertility. *Feminism & Psychology*, 10(3), 323-336.

Webster, A. (2002). Innovative health technologies and the social: Redefining health,

medicine and the body. *Current Sociology*, 50(3).

Weingarten, K., Surrey, J.L., Garcia Coll, C., and Watkins, M. (1998). Introduction. In

      C. Garcia Coll, J.L. Surrey and K. Weingarten (Eds.) *Mothering against the odds:*

      Diverse voices of contemporary mothers (1-14). New York: The Guilford Press.

White, L., McQuillan, J., & Greil, A.L. (2006). Explaining disparities in treatment

      seeking: The case of infertility. *Fertility & Sterility*, *85*(4), 853-857.

Woodward, K. (2003). Representations of motherhood. In S. Earle and G. Letherby

      (Eds.) *Gender, Identity & Reproduction: Social Perspectives* (18-32). New York:

      Palgrave Macmillan.

World Health Organization. (1987). Infections, pregnancies, and infertility: Perspectives

      on prevention. *Fertility & Sterility*, *47*(6), 964-968.

Yang, M. & Yu, R. (2008). The interviewer effect when there is an education gap with

the

      respondent: Evidence from a survey on biotechnology in Taiwan. *Social Science*

      Research, *37*, 1321-1331.

Zadoroznyj, M. (1999). Social class, social selves and social control in childbirth.

      Sociology of Health & Illness, *21*(3), 267-289.